2012 Quality Program Evaluation

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1. EXECUTIVE SUMMARY

UCare is a high-performing, community and member-focused organization and is guided in all that it does by its values, mission and purpose for existence. The senior leadership of our enterprise consistently tests the organization by its alignment with these guiding principles and is committed to continuous improvement.

Our guiding principles are as follows:

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

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 give back to the communities through UCare grants and employee 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.

Statement of Business Purpose
UCare exists to provide comprehensive health care to selected populations through a community-based, holistic approach and to support family practice education and research so that this philosophy of care can be carried into the future.

UCare’s quality program is designed to support our mission by accomplishing the following goals:

- Establish effective partnerships with providers, primary care clinics and provider networks committed to quality care.
- Establish and monitor performance in key aspects of care and service.
- Improve clinical and functional outcomes for our members.
- Improve key business processes that result in better service and operational efficiencies.
- Meet or exceed quality standards set by government agencies.

An important component of UCare’s quality program is a written annual review and evaluation of the quality structure, processes and outcomes. This annual evaluation document constitutes
UCare’s 2012 Quality Program Evaluation and also serves as the foundation for the 2013 Quality Work Plan. It describes analysis for products offered by UCare Minnesota, in addition to the Medicare Advantage plans offered in Wisconsin by UCare Health, Inc.

In 2012, quality monitoring and program initiatives demonstrated many significant activities and outcomes. Although the Quality Program Evaluation will highlight all activities in detail, a few of this year’s highlights are outlined below:

A. CMS Health Plan Star Ratings

The Centers for Medicare and Medicaid Services (CMS) evaluates Medicare Advantage (MA) organizations based on the quality of care and services delivered to its beneficiaries. The Medicare Health Plan Quality and Performance Ratings program incorporates approximately 53 process and outcomes-oriented performance measures to assess the performance of MA plans. The “Overall Rating” is based on a composite of all program measures. CMS encourages beneficiaries to consider these results when choosing a benefit plan and displays overall plan rating on its Medicare.gov plan finder website.

CMS assigns each MA plan an overall rating based on a one to five star scale; with five stars representing the highest quality and one star representing the lowest quality. Each of the current 36 Part C and 17 Part D measures are assessed a star rating which are then combined for a summary Part C and Part D score as well as an Overall Plan Rating.

UCare Health Plan Quality and Performance Ratings
The following are the 2013 summary scores for UCare for Medicare and MSHO that were reported in late 2012.

<table>
<thead>
<tr>
<th>UCare</th>
<th>Summary Rating of Part C Health Plan Quality</th>
<th>Summary Rating of Part D Prescription Drug Plan Quality</th>
<th>Overall MA-PD Summary Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSHO</td>
<td>4 out of 5 stars</td>
<td>3.5 out of 5 stars</td>
<td>3.5 out of 5 stars</td>
</tr>
<tr>
<td>Medicare MN</td>
<td>4.5 out of 5 stars</td>
<td>4.5 out of 5 stars</td>
<td>4.5 out of 5 stars</td>
</tr>
<tr>
<td>Medicare WI</td>
<td>4.5 out of 5 stars</td>
<td>4.5 out of 5 stars</td>
<td>4.5 out of 5 stars</td>
</tr>
</tbody>
</table>

Health Plan Quality Opportunities for Improvement
UCare expended considerable resources in maintaining and improving the Star Ratings for 2013 and is pleased to report that UCare maintained a 4.5 Star summary rating for our Medicare Advantage products in Minnesota and Wisconsin. Unfortunately, our summary rating for the MSHO product dropped from a 4 to a 3.5 Star rating. A comprehensive improvement plan was initiated to prioritize and implement strategies designed to improve our rating within the individual measures. The Stars Program Manager ensures collaboration and communication between the Clinical Initiatives work team, the Pharmacy work team, the Data work team and the Steering Team. 2012 Star activities included member call campaigns, member mailings, additional supplemental data sources, care coordinator strategies, pay for performance programming and quarterly metric reporting.
B. HEDIS

HEDIS® (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. By product, UCare performed at or above the 2011 HEDIS National 75th Percentile for the following measures:

**UCare’s Performance by Product**

<table>
<thead>
<tr>
<th>UFS-MN/UFS-WI</th>
<th>MSHO</th>
<th>Medicaid Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment (MN and WI)</td>
<td>Adult Access: Age 65+</td>
<td>Childhood Immunizations: Combo 2; 3; 6</td>
</tr>
<tr>
<td>Antidepressant Medication Management</td>
<td>Adult BMI Assessment</td>
<td>Chlamydia Screening</td>
</tr>
<tr>
<td>Anti-Rheumatic Drug Treatment (MN and WI)</td>
<td>Care for Older Adults (COA): Advance Care Planning</td>
<td>Cholesterol Management: LDL Screening</td>
</tr>
<tr>
<td>Breast Cancer Screening (MN and WI)</td>
<td>COA: Functional Assessment</td>
<td>Comprehensive Diabetes Care (CDC): BP Control &lt; 140/90</td>
</tr>
<tr>
<td>Cholesterol Management: LDL &lt; 100 (MN and WI)</td>
<td>Comprehensive Diabetes Care (CDC): BP Control &lt; 140/90</td>
<td>CDC: Eye Exam</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (MN and WI)</td>
<td>CDC: Eye Exam</td>
<td>CDC: HbA1c Test</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC): BP Control &lt; 140/90 (MN and WI)</td>
<td>CDC: HbA1c Poor Control</td>
<td>CDC: HbA1c Control &lt; 8</td>
</tr>
<tr>
<td>CDC: Eye Exam</td>
<td>Glaucma Screening</td>
<td>CDC: HbA1c Poor Control</td>
</tr>
<tr>
<td>CDC: HbA1c Test (MN and WI)</td>
<td>Harmful Drug Disease Interactions</td>
<td>CDC: LDL Screening</td>
</tr>
<tr>
<td>CDC: HbA1c Control &lt; 8 (MN and WI)</td>
<td>High Risk Medications (1 and 2 Rx)</td>
<td>CDC: LDL &lt; 100</td>
</tr>
<tr>
<td>CDC: HbA1c Poor Control (MN and WI)</td>
<td>Monitoring Persistent Medications</td>
<td>Follow-up ADHD: Initiation</td>
</tr>
<tr>
<td>CDC: LDL Screening (MN and WI)</td>
<td>Pharmacotherapy Treatment for COPD: Corticosteroid and Bronchodilator</td>
<td>Lead Screenings</td>
</tr>
<tr>
<td>CDC: LDL &lt; 100 (MN and WI)</td>
<td>Monitoring Persistent</td>
<td></td>
</tr>
<tr>
<td>CDC: Monitoring Nephropathy (MN and WI)</td>
<td></td>
<td>Prenatal Care</td>
</tr>
<tr>
<td>Controlling High Blood Pressure (MN and WI)</td>
<td></td>
<td>Well Child Visits 3-6 years</td>
</tr>
</tbody>
</table>
During 2012, quality metric focused work groups, UCare’s Pay for Performance Program, provider education, care management, performance and quality improvement projects, member outreach and UCare-sponsored community events contributed to UCare’s overall performance. Work groups, programs and activities will continue in 2013.

C. HEALTH OUTCOMES SURVEY (HOS)

The Medicare Health Outcomes Survey (HOS) measures outcomes for the Medicare Advantage (MA) populations in managed care. The HOS survey assesses a health plan’s ability to maintain or improve the physical and mental health functioning of Medicare beneficiaries over a two-year period of time. The two-year period of time is considered a cohort. In general, physical health status as measured by the PCS (Physical Health Component Score) is expected to decline in older age groups, while mental health status as measured by the MCS (Mental Health Component Score) is not expected to decline in older age groups.

In 2012, Cohort 12’s survey measurement cycle was completed and results were reported. UFS-MN performed as expected when compared to the HOS national average for both the Physical and Mental Health Component scores. When comparing UCare to other Minnesota plans over the past four years, all health plans performed as expected on both the PCS and MCS with the exception of one health plan performing significantly better than expected on MCS. UFS-WI also performed as expected for both the PCS and MCS scores in Cohort 12 as did other Wisconsin plans. UCare received 4 stars for the physical health component and 2 stars for the mental health component.

In 2012, Quality Management, Clinical Services, Health Promotions, and the Stars Clinical Initiatives Workgroup implemented improvement strategies to address HOS Star measures. Initiatives included member call campaigns, educational brochures and newsletters. Activities will continue in 2013.
D. 2012 MN MANAGED HEALTH CARE PUBLIC PROGRAMS CAHPS® SURVEY

The Minnesota managed health care public programs Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is conducted annually for the Minnesota Department of Human Services (DHS) by a CAHPS survey vendor. The purpose of the survey is to assess and compare the satisfaction of enrollees in programs administered by DHS. The programs represented in this year’s surveys include five programs: Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MnCare), Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC).

Results from the survey were combined into Overall Satisfaction Ratings questions and Composite Score questions. In order to fairly compare managed care organizations with varying numbers of older or more ill members, survey results were adjusted for age and health status for all programs. Statistical testing of differences between health plans was based on these adjusted results.

Performance rates of Overall Rating Measures are described as the percent of members who gave a rating of 9 or 10, where 0 is the lowest possible rating and 10 is the best possible rating. Performance rates of Composite Measures are described as the percent of members who gave a rating of always. Highlights are described below:

- **PMAP**: Comparing 2012 to 2011 performance, UCare’s Customer Service rating improved significantly; although, UCare scored significantly lower than the PMAP plan average on Getting Care Quickly.
- **MnCare**: UCare scored significantly lower than the MnCare plan average on Getting Needed Care.
- **MSHO**: UCare scored significantly lower than the MSHO plan average on Getting Care Quickly and Customer Service.
- **MSC+**: Comparing 2012 to 2011 performance, UCare’s Getting Needed Care and Getting Care Quickly rating improved significantly.
- **SNBC**: UCare scored significantly lower than the SNBC plan average on Getting Needed Care and Overall Rating of Health Plan.

While UCare made improvements in 2012, opportunities for improvement remain. During 2012, several workgroups conducted surveying and analytical projects to better understand the needs of UCare’s SPP membership. Key findings will drive improvement activities during 2013.

E. CMS CAHPS® 2012 SURVEY

Annually, the Centers for Medicare & Medicaid Services (CMS) collect information about Medicare beneficiaries’ experiences with Medicare Advantage (MA) plans via the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS survey has three primary goals: to provide Medicare beneficiaries with information to help them make more informed choices among health plans; to help MA plans identify problems and improve the quality of care and services by providing them with information about their performance relative to that of other health plans; and to enhance CMS’ ability to monitor the quality of care and
performance of MA plans. Individual survey questions are combined to form six Composite Measures. Highlights are described below:

- UFS-MN scored significantly higher than the national average on the following measures: *Overall Rating of Health Care, Overall Rating of Health Plan, Getting Care Quickly, Customer Service and Coordination of Care*. UCare’s *Drug Coverage* rating was significantly lower than the national average.
- UFS-WI scored significantly higher than the national average on the following measures: *Getting Needed Prescription Drugs and How Well Doctors Communicate*. UCare scored significantly lower than the national average on the following two measures: Rating of *Drug Coverage* and *Willingness to Recommend Plan for Drug Coverage*.
- MSHO scored significantly higher than the national average on the following measures: *Overall Rating of Health Care, Overall Rating of Health Plan, Rating of Personal Doctor, Rating of Specialist, Getting Care Quickly, Coordination of Care and How Well Doctors Communicate*. No measures scored significantly lower than the national average.

During the fourth quarter of 2012, UCare began an in-depth member satisfaction analysis project focused on 4 years of MSHO data. Key findings will drive improvement activities during 2013.

### F. Medical Records Standards Audit

In 2012, UCare conducted various activities to assess compliance across UCare’s network with the UCare Policy QPI002 *Member Medical Record Requirements for Providers*. The Provider Network Management Site Survey and, the Quality Management Advance Directive Audit and Medical Records Standards Audit were conducted. The network was found to be in adequate compliance.

Site visits were conducted for 352 contracted primary care clinics and high volume OB/GYN clinics. All provider sites were compliant based on procedure PNM-0107.

In 2012, the Quality Management Department randomly selected 2200 primary care medical records for the Advance Directive Audit as part of the HEDIS 2011 audit (on 2010 records). The overall compliance rate for the clinics audited was 24.7%, an improvement of 8.6 percentage points comparing 2012 to 2011 results.

In 2012, the Quality Management Department randomly selected 241 primary care medical records for the Medical Records Standards Audit as part of HEDIS 2012 (on 2011 records). The average compliance rate was 31%. Due to the results of the 2012 audit, there was concern about the HEDIS vendor’s performance while conducting the medical record standards audit. During 2013, IRR (Inter-Rater Reliability) protocols have been adopted to ensure the integrity of audit findings. Also, UCare’s audit tool has become more detailed in hopes that the results will better direct provider improvement efforts.
G. CLINICAL PRACTICE GUIDELINES

UCare adopts and utilizes clinical practice guidelines to enhance patient and professional decision-making, to improve health care outcomes, and to meet federal and state contractual requirements. Clinical practice guidelines are designed to assist clinicians by providing a framework for the evaluation and treatment of patients. Clinical practice guidelines are not intended to replace a clinician’s judgment or to establish a protocol for all patients with a particular condition.

The preferred source for UCare’s Clinical Practice Guidelines is the Institute for Clinical Systems Improvement (ICSI) Health Care Guidelines, when available for a given topic. UCare has adopted preventive and chronic disease practice guidelines appropriate for children, adolescents, adults of various age groups including one for members sixty-five years of age and older, pregnant women, and members with disabilities.

Current practice guidelines include: Preventive Services for Adults; Preventive Services for Children and Adolescents; Diabetes, Type 2 Diagnosis and Management; Asthma, Diagnosis and Management; Prenatal Care, Routine; and Obesity, Prevention and Management. In 2013, UCare will continue to monitor provider clinical practice guideline audit results for trending to look for further opportunities for improvements.

H. SPECIAL HEALTH CARE NEEDS (SHCN)

The identification and management of members with Special Health Care Needs (SHCN) is an integral part of the medical management of UCare members. UCare follows the DHS contract requirements regarding SHCN. The purpose of the program is to improve care for members with special health care needs. The intent of the program is to identify persons with special health care needs, to assist identified members with access to care, and to monitor their treatment plan. All MHCP members are eligible for case management through this program. Additionally, UCare considers all MSHO, and MSC+ members to have special health care needs and they are assigned an individual care coordinator for ongoing case management.

UCare identifies adults and pediatrics members with special health care needs by regularly analyzing claims data for specific diagnoses and utilization patterns as well as through screenings, requests for services, and other mechanisms or "triggers." UCare has established monthly, quarterly and year to date monitoring reports. The monthly report consists of a rolling 13 months. The report includes:

SHCN - Adults:
- Acute inpatient claims of eligible members who are over the age of 18 and who have one of the following conditions as the primary admission reason to acute care: bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension or chronic pulmonary disease.
- Hospital emergency department utilization.
- Acute inpatient admissions for diagnoses such as multiple traumas.
- Acute hospital readmission within 14 days for the same or similar diagnosis.
• Individual member whose claims reach $100,000 at any point during the year.

SHCN - Pediatrics:
• Members who are between the ages of 0 to 17 that had ER visits for the following specific diagnoses as their primary diagnosis: otitis media, upper respiratory infection (URI), fever, gastrointestinal (GI) and traumatic injury.
• Hospital emergency department utilization of 2 or more visits for any diagnosis.
• Hospital admissions for members who are greater than seven days old to 17 years old for any admit.
• Hospital readmission within 14 days of discharge for same or similar diagnosis
• Individual member whose claims reach $50,000 at any point during the year.

Members with special health care needs are screened for case management, disease management, or referral to specialists, county services or other services that may assist the member. Members who may potentially benefit from case management are assessed to determine their needs and the case manager collaboratively develops a plan of care with the member. UCare members have direct access to specialists in the network.

Note:
Change in procedure was effective with 2012 data (for 2011) and going forward.

Membership increased year over year by 44%.

Analysis - Adults

Total Prevention Quality Indicators: The number of members identified under the category of total prevention quality indicators decreased by 11% in 2012 compared to 2011 based on members/1000. The number of actual members flagged for the following conditions increased:
- Adult Asthma
- COPD
- Dehydration
- Urinary Tract Infection
- Hypertension

The other prevention indicators showed a reduction in actual members identified with Bacterial Pneumonia by 8%, and Congestive Heart Failure by 11% over the previous year.

Hospital Emergency Room (ER) Utilization: ER visit per member is 3.60 for 2012 compared to 3.37 for 2011. Members with 2 ER visits continue to have the highest ER utilization. The top 5 diagnoses were abdominal pain, back/spine pain, headache, dental disorder and chest pain. In addition, UCare has also focused on providing short-term, intensive case management for members that utilized ER services for ambulatory sensitive conditions such as general abdominal pain, asthma, sprain/strain, headache, and pain.

Inpatient Utilization Stay for select diagnoses decreased by 18% based on members/1000. Actual members identified increased by 35 members year over year. Increases were seen in:
– Adult Asthma
– Chronic Obstructive Pulmonary Disease (COPD)
– Diabetes

UCare monitors inpatient stays and readmission rates with a primary diagnosis of HF. Both inpatient stays and readmissions continue to decrease for members in our heart failure programs.

Hospital Readmission within 14 days for a similar diagnosis decreased by 6% year over year based on members/1000. Out of 184 members in 2012, 55 members had a mental health or chemical dependency diagnosis compared to 48 members in 2011.

Paid claims exceeding $100,000 consists of members’ claims totaling $100,000 or more year to date. This category includes both medical and pharmacy claims. The number of members accounting for this spend is 98 members in 2012 and 56 members in 2011. Several of these members had high pharmacy costs which included costs associated with heart failure, chemotherapy, and multiple trauma cases.

Home care services: Overall, members/1000 increased by 17% over last year.

Inpatient length of stay exceeding 7 days: increased by 46 members from the previous year. Overall, members/1000 decreased by 24% year over year.

Multiple traumas include three or more different trauma diagnosis codes for the same claim. There were 31 members with multiple traumas in 2012 compared to 25 members in 2011. Overall, members/1000 decreased 15% over the previous year. The majority of these cases are related to motor vehicle accidents or catastrophic events.

Analysis – Pediatrics

Total Prevention Quality Indicators: The number of members identified under the category of total prevention quality indicators had minimal change of 0.4% year over year based on members/1000.

Hospital Emergency Room (ER) Utilization for specific diagnoses increased by 2% based on members/1000.

Hospital Emergency Room (ER) Utilization (2 or more) increased by 2,869 members. Members with 2 ER visits continue to have the highest ER utilization in 2012 and 2011. The top 5 diagnoses were fever, acute upper respiratory infection, otitis media, pneumonia and asthma.

Hospital Readmission within 14 days for a similar diagnosis: Members/1000 decreased by 24% year over year.

Paid claims exceeding $50,000 consists of member claims totaling $50,000 or more year to date. This category includes both medical and pharmacy claims. The number of members
accounting for this spend is 252 members in 2012 and 159 members in 2011. Several diagnoses associated with high dollar costs were chemotherapy, cardiomyopathy, respiratory failure, feeding problems and skin anomaly.

**Inpatient length stay exceeding 7 days** increased by 26% based on members/1000 year over year. Members increased by 202 over last year.

**Barrier Identification**
UCare has identified the single most significant barrier in assisting members in this population is being able to reach the member. Greater than 50% of member telephone numbers and/or addresses listed at enrollment are no longer in service, or the member has moved without leaving their forwarding address. Other barriers identified include member refusal to participate in case management services, and difficulty changing member behavior such as use of a primary care clinic versus presenting to a hospital emergency department for ambulatory sensitive conditions or other conditions that could be managed at the primary care or urgent care level.

**Plans for 2013**
- UCare will continue to monitor MHCP members for the above clinical and utilization triggers. This activity will continue in 2013 with quarterly reports reviewed by clinical leadership.
- UCare will continue case management of this population. UCare uses the Minnesota Restricted Recipient Program, as appropriate and a Transition Management program for MHCP members with multiple hospital admissions, particularly with chronic conditions.
- UCare will continue the ER avoidance program for members with special health care needs that have multiple ER visits per quarter. This is a telephonic outreach program aimed at supporting members in utilizing appropriate levels of health care, such as primary care or urgent care for ambulatory sensitive conditions like infections. UCare will continue to case manage members with special health care needs between the ages of 7 days - 17 yrs old. UCare has established monthly monitoring reports. The report identifies members whose claims reaches $50,000 at any point during the year, members with 2 or more ER visits, hospital admits, readmits and inpatient stay with 7 or more days.

**I. Over-and-Under Utilization**
The Medical Management Council (MMC) provides oversight and direction to improve utilization of appropriate medical care to reduce the cost of medical services for members. The MMC ensures that utilization management activities align with the strategic objectives of the organization. The MMC ensures that utilization initiatives are implemented, evaluated, monitored, and reviewed for effectiveness and expanded or modified as appropriate.

Delegated entities present their utilization management plans and/or initiatives to the MMC. This allows for consistent monitoring and review of over and under utilization.
Monitoring both the over and under utilization of resources occurs through a variety of mechanisms and at different times in the care delivery process. As contractually required by DHS, the MMC selects the utilization data types each year to monitor for over or under utilization, e.g., inpatient utilization, emergency room utilization, pharmacy utilization and behavioral health services utilization. Pursuant to the DHS contracts, one of the data types must be related to behavioral health.

Monthly analysis of the Special Health Care Needs reports is another mechanism used to detect undesirable utilization patterns. Trends in activity are analyzed and, if any areas are outside of the calculated control limits, additional data may be pulled for further review. In addition, the MMC may conduct ad hoc studies on particular services that may be over or under utilized.

**2012 Activities**

The following utilization data types were selected for over and under-utilization monitoring in 2012:

- Inpatient hospital utilization.
- Emergency room utilization.
- Generic drug dispensing.
- Long term psychotropic medication use and behavioral health provider visits.

All of the above utilization data types remained within internal threshold limits for over and under utilization in 2012.

Also reviewed in 2012 on an ad hoc basis were the following utilization types: dental, chiropractic, spine surgery, atypical antipsychotic medication usage in children, therapies (PT, OT, and ST) and swing bed utilization. Various strategies and interventions were implemented dependent on the service type. As an example, for therapy services, UCare contracted with a therapies utilization review vendor to provide prior authorization services. In addition, the prior authorization threshold was changed from 9 visits to 3 visits prior to requiring plan authorization. This resulted in both a lower utilization rate and cost savings. A study of swing bed utilization was completed and an intensive utilization review process was initiated as a pilot in April 2012 in a select service area. The goal was to ensure members received care at the most appropriate level and setting. Through the pilot, ~50% of requested swing bed admissions were redirected and resulted in a discharge to home, ~40% were redirected to a skilled nursing facility, and the remaining members were admitted to a swing bed stay.

**Plans for 2013**

- UCare will continue with inpatient hospital utilization, emergency room utilization, and generic drug dispensing as over and under utilization types for monitoring in 2013.
- In addition, UCare has selected a new under utilization measure for 2013 focusing on effective medication management of antidepressants.
- UCare will also continue to study and will implement a family intervention for children with over utilization of ADHS and antipsychotic medications.
- UCare will expand the service area for the swing bed intensive utilization approach.
Emergency Room Utilization 2012
The tracking of emergency room utilization over time is an important measure that UCare uses to identify high level medical trends. Emergency room utilization is a key indicator that would drive further analysis, particularly if there is an unexpected material deviation from prior utilization levels.

Measurement:
UCare uses claims data identified as ER visits to calculate an “ER visits per 1,000 members” metric by month. The monthly numbers are graphed with a trailing 18 months using at least three months of lag time to ensure proper claim run-out.

Analysis:
- PMAP: Utilization is remains fairly stable and appears to be trending slightly downward. The utilization remains within the bounds of the upper and lower thresholds. UCare anticipated some increase in the number due to the influx of new members from the early Medicaid expansion in 2012.
- MnCare: Utilization within this population has demonstrated more variation than the PMAP population; however, we began to see a downward trend in 2011 and that trend continued in 2012. We did expect to see utilization trending downward in the product due to the shift of adults without children into the PMAP product due to early Medicaid expansion. The ER utilization measure remains within the upper and lower thresholds.
- MSHO: Utilization is remaining fairly stable. Some upward trend in 2011 and the beginning of 2012 is noted; however that trend appears to have stabilizes.

Plans for 2013:
- UCare will continue to monitor utilization trends in the coming year through the Medical Management Council and will create an ad hoc action group if upper or lower thresholds are exceeded more than three consecutive months.
- UCare will continue several strategies/interventions to reduce avoidable ER visits related to the state ER utilization withhold. These include a telephonic ER Avoidance program which educates members on the continuum of care with an emphasis on primary care; a targeted health coaching program, and robust review for inclusion in the Minnesota Restricted Recipient Program.

Inpatient Admissions Utilization 2012
The tracking of inpatient hospital admissions utilization over time is another important measure UCare uses to identify high-level medical trends. Inpatient hospital utilization is a key indicator that would drive further analysis if we observe a material deviation from historical utilization levels and/or a material deviation from projected utilization levels. UCare uses authorized hospital admission data, because the data is mostly complete within 15 days following the end of the month as opposed to actual claim information which can take several months to be fully completed.
Measurement:
UCare uses authorized inpatient admission data to calculate a “monthly admits per 1,000 members” metric.

Analysis:
- **PMAP**: Utilization is trending very close to the experience of the past two years while being slightly below the projected utilization. There are no unusual utilization spikes upward or downward.
- **MnCare**: Utilization in this product was projected to drop significantly starting in July 2011 due to the early Medicaid expansion transitioning adults into the Medicaid (PMAP) products. The utilization rates for members in transition from MnCare to PMAP tends to be higher than the remaining population, lowering the overall average.
- **MSHO**: Utilization trended slightly lower than the past two years of experience while being below the projected utilization in the second half of the year. There were no unusual utilization spikes upward or downward.
- **SNBC (UCare Connect)**: 2012 hospital utilization in this product has stabilized significantly when compared to past years. This is mainly due to the fact that the population size grew significantly in 2012, making the measurement more stable and credible. UCare did not experience any significant spikes up or down in 2012 while the overall utilization is lower when compared to prior years primarily due to the healthier characteristics of the newly enrolled population.

Plans for 2013:
- UCare will continue to monitor utilization trends in the coming year through the Medical Management Council and will create an ad hoc action group if there is significant variation.
- UCare monitors trends and will implement strategies to reduce admission utilization related to the State of Minnesota’s admission and readmission utilization withhold.

Pharmacy Utilization 2012

Measurement:
Using historical pharmacy data, control charts were constructed for generic utilization across products. Generic utilization is defined as the percentage of all prescriptions where the actual product dispensed by the pharmacy was available as a generic equivalent to a branded drug. Mean rates were calculated and upper and lower threshold rates were established.

Analysis:
Generic utilization across products is at or above the upper threshold limits across all UCare product lines. While overall generic utilization continues to increase throughout Minnesota and the nation, UCare is one of the highest performing plans nationwide. During 2012 a significant number of highly utilized medications became available generically. These included Lexapro, Seroquel, Plavix, Diovan, Singular, Actos, and Provigil. Due to our philosophy of promoting generic drug use when possible, benefit design structure of relatively lower member out-of-pocket costs for generics, and numerous utilization
management tools at point-of-service (step edits, prior authorizations), we will continue to treat more members at lower cost.

**Plans for 2013:**

- For 2013, the Pharmacy department will continue in its efforts to aggressively promote generic utilization.
- Although 2013 appears to have minimal opportunities for new generic introduction, except for Cymbalta, the introduction of a two-tiered generic benefit design in Medicare products should continue to increase member and provider awareness and use of generics.

**Behavioral Health Utilization 2012**

The identification and management of members receiving treatment for symptoms of mental illness is an important component of the medical management of UCare members. The purpose of the program is to identify opportunities to improve care for members receiving pharmacological treatment for symptoms of mental illness.

UCare identifies members through analyzing medical and pharmacy claims data for specific psychotropic medication and visits with a mental health professional. The report includes:

- Presence of psychotropic prescription
- Appointment with a psychiatrist, psychologist, therapist, or other mental health professional
- Product type

Most psychotropic medication is prescribed in primary care settings. For milder and/or stable mental health conditions this treatment setting is adequate and frequently is the preferred setting by the member. Members experiencing severe symptoms that substantially interfere with their daily activities or whose illness is unstable may benefit from screening by a behavioral health care manager to determine if their needs are being adequately met and to develop a collaborative plan of care with the members. UCare members have direct access to specialists in the network.

**Analysis:**

The current reporting period from January of 2011 to June of 2012 demonstrated marked improvement across all UCare products in the percentage of adults who received psychotropic drugs and saw a mental health professional. Keeping with previous trends, this percentage varied widely across products and seniors exhibited a significantly lower number of mental health professional visits compared to members enrolled in Medical Assistance (PMAP) or Minnesota Care (MnCare). PMAP and MnCare members achieved higher numbers in the face of rising enrollment, while senior mental health visits significantly outperformed the previous two year mean during a period of steady enrollment. Limitations in the dataset include a lack of diagnosis linked to psychotropic drug prescription, the severity of mental health symptoms and whether the illness is in an acute or unstable phase. Given the nature of mental illness, this information will be important in determining the course of treatment, whether a psychotropic prescription is appropriate, and whether a visit with a mental health professional is necessary.
Plans for 2013:
UCare has elected to discontinue the data collection and monitoring of mental health visits for members on psychotropic medication. Data limitations highlighted above and ongoing questions in interpreting results call into question the value of continuing this measure.

Moving forward UCare will look to track Antidepressant Medication Management (effective acute phase) in an adult population. Major depression is considered to be a serious medical illness and affects an estimated 20.9 million American adults each year. Without thorough assessment and adherence to treatment plans, symptoms associated with major depression may last for years, leading to personal productivity losses, economic losses, exacerbation of chronic conditions, or may eventually lead to death by suicide or other causes.

Antidepressant Medication Management is a measure used to assess the percentage of members 18 years of age or older who were diagnosed with a new episode of depression and treated with antidepressant medication. Effective acute phase antidepressant medication management requires a sufficient number of prescriptions to allow for 84 days of continuous therapy. To qualify as a new diagnosis, two conditions must be met: One, a 120-day negative diagnosis of depression on or before the start date, and two, a 90-day negative medication history on or before the start date. UCare Behavioral Health sees this measure as an opportunity to use mental health data combined with pharmacy records to identify members with suboptimal depression medication management, thus targeting these patients for more robust care.

Activities:
Most ADHD and Antipsychotic medication for children is prescribed in primary care settings. The use of these medications has continued to rise, along with questions about appropriate dosing levels. In 2010 DHS convened a Drug Thresholds Workgroup to establish thresholds for various drugs by age groups. The workgroup also discussed 1) off-label prescribing and whether there should be a diagnosis on the prescription claim; 2) use of multiple drugs of dose forms within a drug class; 3) how to better ensure that monitoring occurs for medical issues such as metabolic risk associated with atypical antipsychotics. The group recommended and the Department funded a mandatory consultation service for prescribers of medications that exceeded thresholds.

DHS contracted with Mental Health Integration and Transformation (MhINT), a consortium of regional mental health providers - that includes Mayo Clinic Prairie Care, Sanford Health, and Essentia in 2011 to provide psychiatric consultation to primary care providers, pediatricians, psychiatrists, and other mental health professionals who prescribe ADHD and Antipsychotic medications for children. Although the target population is children between the ages of 2-17 years on MA fee-for-service that exceed medication thresholds established by the DHS Drug Thresholds Workgroup, any prescriber can access this consultation service. Their services include outreach, support, training, triage-level assessment, assistance in identifying referral sources to other services as appropriate, mandatory consultations for prescriptions that exceed certain thresholds for children, and voluntary consultations to improve collaboration between primary care and behavioral health. This consultation service
is expected to lead to better health outcomes for young patients with mental health concerns and lower health care costs for the state.

**Analysis:**
UCare used the DHS defined framework to conduct a study of members who exceed the threshold for ADHD and Antipsychotic medications according to the DHS Drug Thresholds Workgroup. The target population is children 17 and under who are prescribed medications that exceed the established thresholds by age and dosage level. The data was reviewed regularly to determine which children moved in and out of the target population because of a refill pattern vs. those who were consistently receiving medication above the thresholds.

**Plans for 2013:**
To gain further understanding of this phenomenon and design future interventions for these members UCare will provide dedicated resources including:

- BH project specialist will contact each member and/or member family to discuss current needs and share resources including the consultation service.
- Providing educational materials about the disorder, ADHD and Antipsychotic medication, information about mental health services, service providers, and treatment for children and adolescents to support their ability to cope with the disease.
- Gathering information, looking for trends, and beginning to develop recommendations within year one.

**J. DELEGATED BUSINESS SERVICES**

UCare delegates several member-related functions to outside entities through a contracting process. UCare currently delegates chiropractic services to Chiropractic Care of Minnesota, Inc. (ChiroCare), dental services to DentaQuest, and behavioral health services to Behavioral Healthcare Providers (BHP) and MMSI. All of the services delegated to these entities on behalf of UCare members are outlined in contracts that are reviewed on an annual basis. In addition, there are several value-added functions and/or programs provided by DentaQuest and Behavioral Healthcare Providers (BHP) on behalf of UCare and its members. These value-added components of the delegation relationship are described in greater detail in the body of the Program Evaluation.

**Delegated Enterprise Results for 2012**
UCare also conducts annual audits of the services described below to ensure that contractual obligations are being met. The auditing and reporting functions are described in greater detail within the body of the Program Evaluation.

**ChiroCare**
ChiroCare was found to be compliant during its review for utilization management, claims administration, credentialing and network access and availability. The review revealed five areas of improvements within its Compliance Program and Fraud, Waste and Abuse: update policies and procedures to incorporate new CMS Medicare Managed Care Manual Chapter 21 requirements; update policies and procedures to incorporate Minnesota’s state programs 24-hour
fraud reporting requirement; develop and implement a scheduled review of its Compliance Program; submit developed monthly process for checking exclusions list; and, revise fraud and abuse investigation Case Summary or otherwise update procedures to ensure case details are documented as part of the case file.

**DentaQuest**
The 2012 review revealed five areas of non-compliance (claims administration, data analytics, Complaints, Appeals and Grievances, Compliance-FWA and utilization management). The five areas of non-compliance required the implementation of corrective action plans.

**BHP**
The 2012 review revealed one area of non-compliance (compliance program) that required a corrective action plan addressing the following areas: develop and submit a process for checking the exclusions list monthly for employees including governing body and FDRs (First Tier, Downstream and Related Entities); provide training documentation for FDRs; and, implement a process for conducting risk assessments or ensure their operational activities are included in Fairview Health System’s risk assessments.

**K. ACCESS AND AVAILABILITY**

UCare is committed to providing access to and availability of quality health care for its membership. The purpose of our access and availability monitoring efforts is to ensure that members can obtain needed care without undue difficulty. Goals include ensuring that providers are meeting access standards as set out in state and federal contracts and that our network of providers is sufficient to meet the needs of our members.

UCare performed a thorough accessibility analysis on the provider network. The initial analysis included both plot point maps and radii maps showing 30- and 60-mile perimeters for the following provider types:

- Primary Care
- Geriatrics
- Gastroenterology
- Nephrology
- Hospitals
- Oncology
- Internal Medicine
- OB/GYN
- General Surgery
- Urology
- Home Care
- Dermatology
- Pediatrics
- Endocrinology
- Rheumatology
- Oral Surgery
- Audiology
- Cardiology

A secondary analysis with the Delegated Business Services department focused on the provider networks for:

- Dental Care
- Chiropractic Care
- Pharmacy Network
- Behavioral Health

Measures of success include provider-to-member ratios and distance/travel time to providers.

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1 Primary care providers, mental health providers, and hospitals must be no more than 30 miles distance or 30 minutes travel time between provider location and member residence. All other health services, including ancillary providers, and specialty hospitals and practitioners, must not be more than 60 miles travel distance or 60 minutes travel time between provider location and member residence.
Final deliverables include a network analysis book for MSHP (Minnesota Health Care Programs), UCare for Seniors, UCare Connect, and the MSHO products. Membership enrollment data is used for each product.

GeoNetwork® mapping and health service delivery (HSD) tables are developed for UCare expansion activities. The appropriate state and federal governmental bodies have approved the UCare network and deemed it adequate to meet the access and availability standards.

Access to Behavioral Health Services
Overall access to behavioral health services increased in 2012 for mental health and chemical dependency treatment services. UCare continues to promote the use of telemedicine as one way to address the shortage of psychiatrists. In addition, UCare supported a multi-county effort to create a virtual crisis-assistance system that has as its hallmark the utilizing of medical prescribers connected to regional emergency department (ED) centers to assist in consulting and evaluating members who “show up” in the ED with behavioral health issues.

Access to Chiropractic Services (ChiroCare)
A chiropractic network was delivered that met all defined access requirements, offering Medicare members access to a contracted chiropractor at an average distance of 2.4 miles, and Medicaid members an average of 2.0 miles. Acupuncture services rendered by chiropractors was added as covered services effective 1/1/12, so the online search tool was enhanced to recognize acupuncture certified chiropractors. The annual UCare network access report was adjusted to quarterly in order to help ensure any network or membership changes are addressed in a timely manner. New credentialing and re-credentialing procedures were implemented to include a review of the clinic name associated with any applicant, to ensure clinic names are reported in a consistent manner for providers. Procedures related to license renewals were adjusted to ensure only active licensed providers are reported as contracted.

Access to Dental Services (DentaQuest)
A dental network was delivered that met a high percentage of all defined regulatory requirements. Areas without provider access within prescribed distances generally are rural areas where the community standard is to travel to larger centers of population for services.

Pharmacy Network
Although Walgreens was removed from the Express Scripts Inc. (UCare’s Pharmacy Benefit Manager (PBM)) network effective 1/1/12, access standards continue to be met. 89.2% of UCare State Public Program members are within 5 miles of a network pharmacy. The average distance for members not meeting the 5 mile radius was 9.4 miles with the farthest distance being 29.4 miles in Tofte.

For 2012, a compound pharmacy network was created to better serve our members. This network allows UCare and our members know which pharmacies are able to provide compound prescriptions and the type of compounds that can be provided. As a result, members have better access to compounded prescriptions and, for Medicare members, it minimizes the need for UCare members to pay cash to an out-of-network provider and then submit a paper claim for reimbursement.
Curascript continues to be UCare’s preferred specialty pharmacy, providing access to specialty drugs 24 hours a day, 365 days a year.

**L. DHS VOLUNTARY DISENROLLMENT SURVEY (DISENROLLMENT IN 2011)**

The results presented in this report are from enrollees who changed health plans in calendar year 2011. DHS uses voluntary disenrollment information along with other quality measures to monitor the performance of plans. The MCOs are expected to integrate this information with other health plan quality information to guide improvement of care and services to members. DHS expects voluntary disenrollment rates to remain below the 5% threshold for MCOs.

PMAP has the lowest disenrollment rates over the past four years. In 2011, all programs were below DHS’ five percent voluntary disenrollment threshold.

In 2011, the overall SNBC voluntary disenrollment rate was very low for all MCOs. UCare had 58 SNBC members who voluntarily disenrolled in 2010 compared to only 1 in 2011. However, UCare’s SNBC enrollment increased 300% from 2010 (556 members) to 2011 (2,276 members).
M. MEMBER SAFETY

UCare has programs, initiatives and processes that support the overall safety of our members. Member safety is a collaborative effort between Clinical Services, Quality Management, Pharmacy, Provider Enrollment, Health Promotion, the Quality Improvement Advisory and Credentialing Committee, the Pharmacy and Therapeutics Committee and the Quality Council. All programs and initiatives in these areas are reviewed to ensure member safety is promoted and incorporated into projects prior to implementation. Key member safety programs, initiatives and processes are highlighted below. Member safety is described in greater detail within the body of the Program Evaluation.

Quality of Care
Quality of Care (QOC) concerns are situations where the reporter indicated that the quality of clinical care or quality of service did, or potentially could have, adversely affected a member’s health or well-being. Potential clinical Quality of Care (QOC) cases may be identified and reported internally by any UCare staff, including Member Services, Quality Management, Clinical Services, or externally by members or their representatives, delegated entities, regulatory agencies, or providers. UCare staff identifies potential QOC grievances when talking with members or their representatives. The internal discovery of a QOC concern is documented and submitted to Complaints, Appeals, and Grievances (CAG) within two business days of discovery.

High Risk Drugs
The Pharmacy and Therapeutics Committee assists UCare in the management of its drug benefits. The committee ensures that the UCare drug formulary is based on the best evidence available, considering safety and efficacy factors. As part of the drug formulary safety review process, the committee refers to the American Geriatrics Society List (Beers Criteria) for potentially inappropriate medication use in older adults. The clinical tool’s purpose is to inform clinical decision-making concerning the prescribing of medications for older adults in order to improve safety and quality of care. The goal of the list is to improve care of older adults by reducing their exposure to Potentially Inappropriate Medications (PIMs). If the criteria deem a drug as being “high risk” or “unsafe”, the committee will consider removing it from UCare’s formulary. As part of UCare’s member safety review process, the HEDIS measure “Use of High Risk Medications in the Elderly” is reviewed by the Quality Council. UCare performed very well on this measure for 2011.

Additional Member Safety Initiatives
UCare supports additional member safety initiatives and programming. Examples include: Seats, Education, And Travel Safety Program (SEATS); the Parents Guide booklet; flu shot reminders; and, the Management of Maternity Services (MOMS) program.

N. FOCUS STUDIES (PERFORMANCE IMPROVEMENT PROJECTS)

UCare determines internal quality improvement/performance improvement activities, including focused studies, based on a number of factors such as analysis of HEDIS results, member survey results, regulatory guidance, top diagnoses, provider and member feedback and results from an
environmental scan on health topics. Based on the results of these analyses, UCare implements targeted interventions and improvement activities with the goal of increasing rates in selected measures.

Planning work occurred for the following areas: Improving Transitions Post-hospitalization, Improving Self-care Management and Post-hospitalization Transitions for Members with Heart Failure, and Improving Chlamydia Screenings.

Formal focused studies conducted during 2012 include: UCare’s 2012 Breast Cancer Screening Performance Improvement Project (PIP), 2012 Reducing Non-Urgent Emergency Department Use in the PMAP/MnCare PIP, 2010 Colorectal Cancer Screening Quality Improvement Project (QIP), 2011 Colorectal Cancer Screening PIP, 2010 Diabetes and Hypertension PIP, and the 2010 Controlling High Blood Pressure QIP.

**Breast Cancer Screening Project**
The goal of this PIP is to increase the breast cancer screening rate in women 40-69 years of age for SNBC, MSHO and MSC+ members.

The project is undertaking four areas of intervention and improvement strategies: clinical service engagement through quarterly action lists, member outreach through incentive mailings and newsletter articles, provider engagement through the UCare provider website, and collaboration with outside organizations.

Measurement year 1 concluded on Dec. 31, 2012 and data will be available in the 2013 Interim Report. Plans for 2013 include continued dissemination of quarterly action lists as well as additional partnership opportunities with entities who share our goal of increasing breast cancer screenings rates.

**Reducing Non-Urgent Emergency Department Use in the PMAP/MnCare Populations Project**
The goal of this PIP is to decrease non-urgent emergency department (ED) use among PMAP and MnCare members 0 to 5 years of age who receive the health literacy intervention delivered by Minnesota Head Start Association (MHSA) programs.

PIP interventions leverage a partnership with MHSA, which coordinates Minnesota Head Start and Early Head Start programs throughout the state. The health plans will provide resources to and support training of MHSA home visitors and health educators to deliver an evidence-based health literacy intervention. Goals of the intervention are to increase parent’s knowledge of what to do for minor illness and injury and to improve understanding of where to go for what types of care.

Measurement year 1 will conclude on March 31, 2013 and data will be available in the 2013 Interim Report. Plans for 2013 include expansion of the program to all MHSA agencies so that more families will receive the health literacy intervention.
Improving Transitions Post-hospitalization Project
The goal of this PIP is to reduce hospital readmissions by improving member support for the transition from hospital to home or a care setting for Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC).

PIP interventions focus on improving the process for post-hospital discharge support by care coordinators for MSHO members. Improvements will include: enhancing the current Transition of Care (TOC) Log to help focus post-hospitalization support on key areas known to impact readmissions; Care Coordinator training and updates on the revised TOC Log and instructions; and annual audits of the TOC Logs based on health plan protocol and schedule.

Measurement year 1 will conclude on December 1, 2013 and data will be available in the 2013 Interim Report. Plans for 2013 include care coordinator training in the use of the revised TOC Log and annual TOC Log audits.

Colorectal Cancer Screening Project
The goal of this PIP is to increase the colorectal cancer (CRC) screening rate for PMAP, MnCare, MSHO, SNBC and MSC+ members who are 50 to 75 years of age.

Interventional strategies include partnering with a clinic to provide: process improvement assistance, training on understanding and using current CRC guidelines, annual updates to providers on CRC screening rates in their patient population, and also supplying providers with tools to promote CRC screening to patients from diverse backgrounds.

The colorectal cancer screening project started in 2011. Measurement Period 1 (7/1/11 – 6/30/12), data resulted in an improvement over baseline (from 42.53% to 50.04%) for the Collaborative PIP; and an improvement over baseline (from 57.14% to 58.82%) for UCare’s internal PIP. In 2013, UCare will work with partner clinics to establish and implement clinic specific interventions and will provide clinical practice guideline training for providers.

Blood Pressure Control for Members with Diabetes Project
The goal of the Blood Pressure Control for Members with Diabetes project is to increase the proportion of members with diabetes who have blood pressure in control as measured by the Healthcare Effectiveness Data and Information Set (HEDIS) Comprehensive Diabetes Care (CDC) 140/90 mmHg Blood Pressure measure in adults with diabetes, ages 18 through 75 years. Member outreach, care coordinator training and provider partnering were employed to meet the relative improvement rate of 3% over the baseline rate.

Interventional strategies include: member-focused interventions—letter on Medication Therapy Management Services (MTMS), postcard messaging focusing on self-monitoring of blood pressure and blood pressure medication management; care coordinator-focused interventions—training and toolkits; and Provider-focused interventions—selective intensive quality improvement (QI) project with subset of interested clinics, training, targeted interventions for MSHO, MSC+, and SNBC members in long term care facilities, and a quality improvement toolkit.
At the end of Measurement Year 2, all products were improving except SNBC. Plans for 2013 include: member mailings to SNBC members only; promoting care coordinator education; promoting provider interventions via health plan newsletters and website; and developing and implementing the quality improvement project with partner clinics.

## O. Disease Management Programs

### Target Disease - Asthma

In alignment with contractual mandates requiring UCare to implement and manage an asthma management program, UCare implemented its Asthma Action Program™. This program follows the National Committee for Quality Assurance (NCQA) guidelines for Disease Management and is focused on two program goals:

- Decrease emergency department (ED) visits and inpatient (IP) admissions for asthma-related events.
- Increase the percent of members appropriately prescribed long-term controller (LTC) medications.

UCare measures its annual asthma performance based on the HEDIS measure, “Use of Appropriate Medications for People with Asthma”. Performance was compared to the MN Plan Average and National Benchmarks. In 2011 (using HEDIS 2012 audit results), UCare’s Medicaid Combined performance was higher than the MN plan average whereas UCare’s PMAP performance was slightly lower than the MN Plan Average. Medicaid Combined and PMAP performance reached the National 75th Percentile.

### Target Disease - Diabetes

In alignment with contractual mandates requiring UCare to implement and manage a diabetes program, UCare implemented and actively manages its diabetes intervention program. This program follows the National Committee for Quality Assurance (NCQA) guidelines for Disease Management and is focused on two program goals:

- Ensure members with diabetes are receiving the HEDIS recommended tests, exams and visits each year.
- Provide prompt follow-up and coaching for members with diabetes-related emergency department (ED) or inpatient (IP) events.

UCare measures its annual diabetes performance based on the HEDIS measure, “Comprehensive Diabetes Care”. Performance was compared to the MN Plan Average and National Benchmarks. In 2011 (using HEDIS 2012 audit results), UCare’s UFS-MN ratings performed at or above the Medicare National 75th percentile on 8 of the 9 diabetes care components; UCare’s MSHO ratings performed at or above the Medicare National 75th percentile on 3 of the 9 diabetes care components; and UCare’s Medicaid Combined ratings performed at or above the Medicaid Combined National 75th percentile on 8 of the 9 diabetes care components.

### Target Disease - Heart Failure Programs

In alignment with contractual mandates to implement a heart failure program, UCare has implemented two heart failure programs aligned by level of patient risk, focusing on the following goals:
• Promote awareness and self-management of heart failure to prevent or delay emergency department (ED) or inpatient (IP) stays for heart failure.
• Reduce admissions and readmissions for heart failure.

Initial results show that high-risk members who are enrolled in the Cardiocom Program experience a significant decrease in inpatient stays and a decrease in ER visits when compared to high-risk members who are not enrolled in the program.

P. CARE MANAGEMENT PROGRAM

Care Management Services
UCare provides care management services for Minnesota Senior Health Options (MSHO); Minnesota Senior Care Plus (MSC+); Medicare Advantage (UCare for Seniors); Special Needs Basic Care Program (SNBC/UCare Connect); MinnesotaCare (MnCare); and Prepaid Medical Assistance Program (PMAP) members. UCare has two teams of internal staff (nurses, social workers, and associate care managers) that manage, on average, approximately 2,100 members per month for the MSHO and MSC+ products; SNBC care management is conducted by delegated entities for members with high needs; and PMAP, MnCare, and UCare for Seniors care management is provided mainly by internal staff.

UCare also contracts with counties, care systems, and care management entities to provide care management services for MSHO, MSC+, UCare for Seniors, and some UCare Connect (SNBC) members affiliated with select medical providers.

Transitions of Care
UCare’s care transitions process is designed to help provide smooth care transitions for our members. UCare continues to collaborate with other Minnesota health plans to review and update transition of care documents to help facilitate consistent documentation of transition activities by care managers across the state of Minnesota. UCare makes the following care transitions documents available to care coordinators:

• Individual Transition of Care (TOC) Log – developed and updated in collaboration with other Minnesota Health Plans.
• “What Do I Do If?” care transitions guide for care coordinators that answers questions related to documentation of care transitions.
• Care Transition Notification to the Physician.
• Transition of Care brochure, designed to help care coordinators educate members about care transitions.

UCare conducted Transition of Care audits in 2010, 2011, and 2012 in order to monitor compliance with transitions of care processes, and identify the need for potential process modifications. The audits identified that care coordinators generally attempt to follow transition of care processes, as seen in the results:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2010</td>
<td>2012</td>
</tr>
</tbody>
</table>
The audit results show overall improvement in compliance with transition of care tasks between 2008-2009 and 2010, with a leveling-off in performance in 2011-2012. UCare believes that the education provided to care coordinators combined with development of consistent transition tracking tools may have resulted in early improvement, with sustainment of this improvement overall. UCare plans to conduct further analysis to identify opportunities for continued improvement.

**Q. MSHO/MSC+/SNBC CARE PLAN AUDIT**

UCare conducted delegation oversight audits in 2012 of all delegates who perform care coordination functions for the MSHO, MSC+, and SNBC (UCare Connect) products. UCare used standardized audit tools to conduct the audits for each of the products.

UCare’s care coordination audit tools are designed to assess the delegate’s ability to perform and document care coordination activities, such as comprehensive assessment and care plan development and evaluation, as well as monitor compliance with the requirements and responsibilities of care coordinators.

**Care Plan Audit Report Results:**
UCare found a high degree of compliance with key elements of the care plan audit. A summary of results is contained in the following chart:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>MSHO/MSC+</th>
<th>SNBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>New enrollee contact within 30 days</td>
<td>2010</td>
<td>2011</td>
</tr>
<tr>
<td>LTCC/ assessment completion</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>Care plan development</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Enrollee signature of the care plan summary</td>
<td>87%</td>
<td>99%</td>
</tr>
<tr>
<td>Advance directives discussion</td>
<td>92%</td>
<td>99%</td>
</tr>
<tr>
<td>Monitored at least every 6 months /every 3</td>
<td>99%</td>
<td>99%</td>
</tr>
</tbody>
</table>

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**Process**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordinator notified of admission prior to or on the date of discharge</td>
<td>33%</td>
<td>63%</td>
<td>64%</td>
</tr>
<tr>
<td>% of admits that were planned</td>
<td>10%</td>
<td>15%</td>
<td>16%</td>
</tr>
<tr>
<td>Average time delay between admission and CC being notified</td>
<td>5 days</td>
<td>3 days</td>
<td>2.76 days</td>
</tr>
<tr>
<td>Plan of care shared with receiving setting within 1 business day</td>
<td>53%</td>
<td>81%</td>
<td>73%</td>
</tr>
<tr>
<td>Plan of care shared with PCP within 1 business day</td>
<td>70%</td>
<td>78%</td>
<td>82%</td>
</tr>
<tr>
<td>Member educated about transition process within 2 business days of return</td>
<td>73%</td>
<td>87%</td>
<td>80%</td>
</tr>
<tr>
<td>Member or rep communicated about change in members condition within 2 business days</td>
<td>73%</td>
<td>83%</td>
<td>84%</td>
</tr>
</tbody>
</table>
The results show high rates of compliance with care plan requirements.

R. COMPLAINTS, APPEALS AND GRIEVANCES

UCare’s Complaints, Appeals, and Grievance (CAG) team supports member needs related to dissatisfaction with UCare’s services. CAG staff members serve as member advocates by reviewing and processing concerns in a respectful, timely manner. The CAG processes are regulated by the Centers for Medicare & Medicaid Services (CMS), the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH).

Pursuant to regulations, UCare’s CAG operation includes the following components:

- a grievance process,
- an appeal process,
- access to the State Fair Hearing system for Medicaid members, and
- access to the independent review entity (IRE) contracted by CMS for Medicare members.

In addition, the CAG team receives and manages quality of care reports from authorized sources, as well as various types of complaints from members.

Timeliness of Case Management and Reporting

MCO’s are subject to standards for case management and reporting to government entities. UCare’s performance for 2012 is reflected below by applicable category:

<table>
<thead>
<tr>
<th>Products</th>
<th>Performance Standards For Case Management</th>
<th>UCare’s 2012 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MN State Public Programs</td>
<td>95% handled within 30 days</td>
<td>97.5%</td>
</tr>
<tr>
<td>MSHO</td>
<td></td>
<td>98.7%</td>
</tr>
<tr>
<td>Across All Products</td>
<td></td>
<td>97.3%</td>
</tr>
</tbody>
</table>

UCare is required to file various reports to CMS, MDH and DHS at different intervals throughout the year. In 2012, all such reports were submitted completely and correctly 100% of the time.

2012 Activity Levels

During 2012, UCare’s CAG team processed a total of 3,562 grievances and appeals; of these cases, 22% or 787 were grievances, and 78% or 2,775 were appeals. The breakdown of activity and the change from 2011 reflected a 9.6% increase in appeals and a 2.6% increase in grievances (see table below). Please note: New methodology was used in 2012 for Complaints, Appeals & Grievance Data within this report. Prior years’ data was recalcualted using same methodology.

<table>
<thead>
<tr>
<th>Year</th>
<th>Grievances</th>
<th>Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>787 (+2.6%)</td>
<td>2,775 (+9.6%)</td>
</tr>
<tr>
<td>2011</td>
<td>767 (+58%)</td>
<td>2,532 (+9%)</td>
</tr>
</tbody>
</table>
2010  485  (+17%)  2,317  (+83%)
2009  311  (+22%)  1,094  (+78%)

It should be noted that UCare has also experienced substantial growth in enrollment over the past five years with a 32% growth in 2012 alone. When adjusted for enrollment numbers at a rate per 1,000 members across all products, the normalized rates of activity are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Grievances</th>
<th>Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>2.70</td>
<td>9.51</td>
</tr>
<tr>
<td>2011</td>
<td>3.47</td>
<td>11.45</td>
</tr>
<tr>
<td>2010</td>
<td>2.48</td>
<td>11.86</td>
</tr>
<tr>
<td>2009</td>
<td>1.86</td>
<td>6.54</td>
</tr>
</tbody>
</table>

Further refinement of the above statistical info for Minnesota’s State Public Programs and the dual eligible Minnesota Seniors’ Health Options (MSHO) product offers the following raw data:

<table>
<thead>
<tr>
<th>Product</th>
<th>MN State Public Programs</th>
<th>MSHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td></td>
<td>Grievances</td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td>225</td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td>69</td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td>65</td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td>49</td>
</tr>
</tbody>
</table>

When adjusted for enrollment numbers at a rate per 1,000 members within each product, the normalized rates of activity are as follows:

<table>
<thead>
<tr>
<th>Product</th>
<th>MN State Public Programs</th>
<th>MSHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td></td>
<td>Grievances</td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td>1.20</td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td>0.56</td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td>0.60</td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td>0.52</td>
</tr>
</tbody>
</table>

In addition, the CAG team processed 409 State Fair Hearings, referred 165 cases for IRE review, received 26 new Quality of Care (QOC) cases, and closed a total of 25 QOC cases, six of which were initiated in 2011. These totals do not include letters received from external entities such as the Attorney General’s Office, Department of Commerce, etc., which were processed per normal procedures.

Of the 409 State Fair Hearings processed, 26 cases were pending as of 12/31/2012. Summarized at a high level, of the 409 cases, only 6.6% (27 cases) were partially changed and 9.2% (38 cases) were fully overturned.

There were 165 appeals (claims, services, and Part D appeals) submitted for a second level of appeal to the independent review entity (IRE). Of these 165 decisions submitted to the IRE, the
IRE upheld 64.8% of UCare’s actions and another 18.1% were dismissed; only 12.1% of UCare’s prior decisions were reversed by the IRE in 2012.

**Improvement Efforts**
UCare is committed to continuous improvement in its work activities including the work processes associated with the management of complaints, appeals and grievances. The staff has periodically reviewed its work in light of current standards and requirements and is poised for additional process improvements, mechanization and coordination with its internal stakeholders in 2013.
APPENDIX A: HEDIS COMPARATIVE RESULTS

MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

Medicaid Combined

Cervical Cancer Screening

Chlamydia Screening

Postpartum Care

Prenatal Timeliness

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**Medicare HEDIS Measures**

Appendix A: HEDIS Comparative Results

Medicaid Combined

Well Child Visits in the First 15 Months of Life: Percent with 6+ Visits

Well Child Visits Ages 3-6 Years

Lead Screening in Children

Adolescent Well Care Visits Ages 12-21

- UCare
- MN Mean
- National Mean
- National 75th Percentile
**MEDICARE HEDIS MEASURES**
Appendix A: HEDIS Comparative Results

**Medicaid Combined**

- **Childhood Immunization Status: Combo 3**
- **Use of Appropriate Medications for People with Asthma**

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**Comprehensive Diabetes Care: HbA1c Testing**

- **Comprehensive Diabetes Care HbA1c Poor Control***

---

*Reverse measure: lower is better*
Appendix A: HEDIS Comparative Results

Medicaid Combined

**Comprehensive Diabetes Care: HbA1C Control <8**

**Comprehensive Diabetes Care: HbA1C Control <7**

**Comprehensive Diabetes Care: Eye Exams**

**Comprehensive Diabetes Care: Nephropathy Monitoring**

- UCare
- MN Mean
- National Mean
- National 75th Percentile
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

Medicaid Combined

Initiation of Alcohol or Drug Treatment

Engagement of Alcohol or Drug Treatment

Breast Cancer Screening

Adult BMI Assessment

- UCare
- MN Mean
- National Mean
- National 75th Percentile
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

Medicaid Combined

Controlling High Blood Pressure

Annual Monitoring of Patients on Persistent Medications

Antidepressant Medication Management: Treatment Acute Phase

Antidepressant Medication Management: Continuation Phase

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WARD MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

Medicaid Combined

Weight Assessment & Counseling for Children: BMI Percentile

Weight Assessment & Counseling for Children: Physical Activity

Weight Assessment & Counseling for Children: Nutrition

- UCare
- MN Mean
- National Mean
- National 75th Percentile
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

UFS Minnesota

Colorectal Cancer Screening

Breast Cancer Screening

Osteoporosis Management in Women with Fractures

Controlling High Blood Pressure

Legend:
- UCare
- MN Mean
- National Mean
- National 75th Percentile
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

UFS Minnesota

Cholesterol Management after Cardiovascular Event: LDL Screening

Cholesterol Management after Cardiovascular Event: LDL < 100

Comprehensive Diabetes Care
HbA1c Testing

Comprehensive Diabetes Care
Poor HbA1C Control*

*Reverse measure: lower is better
Appendix A: HEDIS Comparative Results

### Comprehensive Diabetes Care

- **Eye Exams**
- **LDL Screening**
- **LDL Level <100**
- **Nephropathy Monitoring**

- **UFS Minnesota**

#### Graphs

- **Comprehensive Diabetes Care**
- **Eye Exams**
- **LDL Screening**
- **LDL Level <100**
- **Nephropathy Monitoring**

- **Data ranges**
  - Percent
  - Year: 2008 to 2012

- **Legend**
  - UCare
  - MN Mean
  - National Mean
  - National 75th Percentile
Appendix A: HEDIS Comparative Results

### Comprehensive Diabetes Care

#### BP Control 140/90

- **Percent**

#### BP Control 140/80

- **Percent**
- **Year**: 2011, 2012

#### HbA1c <8

- **Percent**
- **Year**: 2010, 2011, 2012

### Glaucoma Screening in Older Adults

- **Percent**

Legend:
- UCare
- MN Mean
- National Mean
- National 75th Percentile
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

UFS Minnesota

Antidepressant Management
Effective Acute Phase

Antidepressant Management
Continuation Phase

Follow Up Visit After Mental
Illness Hospitalization: 7 Days

Follow Up Visit After Mental
Health Hospitalization: 30 Days

Percent

Percent

Percent

Percent

0 10 20 30 40 50 60 70 80 90 100
0 10 20 30 40 50 60 70 80 90 100
0 10 20 30 40 50 60 70 80 90 100
0 10 20 30 40 50 60 70 80 90 100

2008 2009 2010 2011 2012
2008 2009 2010 2011 2012
2008 2009 2010 2011 2012
2008 2009 2010 2011 2012

UCare MN Mean National Mean National 75th Percentile

Follow Up Visit After Mental
Illness Hospitalization: 7 Days

Follow Up Visit After Mental
Health Hospitalization: 30 Days
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

UFS Minnesota

Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis

Use of Spirometry Testing for COPD

UCare  MN Mean National Mean National 75th Percentile

Annual Monitoring of Persistant Medications

High Risk Drugs in the Elderly: One Rx

*Reverse measure: lower is better
Appendix A: HEDIS Comparative Results

**MEDICARE HEDIS MEASURES**

**UFS Minnesota**

---

**High Risk Drugs in the Elderly: Two+ Rxs**

- Graph showing the percentage of high risk drugs in the elderly over the years 2008 to 2012.

**Potentially Harmful Drug/Disease Interactions in the Elderly**

- Graph showing the percentage of potentially harmful drug/disease interactions in the elderly over the years 2008 to 2012.

---

*Reverse measure: lower is better*

---

**Initiation of Alcohol or Drug Treatment**

- Graph showing the initiation of alcohol or drug treatment over the years 2008 to 2012.

**Engagement of Alcohol or Drug Treatment**

- Graph showing the engagement of alcohol or drug treatment over the years 2008 to 2012.

---

Legend:

- UCare
- MN Mean
- National Mean
- National 75th Percentile

---

UCare 2012 Quality Program Evaluation

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MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

UFS Minnesota

![Chart showing Adult BMI Assessment for 2010, 2011, and 2012](chart.png)

Legend:
- UCare
- MN Mean
- National Mean
- National 75th Percentile
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

MSHO

<table>
<thead>
<tr>
<th>Year</th>
<th>UCare</th>
<th>MN Mean</th>
<th>National Mean</th>
<th>National 75th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
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<td>2011</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td></td>
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</tr>
</tbody>
</table>

**Colorectal Cancer Screening**

**Breast Cancer Screening**

**Osteoporosis Management in Women with Fractures**

**Controlling High Blood Pressure**
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

MSHO

Cholesterol Management for Cardiovascular Conditions: LDL Screening

Cholesterol Management for Cardiovascular Conditions: LDL Level <100

Comprehensive Diabetes Care HbA1C Testing

Comprehensive Diabetes Care Poor HbA1c Control*

UCare  MN Mean  National Mean  National 75th Percentile

*Reverse measure: lower is better
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

MSHO

Comprehensive Diabetes Care
Eye Exams

Comprehensive Diabetes Care
LDL Screening

Comprehensive Diabetes Care
LDL Level <100

Comprehensive Diabetes Care
Nephropathy Monitoring

<table>
<thead>
<tr>
<th>UCare</th>
<th>MN Mean</th>
<th>National Mean</th>
<th>National 75th Percentile</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tr>
</tbody>
</table>

Percent

2008 2009 2010 2011 2012

Percent

2008 2009 2010 2011 2012

Percent

2008 2009 2010 2011 2012

Percent

2008 2009 2010 2011 2012

Comprehensive Diabetes Care
Eye Exams

Comprehensive Diabetes Care
LDL Screening

Comprehensive Diabetes Care
LDL Level <100

Comprehensive Diabetes Care
Nephropathy Monitoring

UCare 2012 Quality Program Evaluation

Final 4/3/2013
Appendix A: HEDIS Comparative Results

**Comprehensive Diabetes Care**
- **BP <140/80**
  - 2011: [Bar chart]
  - 2012: [Bar chart]

- **BP <140/90**
  - 2008: [Bar chart]
  - 2009: [Bar chart]
  - 2010: [Bar chart]
  - 2011: [Bar chart]
  - 2012: [Bar chart]

**Comprehensive Diabetes Care: HbA1c <8**
- 2010: [Bar chart]
- 2011: [Bar chart]
- 2012: [Bar chart]

**Spirometry Testing for COPD**
- 2008: [Bar chart]
- 2009: [Bar chart]
- 2010: [Bar chart]
- 2011: [Bar chart]
- 2012: [Bar chart]
Medicare HEDIS Measures
Appendix A: HEDIS Comparative Results

Antidepressant Management
- Acute Phase
- Continuation Phase

Follow Up Visit After Mental Illness Hospitalization: 7 Days

Follow Up Visit After Mental Health Hospitalization: 30 Days
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

MSHO

Anti-Rheumatic Rx in Rheumatoid Arthritis

Annual Monitoring of Persistent Medications

High Risk Drugs in the Elderly: One Rx*

High Risk Drugs in the Elderly: Two+ Rxs*

*Reverse measure: lower is better
MEDICARE HEDIS MEASURES
Appendix A: HEDIS Comparative Results

MSHO

**Potentially Harmful Drug/Disease Interactions**

- UCare
- MN Mean
- National Mean
- National 75th Percentile

**Adult BMI Assessment**

**Initiation of Alcohol/Drug Treatment**

**Engagement of Alcohol/Drug Treatment**
Medicare HEDIS Measures
Appendix A: HEDIS Comparative Results

MSHO

Care for Older Adults: Advance Care Planning

Care for Older Adults: Pain Screening

Care for Older Adults: Medication Review

Medication Reconciliation Post-Discharge

UCare 2012 Quality Program Evaluation
Page 55
APPENDIX C: UTILIZATION MANAGEMENT PROGRAM

Vision Statement  
UCare is committed to improving the health of our members through innovative services and partnerships across communities.

We provide comprehensive health care coverage to selected populations through a community-based, holistic approach. We support family practice education and research so that this philosophy of care can be carried into the future.

Mission Statement  
The purpose of the Utilization Management (UM) Program Description is to define the structure and processes by which we conduct utilization management and assign responsibility to appropriate individuals. UCare has developed and endorses a medical management strategy that addresses member needs. UCare’s medical management strategy is a cross-functional and interdepartmental approach to improving the member’s overall health while controlling UCare’s financial risk exposure. This strategy encompasses a variety of key functions including: case management, disease management, provider contracting, health promotion, clinical quality initiatives and utilization review.

In addition, the UM Program is designed to ensure effective and efficient quality of care and services to our members. We provide impartial access to care and fair and consistent UM decision making that ensures the delivery of quality care while maximizing benefits and minimizing cost. The objectives of the UM Program are as follows:

- To define the program structure, authority and accountability for UM activities.
- To identify the designated senior practitioner involved in the UM program implementation.
- To define utilization management staff qualifications and responsibilities.
- To describe the scope and content of the UM program.
- To describe policies and procedures used to manage utilization review.
- To outline the evaluation and approval of the utilization management program.

Organizational Structure, Authority and Accountability  
The Clinical Services Director is responsible to ensure that the UM Program including the UM Program Description is reviewed annually and updates are made as necessary. The UM Program Description is reviewed annually by Clinical Services leadership, the Chief Medical Officer (CMO), Associate Medical Directors (AMD), and other key departments and committees such as the Medical Management Council and Quality Council. The UM program is updated as needed based on the annual review, and/or changes in state, federal or national regulations or requirements.

Chief Medical Officer - The CMO is the designated senior physician responsible for implementation, oversight, and evaluation of the UM Program. The CMO has the final authority and responsibility for the UM Program. The CMO is directly accountable to the Chief Executive Officer.
**Associate Medical Director** – The AMD’s are responsible for review of benefit exception requests, service requests that fail to meet approval criteria, all requests that result in a denial, reduction or termination of service, and member and provider appeals. In addition, all requests that are of an investigational nature, new technology, or considered experimental, require the review of a Medical Director.

**Clinical Services Director** - The Clinical Services Director is responsible for supervising the clinical services staff involved in UM activities. The Clinical Services Director is available to assist clinical leaders and staff in UM decision making. This position is directly accountable to the CMO.

Utilization review is conducted by the Clinical Intake and Utilization Review staff which includes the following:

**UR Specialist** – A UR Specialist may be a Registered Nurse (RN) or Licensed Practical Nurse (LPN), and is required to have a current license to practice nursing in Minnesota. This licensure must be kept current during their employment as an UR Specialist for UCare. The UR staff is directly accountable to the Utilization Review Manager. UR Specialists have the authority to approve services only; they cannot deny a service request. A physician, dentist, or chiropractor, as appropriate, must review and make a determination to deny a request for service based on medical necessity.

**Intake Specialist** - Intake Specialists are experienced in data entry and/or telephonic customer service with an understanding of medical terminology, CPT, and ICD-9 coding. They are accountable to the Intake Manager for operational functions. The minimum education requirements include a high school diploma. These staff members may collect data for prior authorization, concurrent review or retrospective review under the supervision of licensed clinical staff. They have the authority to make decisions that do not require clinical assessment or judgment. The Intake Specialist has immediate access to licensed staff for issues requiring clinical judgment.

**Delegated Approval Authority** - UCare also delegates the function of utilization review and utilization management to a select group of entities which are referred to as delegate approval authorities. UCare delegates full utilization management responsibility to delegates who manage the specialty services of chiropractic, dental, pharmacy, rehabilitation therapies, and behavioral health. UCare delegates the specific function of utilization review only to other delegated approval authorities. Delegated approval authorities are required to meet the requirements of performing UM functions as outlined in the contract and delegation agreement. UCare maintains full accountability for all delegated UM and UR activities.

Prior to delegation of any UM activity, UCare conducts a comprehensive pre-delegation assessment. The Clinical Services Compliance team is responsible for oversight and verifying that delegated UM functions are in compliance with state and federal regulations. In addition, the Clinical Services Compliance team is responsible for conducting ad hoc and ongoing
provider performance evaluations as it relates to their performance of specific utilization management activities.

These delegated entities must have a UM Plan that is reviewed annually and updated as necessary. Documentation must support that a Medical Director is involved in the approval of the UM Plan. Each delegated entity’s UM Plan must be reviewed and approved annually by UCare’s Clinical Leadership.

UCare delegates behavioral health UM to a contracted vendor. Any case identified as having a primary behavioral or chemical health diagnosis is referred to the contracted vendor for review.

**Scope and Content of the UM Program**
The Clinical Services staff of UCare use utilization review criteria that are based on scientific evidence and accepted clinical practice guidelines. The process of UR is highly dependent upon the use of medically supported criteria in conjunction with the Department of Human Services (DHS) guidelines, patient records, and conversations with treating providers and other medical experts.

At a minimum, UCare follows either Medicare or DHS guidelines to determine eligibility for specific services based on the individual’s product and medical needs. These criteria are made available to network providers via UCare’s website. UCare also distributes criteria to select providers for review prior to adoption as a clinical practice guideline. In addition, UCare considers national and local coverage decisions as well as member benefits described in the member Evidence of Coverage (EOC) and Certificate of Coverage (COC), the member’s individual needs, and coverage information as described on the DHS website and the UCare Provider Manual. In instances where Medicare or DHS guidelines do not exist, UCare researches the service requested by searching national websites such as FDA.gov, clinicaltrials.gov, or WebMD and also takes into consideration the local community standard. Such requests are presented to UCare medical directors for review and organizational determination. The application of these criteria occurs during all levels of the utilization review process.

**First level review:**
The UR Specialist who receives the request for services, reviews the information against the appropriate criteria/guidelines, and documents the necessary information in order to apply the criteria/guidelines. In 2011, UCare implemented the use of the nationally recognized software application, InterQual. This application includes nationally accepted medical necessity criteria and is a powerful decision support tool which is used by Utilization Review staff and Medical Directors. The criteria are updated on a minimum of annual review by national experts employed by McKesson who licenses InterQual.

UCare requests the minimum necessary clinical information to make a coverage determination as allowed under HIPPA regulations. Clinical information may include pertinent medical record documents, photos, provider notes, provider plans of care, physician consultation, or other records as appropriate. If additional information is needed, the UR Specialist contacts the provider by phone or fax in an attempt to obtain the necessary information.
The UR Specialist has two options after conducting the review: approve the services if medical necessity criteria is clearly met or refer the request to a medical director for review and determination.

**Second level review:**
At this level of review, a medical director reviews the request for services and makes a determination. The physician’s review includes the summarized results of the UR Specialist’s data collection and the reason(s) the request did not meet criteria or guidelines.

UCare does not conduct utilization review for emergency, urgent, and post-stabilization services per policy, CLS009 - Emergency, Urgent, and Post-stabilization Services. UCare complies with Minnesota Statute 62M and Centers for Medicare and Medicaid Services (CMS) regulations related to turnaround times and classification of reviews into the categories of standard or expedited. Refer to policies CLS - 001 Utilization Review and CLS - 002 Expedited Review for detailed information.

Medical necessity reviews are performed for procedures that are considered experimental, investigational, of unproven benefit, new or emerging diagnostic or treatment technologies, alternative or complementary medical services, or other medical devices or services that are not included in a member’s benefit set. See policy, CLS - 045 – Benefit Exceptions and New and Investigational Technologies.

UCare requires prior authorization for select services and procedures and publishes on an annual basis, an authorization and notification grid, which contains all services and procedures that require a medical necessity review and organizational determination. This document is reviewed annually by the UCare Clinical Services Leadership team and updated throughout the year as necessary. Medical necessity criteria for those services and procedures requiring authorization is published in the UCare Provider Manual located on the UCare website. In addition, UCare communicates via the Provider Relations and Contracting department when the authorization and notification grid is published at the beginning of each calendar year, and throughout the year if the authorization and notification grid is modified.

In the event of a Presidential declaration of a disaster or emergency under the Stafford Act or National Emergencies Act, the Secretary of Health and Human Services declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary of Health and Human Services has the right to exercise her waiver authority under Section 1135 of the Social Security Act. If the Secretary exercises her Section 1135 waiver authority, detailed guidance and requirements, including timeframes associated with those requirements for Medicare Advantage plans, is posted on the Department of Health and Human Services (DHHS) website, (http://www.dhhs.gov/) and the CMS web site (http://www.cms.hhs.gov/).

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services, but absent an 1135 waiver by the Secretary, UCare will follow its Business Plan and implement the following:
1. Allow Part A, Part B, and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A and Part B benefits must, per 42 CFR 422.204(b) (3), be furnished at Medicare certified facilities).

2. Waive in full, requirements for authorization or pre-notification.

3. Temporarily reduce plan-approved out-of-network cost sharing to in-network cost sharing amounts.

4. Waive the 30-day notification requirement to members as long as all the changes (such as reduction of cost sharing and waiving authorization) benefit the member.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed 30 days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, UCare will resume normal operations 30 days from the initial declaration.

During emergencies or disasters in which the Secretary has invoked her authority under Section 1135, information about the waiver is posted on the Department of Health and Human Services (DHHS) website. The CMS web site also will provide detailed guidance for Medicare Advantage plans in the event of a disaster or emergency in which the Secretary’s 1135 waiver authority is being exercised. During these disasters and emergencies, UCare will check these web sites frequently.

Intake staff will place a voice message on the Utilization Review Intake line to notify providers of the temporary change in prior authorization requirements should a Presidential declaration of a disaster or emergency be declared.

**Auditing and Compliance Program**

Auditing of staff and department performance is conducted in various ways. Specific Clinical Services activities are reviewed by the UCare Compliance Department on a pre-determined schedule and include such areas as issuing denials, the prior authorization process and delegation oversight. In addition DHS, MDH and CMS periodically audit CLS as part of the overall organizational assessment.

**Types of Utilization Review**

There are three types of Utilization Review performed at UCare. They are:

- Prospective review (also known as pre-service).
- Concurrent review.
- Retrospective review (also known as post-service).

**Prospective Review**

Prospective or pre-service reviews are performed prior to the member receiving the service. Providers or members submit requests for services either via telephone or fax. The request undergoes first level review by a UR Specialist who compares the clinical information against established criteria. The UR Specialist makes a determination to either approve the request based on the clinical information provided meets the established criteria, or routes the request to a medical director for a second level review and determination.
Concurrent Review
Concurrent review occurs while treatment is in progress and typically applies to services that continue over a period of time. Concurrent review may be conducted for those services outlined on the UCare authorization and notification grid published on the UCare website. Examples of services requiring concurrent review may include the following services: Skilled Nursing Facility (SNF) or Nursing Facility (NF) stays, home health care services, therapies, and Durable Medical Equipment rental.

Retrospective Review
Retrospective review (also known as post-service) occurs after treatment is completed. The decision to authorize payment occurs after the fact, and the evaluation of medical necessity and appropriateness of care is based on the clinical information submitted by the provider and available claims data.

Retrospective review may be conducted when a service or procedure on the authorization grid was performed prior to notification to UCare or when review of claim data substantiates potential over or under utilization of services.

The Claims Department, under the guidance of a UCare medical director, may conduct retrospective review of non-network provider claims subsequent to a claim denial.

Appeals
UCare has a full and fair process for resolving member disputes and responding to member request to reconsider a decision they find unacceptable regarding their care and services. UCare follows appeals guidelines outlined by Minnesota Department of Human Services, the Centers for Medicare and Medicaid Services, Minnesota State Statutes, and the Code of Federal Regulations.

UCare has written policies and procedures (QAG008, QAG 014, QAG 020, and QAG 022) in place for registering and responding to appeals. These policies include information on appealing pre-service and post-service requests, expedited reviews, and internal appeals. The policies and procedures also include the timelines of the appeal process, a description of appeal reviewers, notification of appeal decisions, and member rights. These policies describe the review and notification timeframes, documentation of substance and investigation of appeals, opportunities for members and others to submit information, qualifications and specifications of who can conduct the review, notification of appeal rights, and procedures for allowing an authorized representative to act on behalf of the member. The policies and procedures also state how UCare works with external review entities.

A member, their representative, or the legal representative of a deceased member’s estate can request an Appeal orally or in writing. An Attending Health Care Professional (AHCP) may request an Appeal of a utilization review decision without the written consent of the member. All other providers acting on behalf of the member must have written consent from the member to request an Appeal. For expedited appeals, a member or a health care practitioner with knowledge of the member’s condition may act as the member’s authorized representative.
UCare does not delegate appeals to other entities. For Appeals regarding a denial, termination or reduction (DTR) determination involving medical necessity or clinical issues, the Appeal determination will be made by a healthcare professional with appropriate clinical expertise in treating the member’s condition.

In cases of an Appeal to reverse a determination to not approve a treatment, procedure, or service not typically managed within the specialty of the Chief Medical Officer or an Associate Medical Director reviewing the Appeal, UCare has available specialty and subspecialty providers with whom the case may be reviewed as specified in Minnesota Statute 62M.06, Subd. 3, (f).

**Exception Considerations**
UCare has exceptions policies and procedures that describe our process for:
- Making an exception request based on medical necessity.
- Obtaining medical necessity information from prescribing practitioners.
- Using appropriate practitioners to consider exception requests.
- Timely request handling.
- Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request.

**Denials and Appeals Process**
When criteria are not met, a medical director must review the clinical information and make an organizational determination regarding medical necessity. The physician conducting the review must be licensed in Minnesota. The reviewing physician is available by telephone to discuss the determination with the AHCP. Practitioners may access UCare’s medical directors by contacting the CLS Intake line during business hours.

All final decisions not to certify a request are made by a physician or appropriate qualified review authority. For Medicare products, appropriately licensed professionals may make clinical denial decisions for mental health, chiropractic, and dental service reviews as described in CLS - 001 Utilization Review policy.

UCare does not deny payment for service due to lack of prior authorization.

UCare notifies the provider and member in writing of the denial including the specific reason for denial, and also reference to the benefit provision, guideline or criteria on which the decision was based. The written notification includes information on how to obtain a copy of the benefit provision or guideline, a description of appeal rights, how to request an appeal, and the appeal process including a description of the expedited appeal process.

Utilization review decisions are based only on appropriateness of care and service and existence of coverage. UCare does not specifically reward practitioners or other individuals for issuing denials of coverage of care.

**Access to UM Staff**
UCare offers provider access to UR staff via local or toll-free telephone lines and confidential voice mail from 8 a.m. to 5 p.m. Monday through Friday excluding holidays. After normal
business hours a confidential Intake fax line is available for submission of notifications, utilization requests, supporting clinical information and other documentation.

Telephone and fax numbers are published in the Provider Manual and member materials. Intake staff answers incoming calls from providers and others requesting information about the UR process during regular business hours, and make return calls in response to voice mail messages. All review staff identify themselves to telephone contacts by name, title, and organization name for both inbound and outgoing calls.

**Mechanisms for Monitoring Over and Under Utilization of Services**

Monitoring for over and under utilization occurs through a variety of mechanisms and may happen at different time in the care delivery process. The Medical Management Council, which reports to Senior Leadership and is comprised of leadership representatives from Medical Directors, Clinical Services, Quality Management, Business Processes, Health Care Economics, Provider Relations and Contracting, Behavioral Health, Product Management and Development, Claims, Pharmacy, and other senior leaders meets on a routine basis.

As contractually required by DHS, the MMC selects the utilization data types each year to monitor for over or under utilization, e.g., inpatient utilization, emergency room utilization, pharmacy utilization and behavioral health services utilization. Pursuant to the DHS contracts, one of the data types must be related to behavioral health. Upper and lower thresholds are established for each data type based on historical data and available benchmark information. These data types are quantitatively analyzed at a minimum annually. If trend shows utilization outside the established thresholds by a medical group or practice for three or more months, additional analysis is conducted to determine the cause(s) and action is taken to modify negative trend or utilization patterns and measure the effectiveness of the action(s) taken.

The monthly analysis of the Special Health Care Needs reports is another mechanism used to detect undesirable utilization patterns. Trends in activity are analyzed and if any areas are outside of the calculated control limits, additional data may be pulled for further review.

In addition, this council may conduct ad hoc studies on particular services that may be over or under utilized.

**Pharmaceutical Management**

UCare ensures its policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals.

**Policies and Procedures**

UCare's policies and procedures for pharmaceutical management include the criteria used to adopt pharmaceutical management procedures and a process using clinical evidence from appropriate external organizations. Policies and procedures are developed and annually reviewed and updated based on sound clinical evidence.

UCare's pharmaceutical procedures include a written process describing the criteria used when adopting the pharmaceutical management procedures, including those used in constructing the formulary or preferred status, as applicable.
UCare uses clinical evidence that shows how ongoing decisions are made regarding:

- Classes of pharmaceuticals.
- Classes preferred or covered at any level.
- An exceptions process available to members for obtaining non-covered pharmaceuticals.
- Considerations regarding limiting access to drugs in certain classes.
- Within each class of pharmaceuticals:
  - The pharmaceuticals preferred or covered at any level.
  - The criteria for prior authorization of any pharmaceutical.
  - An exceptions process available to members.
  - Substitutions made automatically or with physician permission.
  - Evidence showing how preferred-status pharmaceuticals can produce similar or better results for a majority of the population than other pharmaceuticals in the same class.

Clinical evidence used to make all decisions discussed above includes relevant findings of government agencies, medical associations, national commissions, peer-reviewed journals and authoritative compendia consulted in pharmaceutical determinations.

**Pharmaceutical Restrictions/Preferences**
UCare maintains a list of pharmaceuticals, including restrictions and preferences. UCare has policies and procedures that explain how to use the pharmaceutical management procedures, limits or quotas, how prescribing practitioners must provide information to support an exception request, and UCare's process for generic substitution and step-therapy protocols.

**Pharmaceutical Patient Safety Issues**
UCare's procedures include:

- Adopting or creating a system for point-of-dispensing communications to identify and classify drug-to-drug interactions by severity.
- UCare notifies dispensing providers at the point-of-dispensing of specific interactions when they meet our severity threshold.
- UCare identifies and notifies members and prescribing practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notifications.
- UCare expedites the process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall.

**Reviewing and Updating Procedures**
UCare reviews and updates pharmaceutical management policies and procedures annually and updates them as new pharmaceutical information becomes available.

**Pharmacist and Practitioner Involvement**
UCare involves pharmacists and appropriate practitioners in the development and updating of its pharmaceutical management policies and procedures through the Pharmacy & Therapeutics Committee on a quarterly basis. This committee is comprised of external members made up of physicians of representative specialties and pharmacists. The Pharmacy and Therapeutics
Committee serves in an advisory capacity to UCare Senior Management and does not make benefit or individual coverage decisions with respect to pharmacy benefits.

**Availability of Procedures**
UCare makes available pharmaceutical management policies and procedures to practitioners on an annual basis and as updates are made. This information includes:
- Co-payment and coinsurance requirements and the pharmaceuticals or pharmaceutical classes to which it applies.
- Lists of preferred pharmaceuticals or formularies.
- Prior authorization criteria.
- Procedures for generic substitution, step therapy or other management methods to which the practitioner's prescribing decisions are subject.
- Any other requirements, restrictions, limitations or incentives that apply to the use of certain pharmaceuticals.

**Disease Management**
Disease Management is a coordinated care approach focused on prevention, early identification, and intervention in the chronic disease process. The goal is to provide cost-effective, quality healthcare for the patient population identified as having a specific chronic illness or medical condition. All disease management programs are voluntary and members may opt-out at any time.

The disease management department adopts criteria from the Disease management Association of America (CMAA) and National Committee for Quality Assurance (NCQA) to develop member programs.

**Education and Training**
UCare has an Operations Manager within the Clinical Services department. This manager is responsible for overseeing the development and provision of education and training regarding UM activities for CLS staff and delegates at the direction of the CLS Director.

Clinical Services conducts inter-rater reliability testing annually. This ensures that UCare and delegates who perform utilization review uniformly apply objective, measurable criteria based on reasonable medical evidence to make utilization decisions.

The CLS Operations Manager either develops or selects sample cases for testing. All UM staff, inclusive of medical directors and delegate staff who perform utilization review, review the sample cases and make consistent organizational decisions based on medical necessity criteria. A summary of the inter-rater testing outcomes is documented and the participants are provided the results. Based on the participants input and if deemed necessary, a corrective action is designed, implemented, and monitored to ensure effectiveness.

**Case Management**
Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and
family’s comprehensive health needs through communication and available resources to promote quality cost effective outcomes.® (Case Management Society of America, 2012)

The member is invited to participate in case management and is expected to take an active role in the process. Members may opt out of case management at any time and are closed from case management if they voluntarily disenroll or are disenrolled from UCare. The only exception to voluntary participation is restricted members. Restricted members are automatically enrolled in case management and may not opt out.

The Case Management team uses a number of methodologies for identifying individuals who may benefit from case management. They are:

- Contract required care coordination for MSHO, MSC+, and SNBC.
- Referrals from UCare clinical teams.
- Referrals from an external source (i.e. PCCs, home care agencies, family members, hospitals, specialists, disease management vendors, etc.).
- Claims data-driven identifiers such as: extended length of stay, repeat admissions, over utilization of emergency services, potential or actual high cost utilizers, multiple co-morbid conditions, or health care risk identifiers.

Annually, select Case Management activities are reported to DHS as part of UCare’s Annual Quality Assessment and Performance Improvement Program Evaluation.

**SIGNATURE PAGE:**

**Written by:** Jeri Peters  
**Director, Clinical Services**

**Initiation Date:** April 1, 2011

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Jeri Peters  
Clinical Services Director  
5/17/2011

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Russ Kuzel, MD, CMO  
Medical Management Council  
5/17/2011

**Annual Review Date:** February 2012
Reference Documents
DHS Contracts
Minnesota Statute 62M
NCQA Standards and Guidelines for the Accreditation of Health Plans
UCare Policies & Procedures
ADDENDUM: Behavioral Health
UCare delegates the management and prior authorization/notification to Behavioral Health Providers. Following is the UM Plan for this vendor.

VISION STATEMENT
The BHP network of behavioral professionals is committed to improving the health of our communities through an advanced operational system and exceptional practitioners who provide high quality, convenient, and cost effective behavioral services across the full continuum of care. As a leader in behavioral health in Minnesota, BHP encompasses services and innovations for the treatment of mental illness and substance abuse that address a person’s emotional, physical, and spiritual needs.

BHP works to build bridges and establish beneficial relationships by bringing together the best of mental health and chemical dependency professionals, acute care and hospital services, and purchasers of those services. The result is improved quality of care for those in need, better access to professionals and programs, and improved health status outcomes. BHP’s clinical care and operation system strives to integrate with primary care to provide continued advocacy for those in need and enhance the mental health of our communities.

MISSION STATEMENT
BHP is a nonprofit behavioral health care organization dedicated to helping people and communities reach their potential. BHP is dedicated to enhancing behavioral health through innovation.

The purpose of the Utilization Management (UM) Program is to provide effective and efficient quality of care and services to our members. We provide impartial access to care and fair and consistent UM decision making that ensures the delivery of quality care while maximizing benefits and minimizing cost. The objectives of the UM Program are the following:

- To define the program structure, authority and accountability for UM activities;
- To identify the designated senior practitioner involved in the UM program implementation.
- To define utilization management staff responsibilities;
- To describe the scope and content of the UM program; and
- To describe policies and procedures used to manage utilization review. (These follow the program description in policy and procedure format.)
- To outline UM program evaluation and approval.

AUTHORITY AND ACCOUNTABILITY

- **Board of Directors** - The BHP Board of Directors has the final authority and responsibility for the UM program. The board has delegated oversight of the UM program to the QIC (Quality Improvement Committee). The QIC has delegated the daily functions and operations of the UM program to the Clinical Team.

- **Chief Operating Officer** - All staff and consultants report to the COO of BHP for oversight and direction regarding operational decisions. The COO of BHP is to be kept informed of all UM policies and procedures and is available to the Chief Medical Officer. The COO of BHP is ultimately accountable to the BHP Board.
**Chief Medical Officer** - The Chief Medical Officer is the designated clinical practitioner who is actively involved in implementing the UM Program and participates in the Clinical/Operations Team meetings. The Chief Medical Officer is responsible for supervising and reviewing referral and triage and utilization decisions and is required to sign off on all UM policy changes. The Chief Medical Officer is directly accountable to the BHP COO and Board for clinical and performance on the contract.

**Operations Director** - The Operations Director is responsible for supervising the care management staff. The Operations Director is to assist in administrative utilization decisions when necessary and to refer to the Chief Medical Officer, Reviewers, or Specialists for supervision of clinical utilization determinations. For utilization management and decisions, this position is directly accountable to the Chief Medical Officer. For personnel and operations issues this staff is accountable to the COO.

**Care Managers** - The Care managers are licensed independent behavioral practitioners responsible for gathering all pertinent information and making an accurate and timely utilization decision. They are directly accountable to the Operations Director and have access to the Chief Medical Officer; doctoral level licensed Psychologists, and licensed Specialists in UM decision-making. They are knowledgeable about utilization protocols, procedures, and referring appropriate concerns and decisions as required. They do not have the authority to make decisions to deny a request for authorization. The Care manager is responsible for triage functions when a call is received that requires a clinical determination of the appropriate level of care and practitioner.

**Peer Reviewers** - The doctoral level licensed Psychologist Reviewers are responsible for assisting the care management staff in making accurate utilization determinations on outpatient service requests. A board-certified physician is responsible for assisting the Care managers in making utilization determinations on inpatient and outpatient services. Both physicians and psychologists can assist in all outpatient services based on availability and level of review or appeal. Their involvement is required for any decision when clinical appropriateness is in question, or for mandatory reviews according to policies. They do not have the authority to make decisions to deny a request for authorization. They are accountable to the Chief Medical Officer for clinical oversight and to the COO for contractual and operational oversight. The Peer Reviewers are responsible for triage functions when a call is received that requires a clinical determination of the appropriate level of care and practitioner.

**Licensed Specialty Practitioners** - The licensed specialty practitioners are licensed board certified physicians with designated specialties who provide consultation services. They are responsible for assisting the care management staff in making accurate utilization determinations of clinical appropriateness. They are directly accountable to the Chief Medical Officer.

**Care Management Coordinator** - The Care management Coordinator staff is non-licensed bachelors or master’s level prepared staff responsible for administrative assistance to the care managers and Peer Reviewers. They have the authority to complete
authorizations or denials according to defined policies. They do not have the authority to
make any clinical decisions including the decision to deny a request for authorization.

- **Intake and Referral Staff**: The intake and referral staff is responsible for ensuring
access and securing a referral in the BHP network. They have the authority to make
referral decisions that do not require clinical judgment. They have immediate access to
all licensed staff for issues requiring clinical judgment. They are accountable to the
Intake Manager for operational functions and to the Chief Medical Officer concerning
clinical issues.

**SCOPE AND CONTENT OF THE UM PROGRAM**
The leadership and staff of BHP realize that quality management encompasses several
components of behavioral health care delivery inclusive of the utilization management activities.
The policies that follow demonstrate a commitment to high standards for quality of care and
services. The following statements describe the basis for the development of the Utilization
Management policies and procedures.

**LEVEL OF CARE GUIDELINES**
The care management staff of BHP uses utilization review criteria (level of care guidelines) that
is based on evidence and accepted clinical practice guidelines. These guidelines assist in
defining appropriate behavioral care services based on diagnosis and symptoms. They assist in
determining intensity, frequency, and duration of care. They are established by behavioral health
care professionals and represent the usual and customary practice standards. The goals of these
guidelines are to help restore or maintain a patient’s health and prevent deterioration or the onset
of other health problems. The Clinical Team is responsible for the final approval of practice
standards and guideline determination and, at least annually, review, update and approve the
level of care guidelines. The guidelines are distributed to all practitioners along with their
contract and are available on BHP’s website (www.bhpcare.com). Additional mailings will occur
when additions or revisions to the guidelines have occurred, or upon request.

**Utilization Management**
The UM processes are standardized to ensure consistent and accurate review of all requests for
services. As needed, a licensed behavioral practitioner (board certified physician or doctoral
level licensed Psychologist) is available to supervise and for consultation on all decisions. The
clinical information needed to make a determination will be standardized and consistently
documented. This information is submitted telephonically for Inpatient admission. For outpatient
services, a BHP Treatment Plan or Chemical Health Assessment is required. If additional
information is requested after initial review, this information is accepted telephonically, or via
mail or facsimile. In general, the following information is required:

- Patient demographics
- Provider demographics
- Axis I – V
- Clinical symptoms
- Treatment modality(s), interventions and treatment goals
- Requested treatment and length of stay/number of sessions
• Prognosis
• Other involved providers

UM decisions are made in a timely manner that reflects the clinical urgency. Should treatment be denied for UCare State product members, BHP notifies the practitioner telephonically of the denial within 1 business day and in writing no later than 10 calendar days of service request date. BHP enters the denial information into Amisys no later than 10 calendar days and UCare issues the DTR notice. Should treatment be denied for Medicare Advantage (UCare for Seniors members) BHP enters denial information into Amisys no later than 10 calendar days. BHP issues the NDMC. (See UM 1.01 for guidelines on approval, denial and notification processes.) If new technologies and applications are discovered and determined to be sound and beneficial treatment modalities by the health plan, BHP will establish a mechanism to incorporate these practices in the UM process. BHP assesses member and provider satisfaction with the UM process at least annually to evaluate quality and need for improvement. BHP does not prohibit providers from advocating on behalf of members within the utilization management process.

Inter-rater Reliability
At least annually, BHP evaluates the consistency with which UM staff applies the criteria in decision making. The Department Managers develop or select a sample case profile. All UM staff, inclusive of the doctoral level licensed psychologists and primary consultant physician reviewers, review the information and make a utilization management decision consistent with the level of care guidelines. When differences in the utilization decision occur, the peer reviewers involved meet to discuss the case and their decision. In addition, the Chief Medical Officer may review each staff’s response. If after meeting and discussion the peer reviewers are unable to come to a consensus, the Chief Medical Officer is responsible for resolving the clinical issue. A summary of the inter-rater audit is done and the Clinical Team is updated at that time. Based on the team’s input and if deemed necessary, a corrective action is designed, implemented, and followed up on to ensure effectiveness.

Intake and Referral
BHP members are able to easily access the BHP Intake Staff, and by one telephone call, ensure access to the BHP network. BHP’s Intake and UM Staff use protocols that define the level of urgency and the level of care appropriate to address a member’s need and degree of risk. Referral protocols are based on sound clinical evidence and accepted community standards for mental health and chemical dependency needs and services. All triage and referral decisions that require clinical judgment are made by licensed UM staff. Staff with the relevant knowledge, skills and experience makes all triage and referral decisions not requiring clinical judgment. Appropriate staff follows up with members, emergency rooms or practitioners on all triage calls in which the member was in danger of harming self or others. For clinical oversight and accountability, a licensed psychiatrist is responsible for all Triage and Referral staff. For operational issues, staff is accountable to the Operations Director.

STAFF RESPONSIBILITIES
Chief Medical Officer
The Chief Medical Officer is a licensed physician board certified in psychiatry. The Chief Medical Officer is responsible for ensuring proper implementation of the UM Program. The
Chief Medical Officer is available to all care management staff and practitioners to assist in the following:

- Implementation of the UM Program
- The Chief Medical Officer is expected to have a working knowledge of the adopted level of care guidelines and community and discipline standards for treatment.
- The Chief Medical Officer is responsible for reviewing cases within 24 hours, or as agreed to by protocol. These cases may need review for referral and triage, medical necessity, concurrent review of a proposed treatment plan, review for denial, termination or reduction of services, recommendations for treatment, or retrospective review. The Chief Medical Officer consults with specialists, as needed, to make the best determination and document the decision and rationale. The Chief Medical Officer makes all denial determinations.

Licensed Specialty Practitioner and Peer Reviewers
The licensed specialty practitioners and Peer Reviewers may be of the following disciplines: a board-certified physician, a Nurse practitioner, a doctoral level licensed Psychologist, or a Chemical Dependency Assessor. These individuals are available for consultation regarding standards of care and assist in making a recommendation for appropriate treatment and/or denial and reduction or termination of services specific in their area(s) of specialties. They are expected to document their rationale and review recommendation. They are required to be knowledgeable in UM processes, the adopted level of care guidelines, NCQA, 62M, and CMS standards as set forth in the utilization management policies and procedures.

Utilization Management Staff Responsibilities
Care managers are licensed registered Nurses, licensed alcohol and drug counselor, or licensed master level prepared professionals with significant background in behavioral services and/or utilization review. They are required to be knowledgeable in UM processes, the adopted level of care guidelines, NCQA, 62M, CMS standards. They may perform the following functions for all care levels of mental health and substance use services, as applicable:

- **Utilization Review**- Utilization review includes the evaluation of the necessity and appropriateness of behavioral treatment modalities proposed for a patient at inpatient and outpatient levels of care. See UM1.01 “Utilization Review Process Description for UCare”.

- **Care Management**- Care managers provide supervision and coordination of treatment for patients that require individual management. These patients are identified by the need for long-term care, complex medical and psychiatric care, or high-cost care.

- **Discharge Planning**- By an interdisciplinary coordination of efforts, Care managers are available to aid patients or providers in developing a feasible plan for care following release from an inpatient or outpatient program.

- **Triage**- When necessary, Care managers or peer reviewers are responsible for triage and assessing the degrees of risk of a member calling in to schedule an appointment with a practitioner. They assist in determining the level of care needed and the urgency of the need.
**Care Management Coordinator**
The Care management Coordinators are responsible for providing administrative support to the Care managers and Peer Reviewers in the above mentioned functions. They have a minimum of a bachelor’s degree and related experience in behavioral healthcare. They are non-licensed and non-clinical staff. As such, they do not have the authority to make clinical decisions. They are required to have a thorough working knowledge of all pertinent policies and procedures, specifically those that pertain to utilization management. The Licensed Chemical Health (LADC) UM staff while called CMC’s, do have the authority to make clinical decision. The non-licensed CD staff may not make clinical decisions.

**Intake and Referral Staff**
The intake and referral staff is non-licensed, non-clinical personnel. They are responsible for collecting non-clinical data (i.e., demographics, insurance), making referrals, and the scheduling of initial appointments. They collect limited clinical data that assist in making an appropriate referral and that provides information to the practitioners. They do not have the authority to evaluate or interpret clinical information. They are trained and required to identify a clinical emergency (i.e., suicidal/homicidal ideation, thought disorder). This identification is for the purpose of transferring a call directly to a trained and qualified Care manager or other licensed UM staff. All Intake Staff are responsible for obtaining a working knowledge of the BHP Intake and Product policies and procedures. The staff are trained and oriented at the time of hire. The staff is updated as policies or procedures change.

All staff is expected to maintain the confidentiality of all patient and practitioner specific information in accordance with Confidentiality Policy PRV 10.0. All staff is required to sign a confidentiality statement at the time of hire.

**Clinical Services**
- This section focuses primarily on utilization management, denials and appeals, clinical quality case reviews, complaints and appeals related to clinical care, as well as the clinical quality activities and preventive health activities. The ongoing analysis of the following monitoring reports is to ensure adherence to BHP policies, NCQA, and UM standards. The following monitoring section applies to all insurance products that BHP works with. When a discrepancy is identified, interventions will be taken to improve performance. These activities will in turn be monitored to ensure effectiveness. As indicated, staff will be informed of all improvement activities and results.

- **Denials and Appeals**- All denials and appeals are processed according to policies and procedures. Note: There are different policies and procedures based on insurance product.

- **Clinical quality case reviews**- These cases are reviewed as required. A designated Quality Staff is responsible for gathering all necessary information. The Clinical Team conducts the review according to the policy. The Chief Medical Officer is responsible for informing the practitioner of any adverse outcome and monitoring any necessary corrective action plan. A summary report of all clinical quality case reviews is reviewed by the Clinical Team semi-annually, unless otherwise needed.
• **Complaints related to clinical care or treatment rendered**- All complaints, appeals and grievances from UCare members are referred immediately to the UCare Complaints, Appeals and Grievances Department.

• **Internal Recordkeeping**- At a minimum of biweekly the Department Managers review a minimum of three charts of each UM staff to ensure appropriateness of documentation. The Manager forwards this information onto the Operations Director weekly. The Manager forwards written feedback to the appropriate staff and meets with the staff when deemed necessary.

• **Treatment Recordkeeping Reviews and office site reviews**- These reviews are conducted on our potential high volume practitioners and organization wide summary reports are reviewed by the Clinical Team on a quarterly basis. The individual practitioner reviews are reviewed at the Credentialing Meeting.

**Clinical Quality Activities**

BHP continues to monitor and assess clinical quality activities that reflect our organization’s delivery system and member population. We assess and evaluate at least three meaningful clinical issues that address the following considerations:

- Are meaningful and relevant to BHP’s enrollees;
- Uses measures that are objective and quantifiable;
- Uses measures that are based on current scientific knowledge;
- Establishes goals or benchmarks for each measure;
- Data collection methods identify the appropriate population, draws appropriate samples and collect valid data;
- Data collected is quantitatively and qualitatively analyzed;
- Identifies opportunities for improvement, implements intervention to improve and measures the effectiveness of the interventions.

The data collected during the UM process is provides an array of reporting capabilities that allows BHP to design clinical quality activities and UM activities that address and satisfy the considerations listed above. BHP’s Care management system is internally designed to meet the varying requirements by health plan and to capture extensive data that allows BHP to develop reports that are used in the daily monitoring and planning of quality and UM activities. An analysis of potential underutilization or over utilization of services is done annually. The results of this analysis are documented in the QMI yearend report.

**STAFF TRAINING AND EVALUATION**

All staff receives initial training and orientation to the utilization management operations and the principles and procedures of utilization management. This is to ensure that care management staff is knowledgeable in NCQA, CMS and 62M utilization standards and their use. Ongoing training will include the following:

- Orientation at hire, including a test on policies and procedures;
- Upholding compliance with licensure requirements for continuing education units (CEU);
- Providing staff with information on and the time to attend conferences, seminars, courses, etc. to obtain continuing education units;
• Weekly peer review of cases with a Psychiatric or Psychologist Consultant to ensure compliance and reinforce knowledge of UM guidelines and criteria;
• Quarterly Inter-rater reliability evaluation and policy and procedure testing
• Yearly performance reviews.

Through direct clinical supervision the Chief Medical Officer ensures appropriate implementation of UM policies and procedures. Through case consultations, the doctoral level licensed Psychologist Reviewers oversee and reinforce appropriate implementation of UM standards, policies, and procedures. The weekly Clinical/Operations Team meeting includes the Chief Medical Officer, Psychologist Reviewers, Managers, and Quality Oversight Staff. These meetings provide continuous evaluation of the UM Program implementation.

AFFIRMATIVE STATEMENT REGARDING INCENTIVES
BHP UM Staff attest to the following:
I attest that all UM decisions that I make are based solely on the appropriateness of care and service. My employer, BHP, does not specifically reward me for conducting utilization review for issuing denials or coverage or service. There are not financial incentives related to utilization decisions that would result in or encourage underutilization.

UM staff signs off to the above statement on the Employee Confidentiality Agreement.

DELEGATION
If BHP delegates UM functions, we will maintain oversight of the delegated or subcontracted agency. We will ensure the following:
• The delegate performs these functions in accordance with NCQA, CMS and 62M standards, as applicable.
• Have a written, signed, and dated contract that specifies that at a minimum the agency will be in substantial compliance with these standards.
• BHP is responsible for periodic, no less than annual, review or audit of the agency’s policies, procedures and quality improvement plan. This includes monitoring performance and compliance, adherence to its QI Plan.
• Will ensure and monitor the effectiveness of communications between the BHP and the agency.

PLAN EVALUATION
The Clinical Team, at a minimum, evaluates the UM Program (including policies, procedures, and level of care guidelines) annually. The program is updated as needed based on the Clinical Team review, input, and recommendations and/or changes in state, federal or national regulations or requirements.

Regulatory / External References:  
NCQA: UM 1, UM 4; UM 14
QISMC: UM01; HS04
Internal References:

Source: Renee Treberg, Amy Wrightson

Date Effective: January 1997

