ITASCA COUNTY
BOARD OF COMMISSIONERS

Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744
(218) 327-2847

Tuesday, April 20, 2021 | 2:30 PM | Itasca County Boardroom

FINAL

WORK SESSION MINUTES

I. CALL TO ORDER

Chair Ives called the meeting to order at 2:30 PM.

Attendee Name	Title	Status	Arrived
Davin Tinquist	District #1	Present	2:30 PM
Terry Snyder	District #2	Present	2:30 PM
Leo Trunt	District #3	Present	2:30 PM
Burl Ives	District #4	Present	2:30 PM
Ben DeNucci	District #5	Present	2:30 PM

II. PLEDGE OF ALLEGIANCE

III. APPROVAL OF AGENDA

Motion To: Pull Item #5.4 (2021 Chloride Contract), add the item as Item #6.6, add Item #6.7 (CDBG Program Discussion), and approve the agenda, as amended.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Terry Snyder
SECONDER:	Commissioner Leo Trunt
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

IV. MINUTES APPROVAL

Motion To: Approve the minutes of the Tuesday, April 13, 2021 County Board Regular Session.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Leo Trunt
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

V. RECOMMENDED FOR CONSENT AGENDA

1. Approve the CARES Act Grant Agreement for airport operations and maintenance at the Grand Rapids/Itasca County Airport and authorize necessary signatures.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

2. Authorize IMCare Director and County Board Chair to sign the contract between IMCare and The Woods Therapy and Counseling Services, PLLC.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

3. Authorize the IT Director to sign the 2021 Enterprise Agreement with ESRI to renew services for a further three years and authorize payment of the agreement from the Recorder's Compliance Fund.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

5. Award bids for Propane, Diesel Fuel, and Gasoline for a one (1) year period from May 1, 2021 through April 30, 2022 to the lowest responsible bidders, as follows, and authorize the county engineer to sign the service agreement: Propane: Edwards Oil Inc. - Swan River, Togo, Old Balsam, Deer River, Arbo, Balsam, Max, Nashwauk; Diesel Fuel: Edwards Oil Inc. - Cohasset, Arbo, Bigfork, Balsam, Swan River, Nashwauk and Davis Oil Inc. - Togo; and Gasoline: Edwards Oil Inc. - Courthouse, Deer River, Cohasset, Balsam, Bigfork, Nashwauk, Swan River.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

6. Approve the 2021/2022 Annual Road Maintenance Agreements and authorize the County Board Chairperson and the Clerk to the County Board to sign Agreements and authorize the County Engineer to modify Attachment "A" to Agreements as needed and upon mutual agreement with the Township or City.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

7. Authorize notice of intermediate and regular oral bid auction of timber be given by publication in the official newspaper of the County as provided by law and that Land Commissioner offers such tracts of timber associated with said notice of sale, and the auction shall commence at 10:00 AM on Wednesday, June 9th, 2021 at the Gunn Park Pavilion in Grand Rapids, MN. Special COVID-19 public safety guidelines and precautious shall apply.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

8. Adopt the Resolution Re: Repurchase of the South Four hundred Sixty-two feet (S. 462') of the Northeast Quarter of the Southeast Quarter (NE1/4 SE1/4), Section Nine (9), Township Fifty-seven (57), Range Twenty-four (24) to Allen Wayne Chastan.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

9. Adopt the Resolution Re: Repurchase of Lot Five (5), Block One (1), Third Addition to Marble to Steven Keske.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

10. Adopt the Resolution Re: Authorizing and Fixing the Notice and Terms of Tax-Forfeited Land Sale to Adjoining Landowners.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

11. Adopt the Resolution Re: Sale of Tax-forfeited Land to the City of Keewatin, which approves sale of Lots 1 & 2, Block 4 SPINA ADDITION TO KEEWATIN under the terms provided in Minnesota Statute 282.01, Subd. 1a para. (d) for a price of $100.00 plus all associated costs.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

12. Approve the 2021 Fairgrounds Race Track Agreement between Itasca County and Grand Rapids Speedway Inc. and authorize necessary signatures.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

13. Adopt the Resolution Re: Approving State of Minnesota Joint Powers Agreements with the County of Itasca on Behalf of its Probation Department and authorize Itasca County Board Chair Burl Ives, Itasca County Administrator Brett Skyles, and Itasca County Probation Director Jason Anderson to sign the State of Minnesota Joint Powers Agreement and Court Data Services Subscriber Amendment to CJDN Subscriber Agreement between the Itasca County and the State of Minnesota.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

VI. DISCUSSION / INFORMATIONAL

1. Citizen Input

   No citizen input provided.

2. Resolution to Oppose Parole of James Shane Swanson

   Motion To: Adopt the Resolution Re: Opposition for the Parole of James Shane Swanson.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Terry Snyder
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

3. Review and Approval of IMCare QI/UM Documents

   QI/UM Director Alexis Martire provided information regarding the request to approve the IMCare 2021 Quality Program Description, 2021 UM Program Description, 2021 QI UM Program Evaluation, and the 2021 QI/UM Workplan.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

4. Updated Tobacco Ordinance

   Public Health Division Manager Kelly Chandler provided information regarding the request to approve the updated Tobacco Ordinance.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

5. Change in Allocation Sign Tech/Highway Maintenance Worker Position

   Maintenance Engineer Kory Johnson provided information regarding the request to approve the change in allocation of one (1) Sign Tech/Highway Maintenance Worker position to Highway Maintenance Worker position.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

6. 2021 Chloride Contract

   Maintenance Engineer Kory Johnson provided information regarding the request to award County Project 2021-10 for 2021 Calcium Chloride to the lowest responsible bidder, Knife River Corporation and Magnesium Chloride to the lowest responsible bidder, Trimark Industrial and authorize the necessary signatures to execute the contract documents.

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

7. CDBG Program Discussion

   Commissioner DeNucci provided information regarding the Small Cities Coronavirus Community Development Block Grant (CDBG) opportunity offered by the Minnesota Department of Employment and Economic Development (DEED) for broadband expansion, utility relief funding, or building renovations and upgrades. It was the consensus of the County Board to direct staff to communicate program information with Itasca County cities and townships.

RESULT:	**INFORMATIONAL - NO ACTION TAKEN**

VII. COMMITTEE REPORTS

Commissioner Tinquist reported on his attendance of recent Jail Committee, Blackduck Joint Powers Board, Extension Committee, and Project Frontier meetings, as well as a meeting with Itasca Economic Development Corporation (IEDC)/Tamara Lowney.

Commissioner Trunt reported on his attendance of recent Fairgrounds Park Committee, Western Mesabi Mine Planning Board (WMMPB), and City/County Cooperating Committee meetings, as well

as a meeting with Itasca Economic Development Corporation (IEDC)/Tamara Lowney and a tour of the Emergency Operations Center (EOC).

Commissioner Snyder reported on his attendance of recent Fairgrounds Park Committee, Chippewa Resource Advisory Committee (RAC), Extension Committee, and City/County Cooperating Committee meetings, as well as meetings with Community and Economic Development Associates (CEDA)/Sarah Carling and Itasca Economic Development Corporation (IEDC)/Tamara Lowney.

Commissioner DeNucci reported on his attendance of a recent Northeast Minnesota Area Transportation Partnership (NEMNATP) meeting, as well as an ISD 319 School Board meeting, a Nashwauk City Council meeting, and a meeting with Itasca Economic Development Corporation (IEDC)/Tamara Lowney.

Commissioner Ives reported on his attendance of recent meetings with Community and Economic Development Associates (CEDA)/Sarah Carling and Itasca Economic Development Corporation (IEDC)/Tamara Lowney.

VIII. ADMINISTRATOR UPDATE

IX. COMMISSIONER COMMENTS

County Attorney Matti Adam provided comment regarding her recent experience speaking with Greenway students.

X. CLOSED SESSIONS

XI. ADJOURN

Chair Ives adjourned the meeting at 3:32 PM.

ATTEST

Burl Ives
Chair of the County Board

Brett Skyles
Clerk of the County Board

ITASCA COUNTY
BOARD OF COMMISSIONERS

Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

RESOLUTION 2021-25

RE: OPPOSITION FOR THE PAROLE OF JAMES SHANE SWANSON

WHEREAS, on June 15, 1991 at 2:45 a.m., Carin Streufert, a resident of Itasca County, left a downtown Grand Rapids restaurant never to be seen again; and

WHEREAS, after an intense investigation by the Itasca County Sheriff's Department and the Grand Rapids Police Department, James Shane Swanson and his co-defendant were arrested and admitted to the killing of Carin Streufert; and

WHEREAS, James Shane Swanson was convicted on December 14, 1991 of Count 1 - First Degree Murder-Premeditated (Life Sentence), Count 2 - First Degree Murder in the Commission of Another Crime (Life Sentence), Count 3 - First Degree Murder Aid and Abet (Life Sentence), Count 4 - First Degree Murder with First Degree Criminal Sexual Conduct (Life Sentence), and Count 5 - Kidnapping (91 Years); and

WHEREAS, the Itasca County Board of Commissioners feels that the release of James Shane Swanson would create an extreme safety risk.

NOW THEREFORE BE IT RESOLVED, on this date of April 20, 2021, that the Itasca County Board of Commissioners does hereby oppose the parole of James Shane Swanson and does recommend his continued incarceration.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Terry Snyder
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

STATE OF MINNESOTA
Office of County Administrator
ss. County of Itasca

I, BRETT SKYLES, Administrator of the County of Itasca, do hereby certify that I have compared the foregoing with the original resolution filed in my office on the 20th day of April A.D. 2021 and that the same is a true and correct copy of the whole thereof.

WITNESS MY HAND AND SEAL OF OFFICE at Grand Rapids, Minnesota, this 20th day of April A.D. 2021.

Administrator

April 20, 2021

Chair:

PULL:
1. Item #5.4 – 2021 Chloride Contract

ADDITIONS:
1. Item #6.6 – 2021 Chloride Contract (previously Item #5.4)

CHANGES: None

INFORMATIONAL:
1. Item #6.2 – Additional Information

2. Item #6.4 – Additional Information

Amanda

ITASCA COUNTY
BOARD OF COMMISSIONERS

Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744
(218) 327-2847

Tuesday, April 13, 2021 | 2:30 PM | Itasca County Boardroom

DRAFT

REGULAR SESSION MINUTES

I. CALL TO ORDER

Chair Ives called the meeting to order at 2:32 PM.

Attendee Name	Title	Status	Arrived
Davin Tinquist	District #1	Present	2:32 PM
Terry Snyder	District #2	Present	2:32 PM
Leo Trunt	District #3	Present	2:32 PM
Burl Ives	District #4	Present	2:32 PM
Ben DeNucci	District #5	Present	2:32 PM

II. PLEDGE OF ALLEGIANCE

III. APPROVAL OF AGENDA

Motion To: Pull Item #5.24 (WatchGuard Video Lease Agreement), add Item #6.11 (National Public Safety Telecommunicators Week Proclamation), and approve the agenda, as amended.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Davin Tinquist
SECONDER:	Commissioner Terry Snyder
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

IV. MINUTES APPROVAL

Motion To: Approve the minutes of the Tuesday, April 6, 2021 County Board Work Session.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Leo Trunt
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

V. CONSENT AGENDA

Motion To: Approve the Consent Agenda, as amended and delineated below.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Leo Trunt
SECONDER:	Commissioner Terry Snyder
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

1. Approve the updated Interim Policy 21-01:COVID Program for Employees
2. Authorize the County Board to approve Itasca County as sponsors for existing snowmobile, ski, and ATV trails from May 1, 2021 to April 30, 2026, with the stipulation the DNR approves Performance Based Grants and Grant in Aid Grants.

3. Approve a Premises Permit Application for gambling, as requested by the Community Charities of MN for gambling to be held at Deer Lake Charlies located at 64051 County Road 533, Effie, MN 56639.
4. Accept the minutes of the March 11th, 2021 HHS Advisory Committee meeting.
5. Request authorization to hire one Managed Care Nurse in the IMCare Division of the Itasca County Health and Human Services Department.
6. Authorize posting of two (2) Eligibility Specialist positions, Family Services Division, Health & Human Services Department on an open competitive basis, if not filled on an internal basis.
7. Approve a Change in Allocation of a 1.0 FTE Public Health Nurse, currently vacant, to 1.0 FTE Public Health Educator in the Public Health Division of the Itasca County Health and Human Services Department.
8. Authorize Itasca County Health & Human Services to go out for bids for the Itasca Resource Center (IRC) Siding Replacement with funds to be paid from Itasca Resource Center building fund.
9. Approve $20,000 of additional funding in 2021 for both the Bigfork Ambulance Service and the Nashwauk Ambulance Service with payment of these additional costs either through the new pandemic relief funds coming to Counties or through HHS reserves in 2021, with the conversation continuing into the budget sessions for future budget years.
10. Award Contract 202107 - Crushing, Hauling, and Placement of Aggregate Surfacing to the lowest responsible bidder Wm. J. Schwartz & Son Inc. in the amount of $739,635.00 and authorize the required signatures on the contract documents.
11. Award contract 64507 for CSAH 45 & CSAH 60 Bituminous Projects to the lowest responsible bidder, Hawkinson Construction Co, Inc., in the amount of $4,455,322.14 and authorize the required signatures on the contract documents.
12. Approve the Crossing Surface Installation Agreement between Itasca County and BNSF and authorize the County Engineer to sign the agreement.
13. Adopt the Five Year Plan for Highway Improvement Projects and authorize the expenditure of unorganized township funds on projects listed in the plan.
14. Approve use of Transportation Reserve Funds for Capital Improvement Project and authorize the County Engineer to enter into the Contract with Sourcewell/Jamar for Maintenance Facility Salt Shed Roof repairs.
15. Adopt the Resolution Re: Repurchase of an Undivided One-Half interest in the Southeast Quarter of the Southwest Quarter (SE of SW), Section Eighteen (18), Township Sixty-one (61), Range Twenty-two (22) by Robin Scofield.
16. Adopt the Resolution Re: Repurchase of Lots Eight (8) and Nine (9), Block Eleven (11), NASHWAUK by Lance Hopke.
17. Adopt the Resolution Re: Sale of Tax-forfeited Land to the City of Calumet, which approves sale of Lots 1 & 2, Block 5 ORIGINAL TOWNSITE OF THE VILLAGE OF CALUMET under the terms provided in Minnesota Statute 282.01, Subd. 1a para. (d) for a price of $100.00 plus all associated costs.
18. Award Earthen Materials Lease located in NWSW, Section 4, Township 60 North, Range 23 West (Unorganized Township) to William J. Schwartz & Son's Excavating and authorize signatures.

19. Award Earthen Materials lease located in SESE, Section 2; NWSW, Section 4; S1/2SE1/4, Section 5; All in Township 60 North, Range 23 West (Unorganized Township) to Kern & Tabery, Inc. and authorize necessary signatures.
20. Set time and date for the Land Department to conduct an oral auction of earthen materials at the Itasca County Land Department, 1177 LaPrairie Avenue, Grand Rapids, MN and authorize publication: Thursday, April 22, 2021 at 8:30 AM, base royalty rate of $1.50/cubic yard loose volume, minimum 8,000 cubic yards, in S1/2SW1/4, Section 7, and NENW, Section 18, all in Township 59 North, Range 24 West (Unorganized Township), award earthen materials lease to high bidder and authorize necessary signatures.
21. Request authorization to hire one (1) vacant Survey Technician position in the Department of Surveying and Mapping.
22. Authorize signatures of Administrator Brett Skyles and Board Chair Burl Ives to execute the Amended Joint Powers Agreement between the State of MN and Itasca County Sheriff's Office as it relates to the Minnesota Human Trafficking Investigators Task Force (MNHITF).
23. Authorize out-of-state travel for Correctional Deputy Nate O'Brien to attend MRT Training in Las Vegas, Nevada July 6-9, 2021.

VI. REGULAR AGENDA

1. Citizen Input

   No citizen input provided.

2. Recognition of County Employees

   The following employees were recognized:

   Welcome new employee, Dan Neary who was hired as a Forester, Land Department effective April 12, 2021.

   Welcome new employee, Greg Wyatt who was hired as a Park Maintenance Worker, Land Department effective April 12, 2021.

   Farewell to Cathy Castle, whose last day as an Eligibility Specialist in the Health & Human Services Department will be April 30, 2021 after 15+ years of service.

RESULT:	**INFORMATIONAL - NO ACTION TAKEN**

3. Commissioner Warrants

   Motion To: Approve Commissioner Warrants with a check date of April 16, 2021 in the amount of $525,798.97.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Terry Snyder
SECONDER:	Commissioner Ben DeNucci
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

4. COVID-19 Update

   Public Health Division Manager Kelly Chandler provided a situational and informational update regarding COVID-19 (novel coronavirus) in Itasca County, including information regarding vaccination roll-out. If you have questions or concerns regarding COVID-19, please call the Public Health Hotline at (218) 327-6784, visit http://www.co.itasca.mn.us/798/COVID-19-Coronavirus-Information, or contact First Call for Help/211 at (218) 326-8565.

RESULT:	**INFORMATIONAL - NO ACTION TAKEN**

5. 2020 Itasca SWCD AIS Program Report / SFY 2022 Budget Proposal

   Itasca County Aquatic Invasive Species (AIS) Coordinator Bill Grantges provided an Itasca County AIS Program Update for 2020, as well as recommendations for the State Fiscal Year (SFY) 2022 Itasca County AIS Program Budget.

   Motion To: Approve the State Fiscal Year (SFY) 2022 Itasca County Soil & Water Conservation District (SWCD) Aquatic Invasive Species (AIS) Program Budget Proposal.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Leo Trunt
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

6. Discuss Hiring Freeze

   Motion To: Extend the process where by departments request County Board approval for filling of budgeted positions for another six (6) months.

RESULT:	**FAILED (2 TO 3)**
MOVER:	Commissioner Leo Trunt
SECONDER:	Commissioner Burl Ives
AYES:	Leo Trunt, Burl Ives
NAYS:	Davin Tinquist, Terry Snyder, Ben DeNucci

   Motion To: Return to the previous process for filling of budgeted positions with the addition of directing Department Heads making requests for hiring to distribute the completed Hiring Request form to the full Board and County Administrator.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Terry Snyder
SECONDER:	Commissioner Leo Trunt
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

7. Settlement Agreement – County Sheriff

   Motion To: Adopt the Resolution Re: Approving the Settlement of the 2021 Salary Appeal Between the County of Itasca and Itasca County Sheriff Victor Williams.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Terry Snyder
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

8. Settlement Agreement – County Auditor/Treasurer

   Motion To: Adopt the Resolution Re: Approving the Settlement of the 2021 Salary Appeal Between the County of Itasca and Itasca County Auditor/Treasurer Jeffrey Walker.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Leo Trunt
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

9. Bid Award – Asbestos Abatement Project

   Motion To: Award bid for Itasca County Correction Facility future site asbestos abatement project to the low bidder, ECCO Midwest, for the amount of $82,250 and approve County Administrator to obtain necessary signatures.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Davin Tinquist
SECONDER:	Commissioner Leo Trunt
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

10. Update on Bid Package #1 for New Correctional Facility

County Administrator Brett Skyles provided an update regarding Bid Package #1 for the new Correctional Facility project.

RESULT:	**INFORMATIONAL - NO ACTION TAKEN**

11. National Public Safety Telecommunicators Week Proclamation

Motion To: Adopt the National Public Safety Telecommunicators Week Proclamation, which proclaims the week of April 11-17, 2021 as National Public Safety Telecommunicators Week in Itasca County.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Davin Tinquist
SECONDER:	Commissioner Ben DeNucci
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

VII. COMMISSIONER COMMENTS

Commissioner Tinquist provided comment regarding the Chippewa National Forest Regional Advisory Committee (RAC) and their goal for disbursement of RAC funds for eligible projects.

RECESS

Chair Ives recessed the meeting at 3:46 PM.

RECONVENE

Chair Ives reconvened the meeting at 4:04 PM, with all members present.

VIII. CLOSED SESSIONS

1. Closed Session per MN Statutes 13D.05, Subd. 3(b) Re: Itasca County Jail Project

Motion To: Go into Closed Session per MN Statutes 13D.05, Subd. 3(b), based upon Attorney Client Privilege MN Statutes 595.02, Subd. 1(b), to consult with its attorney in reference to the Itasca County Jail Project.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Terry Snyder
SECONDER:	Commissioner Ben DeNucci
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

Others Present: County Attorney Matti Adam, County Administrator Brett Skyles, and Deputy Clerk of the County Board Amanda Schultz.

Motion To: Go into Open Session.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Terry Snyder
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

RESULT:	**INFORMATIONAL - NO ACTION TAKEN**

IX. ADJOURN

Chair Ives adjourned the meeting at 4:26 PM.

ATTEST

Burl Ives Chair of the County Board	Brett Skyles Clerk of the County Board

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1530

DEPARTMENT: Administrative Services
TIME REQUESTED: 5 Minutes
PRESENTER: Matt Wegwerth

AGENDA ITEM:
CARES Act Grant Agreement

BOARD ACTION REQUESTED:
Approve the CARES Act Grant Agreement for airport operations and maintenance at the Grand Rapids/Itasca County Airport and authorize necessary signatures.

BACKGROUND:
The Federal CARES Act provided for grant funding to airports to help cover operations and maintenance costs due to the COVID-19 pandemic. The total of the grant is $23,000 and funds are available for four years. Dollars are available on a reimbursement basis provided the expenses meet certain criteria.

COUNTY ATTORNEY REVIEW: Yes and/or Pending

SUPPORTING DOCUMENTATION:
1. GPZ-GLG-3-27-0037-025-2021-Grant Agreement - unsigned

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

U.S. Department of Transportation Federal Aviation Administration

Airports Division
Great Lakes Region
Minnesota, North Dakota, South Dakota

FAA DMA ADO
6020 28th Ave. S.
Suite 102
Minneapolis, MN 55450

CRRSA Transmittal Letter

April 8, 2021

Mr. Matt Wegwerth
420 N Pokegama Ave
Grand Rapids, MN 55744

Dear Mr. Wegwerth:

Please find the following electronic Airport Coronavirus Response Grant Program (ACRGP) Grant Offer, Grant No. **3-27-0037-025-2021 for Grand Rapids/Itasca County-Gordon Newstrom Field Airport**. This letter outlines expectations for success. Please read and follow the instructions carefully.

To properly enter into this agreement, you must do the following:

a. The governing body must provide authority to execute the grant to the individual signing the grant; i.e. the sponsor's authorized representative.

b. The sponsor's authorized representative must execute the grant, followed by the attorney's certification, no later than **June 1, 2021** in order for the grant to be valid.

c. You may not make any modification to the text, terms or conditions of the grant offer.

d. The grant offer must be digitally signed by the sponsor's legal signatory authority and then the grant offer will be routed via email to the sponsor's attorney. Once the attorney has digitally attested to the grant, an email with the executed grant will be sent to all parties.

Subject to the requirements in 2 CFR §200.305, each payment request for reimbursement under this grant must be made electronically via the Delphi eInvoicing System. Please see the attached Grant Agreement for more information regarding the use of this System. The terms and conditions of this agreement require you drawdown and expend these funds within four years.

An airport sponsor may use these funds for costs related to operations, personnel, cleaning, sanitization, janitorial services, combating the spread of pathogens at the airport, and debt service payments. Please refer to the ACRGP Frequently Asked Questions for further information.

With each payment request you are required to upload an invoice summary directly to Delphi. The invoice summary should include enough detail to permit FAA to verify compliance with the Coronavirus Response and Relief Supplemental Appropriations Act (Public Law 116-260).

For the final payment request, in addition to the requirement listed above for all payment requests, you are required to upload directly to Delphi:

- A final financial report summarizing all of the costs incurred and reimbursed, and
- An SF-425, and.
- A closeout report (A sample report is available here).

Until the grant is completed and closed, you are responsible for submitting a signed/dated SF-425 annually, due 90 days after the end of each federal fiscal year in which this grant is open (due December 31 of each year this grant is open).

As a condition of receiving Federal assistance under this award, you must comply with audit requirements as established under 2 CFR part 200. Subpart F requires non-Federal entities that expend $750,000 or more in Federal awards to conduct a single or program specific audit for that year. Note that this includes Federal expenditures made under other Federal-assistance programs. Please take appropriate and necessary action to assure your organization will comply with applicable audit requirements and standards.

I am readily available to assist you and your designated representative with the requirements stated herein. We sincerely value your cooperation in these efforts.

Sincerely,

E. Lindsay Butler
Acting Manager

U.S. Department of Transportation Federal Aviation Administration

AIRPORT CORONAVIRUS RELIEF GRANT PROGRAM (ACRGP)

GRANT AGREEMENT

Part I - Offer

Federal Award Offer Date April 8, 2021

Airport/Planning Area Grand Rapids/Itasca County-Gordon Newstrom Field Airport

ACRGP Grant Number 3-27-0037-025-2021

Unique Entity Identifier 080240526

TO: County of Itasca and City of Grand Rapids

(herein called the "Sponsor")

Channeled through the State of Minnesota

FROM: **The United States of America** (acting through the Federal Aviation Administration, herein called the "FAA")

WHEREAS, the Sponsor has submitted to the FAA an Airports Coronavirus Response Grant Program (herein called "ACRGP") Application dated February 16, 2021, for a grant of Federal funds at or associated with the Grand Rapids/Itasca County-Gordon Newstrom Field Airport, which is included as part of this ACRGP Grant Agreement; and

WHEREAS, the Sponsor has accepted the terms of FAA's ACRGP Grant offer;

WHEREAS, in consideration of the promises, representations and assurances provided by the Sponsor, the FAA has approved the ACRGP Application for the Grand Rapids/Itasca County-Gordon Newstrom Field Airport, (herein called the "Grant" or "ACRGP Grant") consisting of the following:

This ACRGP Grant is provided in accordance with the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA Act or "the Act"), Division M of Public Law 116-260, as described below, to provide eligible Sponsors with funding for costs related to operations, personnel, cleaning, sanitization, janitorial services, combating the spread of pathogens at the airport, and debt service payments. ACRGP Grant amounts to specific airports are derived by legislative formula (See Division M, Title IV of the Act).

The purpose of this ACRGP Grant is to prevent, prepare for, and respond to coronavirus. Funds provided under this ACRGP Grant Agreement must only be used for purposes directly related to the airport. Such purposes can include the reimbursement of an airport's operational and maintenance expenses or debt

service payments in accordance with the limitations prescribed in the Act. ACRGP Grants may be used to reimburse airport operational and maintenance expenses directly related to Grand Rapids/Itasca County-Gordon Newstrom Field incurred no earlier than January 20, 2020. ACRGP Grants also may be used to reimburse a Sponsor's payment of debt service where such payments occur on or after December 27, 2020. Funds provided under this ACRGP Grant Agreement will be governed by the same principles that govern "airport revenue." New airport development projects not directly related to combating the spread of pathogens and approved by the FAA for such purposes, may not be funded with this Grant.

NOW THEREFORE, in accordance with the applicable provisions of the CRRSA Act, Public Law 116-260, the representations contained in the Grant Application, and in consideration of (a) the Sponsor's acceptance of this Offer; and, (b) the benefits to accrue to the United States and the public from the accomplishment of the Grant and in compliance with the conditions as herein provided,

THE FEDERAL AVIATION ADMINISTRATION, FOR AND ON BEHALF OF THE UNITED STATES, HEREBY OFFERS AND AGREES to pay 100% percent of the allowable costs incurred as a result of and in accordance with this Grant Agreement.

Assistance Listings Number (Formerly CFDA Number): 20.106

This Offer is made on and **SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS**:

CONDITIONS

1. **Maximum Obligation.** The maximum obligation of the United States payable under this Offer is **$23,000**, allocated as follows:

   $23,000 Non Primary KU2021

2. **Grant Performance.** This ACRGP Grant Agreement is subject to the following federal award requirements:

   a. The Period of Performance:

      1. Shall start on the date the Sponsor formally accepts this agreement, and is the date signed by the last Sponsor signatory to the agreement. The end date of the period of performance is 4 years (1,460 calendar days) from the date of acceptance. The period of performance end date shall not affect, relieve or reduce Sponsor obligations and assurances that extend beyond the closeout of this Grant Agreement.

      2. Means the total estimated time interval between the start of an initial Federal award and the planned end date, which may include one or more funded portions, or budget periods. (2 Code of Federal Regulations (CFR) § 200.1)

   b. The Budget Period:

      1. The budget period for this ACRGP Grant is 4 years (1,460 calendar days). Pursuant to 2 CFR § 200.403(h), the Sponsor may charge to the Grant only allowable costs incurred during the budget period.

      2. Means the time interval from the start date of a funded portion of an award to the end date of that funded portion during which the Sponsor is authorized to expend the funds awarded, including any funds carried forward or other revisions pursuant to §200.308.

c. Close out and Termination.

1. Unless the FAA authorizes a written extension, the Sponsor must submit all Grant closeout documentation and liquidate (pay-off) all obligations incurred under this award no later than 120 calendar days after the end date of the period of performance. If the Sponsor does not submit all required closeout documentation within this time period, the FAA will proceed to close out the grant within one year of the period of performance end date with the information available at the end of 120 days. (2 CFR § 200.344)

2. The FAA may terminate this ACRGP Grant, in whole or in part, in accordance with the conditions set forth in 2 CFR § 200.340, or other Federal regulatory or statutory authorities as applicable.

3. **Unallowable Costs.** The Sponsor shall not seek reimbursement for any costs that the FAA has determined to be unallowable under the CRRSA Act.

4. **Indirect Costs - Sponsor.** The Sponsor may charge indirect costs under this award by applying the indirect cost rate identified in the Grant Application as accepted by the FAA, to allowable costs for Sponsor direct salaries and wages only.

5. **Final Federal Share of Costs.** The United States' share of allowable Grant costs is 100%.

6. **Completing the Grant without Delay and in Conformance with Requirements.** The Sponsor must carry out and complete the Grant without undue delays and in accordance with this ACRGP Grant Agreement, the CRRSA Act, and the regulations, policies, standards, and procedures of the Secretary of Transportation ("Secretary"). Pursuant to 2 CFR § 200.308, the Sponsor agrees to report to the FAA any disengagement from funding eligible expenses under the Grant that exceeds three months or a 25 percent reduction in time devoted to the Grant, and request prior approval from FAA. The report must include a reason for the stoppage. The Sponsor agrees to comply with the attached assurances, which are part of this agreement and any addendum that may be attached hereto at a later date by mutual consent.

7. **Amendments or Withdrawals before Grant Acceptance.** The FAA reserves the right to amend or withdraw this offer at any time prior to its acceptance by the Sponsor.

8. **Offer Expiration Date.** This offer will expire and the United States will not be obligated to pay any part of the costs unless this offer has been accepted by the Sponsor on or before June 1, 2021, or such subsequent date as may be prescribed in writing by the FAA.

9. **Improper Use of Federal Funds.** The Sponsor must take all steps, including litigation if necessary, to recover Federal funds spent fraudulently, wastefully, or in violation of Federal antitrust statutes, or misused in any other manner, including uses that violate this ACRGP Grant Agreement, the CRRSA Act or other provision of applicable law. For the purposes of this ACRGP Grant Agreement, the term "Federal funds" means funds however used or dispersed by the Sponsor, that were originally paid pursuant to this or any other Federal grant agreement(s). The Sponsor must return the recovered Federal share, including funds recovered by settlement, order, or judgment, to the Secretary. The Sponsor must furnish to the Secretary, upon request, all documents and records pertaining to the determination of the amount of the Federal share or to any settlement, litigation, negotiation, or other efforts taken to recover such funds. All settlements or other final positions of the Sponsor, in court or otherwise, involving the recovery of such Federal share require advance approval by the Secretary.

10. **United States Not Liable for Damage or Injury.** The United States is not responsible or liable for damage to property or injury to persons which may arise from, or relate to this ACRGP Grant Agreement, including, but not limited to, any action taken by a Sponsor related to or arising from, directly or indirectly, this ACRGP Grant Agreement.

11. **System for Award Management (SAM) Registration and Unique Entity Identifier (UEI).**

    a. Requirement for System for Award Management (SAM): Unless the Sponsor is exempted from this requirement under 2 CFR 25.110, the Sponsor must maintain the currency of its information in the SAM until the Sponsor submits the final financial report required under this grant, or receives the final payment, whichever is later. This requires that the Sponsor review and update the information at least annually after the initial registration and more frequently if required by changes in information or another award term. Additional information about registration procedures may be found at the SAM website (currently at http://www.sam.gov).

    b. Unique entity identifier (UEI) means a 12-character alpha-numeric value used to identify a specific commercial, nonprofit or governmental entity. A UEI may be obtained from SAM.gov at https://sam.gov/SAM/pages/public/index.jsf.

12. **Electronic Grant Payment(s).** Unless otherwise directed by the FAA, the Sponsor must make each payment request under this agreement electronically via the Delphi eInvoicing System for Department of Transportation (DOT) Financial Assistance Awardees.

13. **Air and Water Quality.** The Sponsor is required to comply with all applicable air and water quality standards for all projects in this grant. If the Sponsor fails to comply with this requirement, the FAA may suspend, cancel, or terminate this agreement.

14. **Financial Reporting and Payment Requirements.** The Sponsor will comply with all Federal financial reporting requirements and payment requirements, including submittal of timely and accurate reports.

15. **Buy American.** Unless otherwise approved in advance by the FAA, in accordance with 49 United States Code (U.S.C.) § 50101 the Sponsor will not acquire or permit any contractor or subcontractor to acquire any steel or manufactured goods produced outside the United States to be used for any project for which funds are provided under this grant. The Sponsor will include a provision implementing Buy American in every contract.

16. **Audits for Sponsors.**

    PUBLIC SPONSORS. The Sponsor must provide for a Single Audit or program-specific audit in accordance with 2 CFR Part 200. The Sponsor must submit the audit reporting package to the Federal Audit Clearinghouse on the Federal Audit Clearinghouse's Internet Data Entry System at http://harvester.census.gov/facweb/ . Upon request of the FAA, the Sponsor shall provide one copy of the completed audit to the FAA.

17. **Suspension or Debarment.** When entering into a "covered transaction" as defined by 2 CFR § 180.200, the Sponsor must:

    a. Verify the non-Federal entity is eligible to participate in this Federal program by:

        1. Checking the excluded parties list system (EPLS) as maintained within the System for Award Management (SAM) to determine if the non-Federal entity is excluded or disqualified; or

2. Collecting a certification statement from the non-Federal entity attesting the entity is not excluded or disqualified from participating; or
3. Adding a clause or condition to covered transactions attesting the individual or firm is not excluded or disqualified from participating.

b. Require prime contractors to comply with 2 CFR § 180.330 when entering into lower-tier transactions (e.g. sub-contracts).

c. Immediately disclose to the FAA whenever the Sponsor (1) learns the Sponsor has entered into a covered transaction with an ineligible entity, or (2) suspends or debars a contractor, person, or entity.

18. **Ban on Texting While Driving.**

a. In accordance with Executive Order 13513, Federal Leadership on Reducing Text Messaging While Driving, October 1, 2009, and DOT Order 3902.10, Text Messaging While Driving, December 30, 2009, the Sponsor is encouraged to:

1. Adopt and enforce workplace safety policies to decrease crashes caused by distracted drivers including policies to ban text messaging while driving when performing any work for, or on behalf of, the Federal government, including work relating to this ACRGP Grant or subgrant funded by this Grant.
2. Conduct workplace safety initiatives in a manner commensurate with the size of the business, such as:

A. Establishment of new rules and programs or re-evaluation of existing programs to prohibit text messaging while driving; and

B. Education, awareness, and other outreach to employees about the safety risks associated with texting while driving.

b. The Sponsor must insert the substance of this clause on banning texting while driving in all subgrants, contracts, and subcontracts funded by this ACRGP Grant.

19. **Trafficking in Persons.**

a. You as the recipient, your employees, subrecipients under this ACRGP Grant, and subrecipients' employees may not –

1. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;
2. Procure a commercial sex act during the period of time that the award is in effect; or
3. Use forced labor in the performance of the award or subawards under the ACRGP Grant.

b. The FAA as the Federal awarding agency may unilaterally terminate this award, without penalty, if you or a subrecipient that is a private entity –

1. Is determined to have violated a prohibition in paragraph A of this ACRGP Grant Agreement term; or
2. Has an employee who is determined by the agency official authorized to terminate the ACRGP Grant Agreement to have violated a prohibition in paragraph A.1 of this ACRGP Grant term through conduct that is either –

A. Associated with performance under this ACRGP grant; or

B. Imputed to the subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR Part 180, "OMB Guidelines to Agencies on Government-wide Debarment and Suspension (Nonprocurement),"as implemented by the FAA at 2 CFR Part 1200.

c. You must inform us immediately of any information you receive from any source alleging a violation of a prohibition in paragraph A during this ACRGP Grant Agreement.

d. Our right to terminate unilaterally that is described in paragraph A of this section:

1. Implements section 106(g) of the Trafficking Victims Protection Act of 2000 (TVPA), as amended (22 U.S.C. § 7104(g)), and

2. Is in addition to all other remedies for noncompliance that are available to the FAA under this ACRGP Grant.

20. **Employee Protection from Reprisal.**

a. Prohibition of Reprisals —

1. In accordance with 41 U.S.C. § 4712, an employee of a grantee or subgrantee may not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing to a person or body described in sub-paragraph (A)(2), information that the employee reasonably believes is evidence of:

a. Gross mismanagement of a Federal grant;
b. Gross waste of Federal funds;
c. An abuse of authority relating to implementation or use of Federal funds;
d. A substantial and specific danger to public health or safety; or
e. A violation of law, rule, or regulation related to a Federal grant.

2. Persons and bodies covered: The persons and bodies to which a disclosure by an employee is covered are as follows:

a. A member of Congress or a representative of a committee of Congress;
b. An Inspector General;
c. The Government Accountability Office;
d. A Federal office or employee responsible for oversight of a grant program;
e. A court or grand jury;
f. A management office of the grantee or subgrantee; or
g. A Federal or State regulatory enforcement agency.

3. Submission of Complaint — A person who believes that they have been subjected to a reprisal prohibited by paragraph A of this ACRGP Grant Agreement may submit a complaint regarding the reprisal to the Office of Inspector General (OIG) for the U.S. Department of Transportation.

4. Time Limitation for Submittal of a Complaint — A complaint may not be brought under this subsection more than three years after the date on which the alleged reprisal took place.

5. Required Actions of the Inspector General — Actions, limitations, and exceptions of the Inspector General's office are established under 41 U.S.C. § 4712(b).

6. Assumption of Rights to Civil Remedy — Upon receipt of an explanation of a decision not to conduct or continue an investigation by the Office of Inspector General, the person submitting a complaint assumes the right to a civil remedy under 41 U.S.C. § 4712(c).

21. **Limitations.** Nothing provided herein shall be construed to limit, cancel, annul, or modify the terms of any Federal grant agreement(s), including all terms and assurances related thereto, that have been entered into by the Sponsor and the FAA prior to the date of this ACRGP Grant Agreement.

22. **Face Coverings Policy.** The sponsor agrees to implement a face-covering (mask) policy to combat the spread of pathogens. This policy must include a requirement that all persons wear a mask, in accordance with Centers for Disease Control (CDC) and Transportation Security Administration (TSA) requirements, as applicable, at all times while in all public areas of the airport property, except to the extent exempted under those requirements. This special condition requires the airport sponsor continue to require masks until Executive Order 13998, Promoting COVID-19 Safety in Domestic and International Travel, is no longer effective.

SPECIAL CONDITIONS FOR USE OF ACRGP FUNDS

CONDITIONS FOR ROLLING STOCK/EQUIPMENT -

1. **Equipment or Vehicle Replacement.** The Sponsor agrees that when using funds provided by this grant to replace equipment, the proceeds from the trade-in or sale of such replaced equipment shall be classified and used as airport revenue.
2. **Equipment Acquisition.** The Sponsor agrees that for any equipment acquired with funds provided by this grant, such equipment shall be used solely for purposes directly related to the airport.
3. **Low Emission Systems.** The Sponsor agrees that vehicles and equipment acquired with funds provided in this grant:
   a. Will be maintained and used at the airport for which they were purchased; and
   b. Will not be transferred, relocated, or used at another airport without the advance consent of the FAA.

   The Sponsor further agrees that it will maintain annual records on individual vehicles and equipment, project expenditures, cost effectiveness, and emission reductions.

CONDITIONS FOR UTILITIES AND LAND -

4. **Utilities Proration.** For purposes of computing the United States' share of the allowable airport operations and maintenance costs, the allowable cost of utilities incurred by the Sponsor to operate and maintain airport(s) included in the Grant must not exceed the percent attributable to the capital or operating costs of the airport.
5. **Utility Relocation in Grant.** The Sponsor understands and agrees that:
   a. The United States will not participate in the cost of any utility relocation unless and until the Sponsor has submitted evidence satisfactory to the FAA that the Sponsor is legally responsible for payment of such costs;
   b. FAA participation is limited to those utilities located on-airport or off-airport only where the Sponsor has an easement for the utility; and
   c. The utilities must serve a purpose directly related to the Airport.
6. **Land Acquisition.** Where funds provided for by this grant are used to acquire land, the Sponsor shall record the grant agreement, including the grant assurances and any and all related requirements, encumbrances, and restrictions that shall apply to such land, in the public land records of the jurisdiction in which the land is located.

The Sponsor's acceptance of this Offer and ratification and adoption of the ACRGP Grant Application incorporated herein shall be evidenced by execution of this instrument by the Sponsor. The Offer and Acceptance shall comprise an ACRGP Grant Agreement, as provided by the CRRSA Act, constituting the contractual obligations and rights of the United States and the Sponsor with respect to this Grant. The effective date of this ACRGP Grant Agreement is the date of the Sponsor's acceptance of this Offer.

Please read the following information: By signing this document, you are agreeing that you have reviewed the following consumer disclosure information and consent to transact business using electronic communications, to receive notices and disclosures electronically, and to utilize electronic signatures in lieu of using paper documents. You are not required to receive notices and disclosures or sign documents electronically. If you prefer not to do so, you may request to receive paper copies and withdraw your consent at any time.

Dated April 8, 2021

UNITED STATES OF AMERICA
FEDERAL AVIATION ADMINISTRATION

(Signature)

E. Lindsay Butler

(Typed Name)

Acting Manager, FAA-DMA-ADO

(Title of FAA Official)

Part II - Acceptance

The Sponsor does hereby ratify and adopt all assurances, statements, representations, warranties, covenants, and agreements contained in the ACRGP Grant Application and incorporated materials referred to in the foregoing Offer under Part I of this ACRGP Grant Agreement, and does hereby accept this Offer and by such acceptance agrees to comply with all of the terms and conditions in this Offer and in the ACRGP Grant Application and all applicable terms and conditions provided for in the CRRSA Act and other applicable provisions of Federal law.

Please read the following information: By signing this document, you are agreeing that you have reviewed the following consumer disclosure information and consent to transact business using electronic communications, to receive notices and disclosures electronically, and to utilize electronic signatures in lieu of using paper documents. You are not required to receive notices and disclosures or sign documents electronically. If you prefer not to do so, you may request to receive paper copies and withdraw your consent at any time.

I declare under penalty of perjury that the foregoing is true and correct. [1]

Dated

City of Grand Rapids

(Name of Sponsor)

(Signature of Sponsor's Designative Official/Representative)

By: _____

(Type Name of Sponsor's Designative Official/Representative)

Title: _____

(Title of Sponsor's Designative Official/Representative)

[1] Knowingly and willfully providing false information to the Federal government is a violation of 18 U.S.C. Section 1001 (False Statements) and could subject you to fines, imprisonment, or both.

CERTIFICATE OF SPONSOR'S ATTORNEY

I, , acting as Attorney for the Sponsor do hereby certify:

That in my opinion the Sponsor is empowered to enter into the foregoing Grant Agreement under the laws of the State of __Minnesota__. Further, I have examined the foregoing Grant Agreement and the actions taken by said Sponsor and Sponsor's official representative has been duly authorized and that the execution thereof is in all respects due and proper and in accordance with the laws of the said State and the CRRSA Act. The Sponsor understands funding made available under this Grant Agreement may only be used to reimburse for airport operational and maintenance expenses, and debt service payments. The Sponsor further understands it may submit a separate request to use funds for new airport/project development purposes, subject to additional terms, conditions, and assurances. Further, it is my opinion that the said Grant Agreement constitutes a legal and binding obligation of the Sponsor in accordance with the terms thereof.

Please read the following information: By signing this document, you are agreeing that you have reviewed the following consumer disclosure information and consent to transact business using electronic communications, to receive notices and disclosures electronically, and to utilize electronic signatures in lieu of using paper documents. You are not required to receive notices and disclosures or sign documents electronically. If you prefer not to do so, you may request to receive paper copies and withdraw your consent at any time.

Dated at

By: _____

(Signature of Sponsor's Attorney)

The Sponsor does hereby ratify and adopt all assurances, statements, representations, warranties, covenants, and agreements contained in the ACRGP Grant Application and incorporated materials referred to in the foregoing Offer under Part I of this ACRGP Grant Agreement, and does hereby accept this Offer and by such acceptance agrees to comply with all of the terms and conditions in this Offer and in the ACRGP Grant Application and all applicable terms and conditions provided for in the CRRSA Act and other applicable provisions of Federal law.

Please read the following information: By signing this document, you are agreeing that you have reviewed the following consumer disclosure information and consent to transact business using electronic communications, to receive notices and disclosures electronically, and to utilize electronic signatures in lieu of using paper documents. You are not required to receive notices and disclosures or sign documents electronically. If you prefer not to do so, you may request to receive paper copies and withdraw your consent at any time.

I declare under penalty of perjury that the foregoing is true and correct. [1]

Dated

County of Itasca

(Name of Sponsor)

(Signature of Sponsor's Designative Official/Representative)

By: _____

(Type Name of Sponsor's Designative Official/Representative)

Title: _____

(Title of Sponsor's Designative Official/Representative)

[1] Knowingly and willfully providing false information to the Federal government is a violation of 18 U.S.C. Section 1001 (False Statements) and could subject you to fines, imprisonment, or both.

CERTIFICATE OF SPONSOR'S ATTORNEY

I, , acting as Attorney for the Sponsor do hereby certify:

That in my opinion the Sponsor is empowered to enter into the foregoing Grant Agreement under the laws of the State of __Minnesota__. Further, I have examined the foregoing Grant Agreement and the actions taken by said Sponsor and Sponsor's official representative has been duly authorized and that the execution thereof is in all respects due and proper and in accordance with the laws of the said State and the CRRSA Act. The Sponsor understands funding made available under this Grant Agreement may only be used to reimburse for airport operational and maintenance expenses, and debt service payments. The Sponsor further understands it may submit a separate request to use funds for new airport/project development purposes, subject to additional terms, conditions, and assurances. Further, it is my opinion that the said Grant Agreement constitutes a legal and binding obligation of the Sponsor in accordance with the terms thereof.

Please read the following information: By signing this document, you are agreeing that you have reviewed the following consumer disclosure information and consent to transact business using electronic communications, to receive notices and disclosures electronically, and to utilize electronic signatures in lieu of using paper documents. You are not required to receive notices and disclosures or sign documents electronically. If you prefer not to do so, you may request to receive paper copies and withdraw your consent at any time.

Dated at

By: _____

(Signature of Sponsor's Attorney)

AIRPORT CORONAVIRUS RELIEF GRANT PROGRAM (ACRGP) ASSURANCES

AIRPORT SPONSORS

A. General.

1. These Airport Coronavirus Relief Grant Program (ACRGP) Assurances are required to be submitted as part of the application by sponsors requesting funds under the provisions of the Coronavirus Response and Relief Supplemental Appropriations Act of 2020 (CRRSA Act or "the Act"), Public Law 116-260. As used herein, the term "public agency sponsor" means a public agency with control of a public-use airport; the term "private sponsor" means a private owner of a public-use airport; and the term "sponsor" includes both public agency sponsors and private sponsors.
2. Upon acceptance of this ACRGP Grant offer by the sponsor, these assurances are incorporated into and become part of this ACRGP Grant Agreement.

B. Sponsor Certification.

The sponsor hereby assures and certifies, with respect to this ACRGP Grant that:

It will comply with all applicable Federal laws, regulations, executive orders, policies, guidelines, and requirements as they relate to the application, acceptance, and use of Federal funds for this ACRGP Grant including but not limited to the following:

FEDERAL LEGISLATION

a. 49 U.S.C. Chapter 471, as applicable
b. Davis-Bacon Act — 40 U.S.C. 276(a), et. seq.
c. Federal Fair Labor Standards Act — 29 U.S.C. 201, et. seq.
d. Hatch Act — 5 U.S.C. 1501, et. seq. [2]
e. Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 Title 42 U.S.C. 4601, et. seq.
f. National Historic Preservation Act of 1966 — Section 106 — 16 U.S.C. 470(f).
g. Archeological and Historic Preservation Act of 1974 — 16 U.S.C. 469 through 469c.
h. Native Americans Grave Repatriation Act — 25 U.S.C. Section 3001, et. seq.
i. Clean Air Act, P.L. 90-148, as amended.
j. Coastal Zone Management Act, P.L. 93-205, as amended.
k. Flood Disaster Protection Act of 1973 — Section 102(a) — 42 U.S.C. 4012a.
l. Title 49, U.S.C., Section 303, (formerly known as Section 4(f)).
m. Rehabilitation Act of 1973 — 29 U.S.C. 794.
n. Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq., 78 stat. 252) (prohibits discrimination on the basis of race, color, national origin).
o. Americans with Disabilities Act of 1990, as amended, (42 U.S.C. § 12101 et seq.), prohibits discrimination on the basis of disability).

p. Age Discrimination Act of 1975 — 42 U.S.C. 6101, et. seq.

q. American Indian Religious Freedom Act, P.L. 95-341, as amended.

r. Architectural Barriers Act of 1968 — 42 U.S.C. 4151, et. seq.

s. Power plant and Industrial Fuel Use Act of 1978 — Section 403- 2 U.S.C. 8373.

t. Contract Work Hours and Safety Standards Act — 40 U.S.C. 327, et. seq.

u. Copeland Anti-kickback Act — 18 U.S.C. 874.1.

v. National Environmental Policy Act of 1969 — 42 U.S.C. 4321, et. seq.

w. Wild and Scenic Rivers Act, P.L. 90-542, as amended.

x. Single Audit Act of 1984 — 31 U.S.C. 7501, et. seq. [2]

y. Drug-Free Workplace Act of 1988 — 41 U.S.C. 702 through 706.

z. The Federal Funding Accountability and Transparency Act of 2006, as amended (Pub. L. 109-282, as amended by section 6202 of Pub. L. 110-252).

EXECUTIVE ORDERS

a. Executive Order 11246 – Equal Employment Opportunity

b. Executive Order 11990 – Protection of Wetlands

c. Executive Order 11998 – Flood Plain Management

d. Executive Order 12372 – Intergovernmental Review of Federal Programs

e. Executive Order 12699 – Seismic Safety of Federal and Federally Assisted New Building Construction

f. Executive Order 12898 – Environmental Justice

g. Executive Order 14005 – Ensuring the Future Is Made in All of America by All of America's Workers.

FEDERAL REGULATIONS

a. 2 CFR Part 180 – OMB Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement).

b. 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. [3, 4]

c. 2 CFR Part 1200 – Nonprocurement Suspension and Debarment.

d. 28 CFR Part 35 – Discrimination on the Basis of Disability in State and Local Government Services.

e. 28 CFR § 50.3 – U.S. Department of Justice Guidelines for Enforcement of Title VI of the Civil Rights Act of 1964.

f. 29 CFR Part 1 – Procedures for predetermination of wage rates. [1]

g. 29 CFR Part 3 – Contractors and subcontractors on public building or public work financed in whole or part by loans or grants from the United States. [1]

h. 29 CFR Part 5 – Labor standards provisions applicable to contracts covering Federally financed and assisted construction (also labor standards provisions applicable to non-construction contracts subject to the Contract Work Hours and Safety Standards Act). [1]

i. 41 CFR Part 60 – Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor (Federal and Federally assisted contracting requirements). [1]

j. 49 CFR Part 20 – New restrictions on lobbying.

k. 49 CFR Part 21 – Nondiscrimination in Federally-assisted programs of the Department of Transportation - effectuation of Title VI of the Civil Rights Act of 1964.

l. 49 CFR Part 23 – Participation by Disadvantage Business Enterprise in Airport Concessions.

m. 49 CFR Part 26 – Participation by Disadvantaged Business Enterprises in Department of Transportation Program.

n. 49 CFR Part 27 – Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial Assistance. [1]

o. 49 CFR Part 28 – Enforcement of Nondiscrimination on the Basis of Handicap in Programs or Activities conducted by the Department of Transportation.

p. 49 CFR Part 30 – Denial of public works contracts to suppliers of goods and services of countries that deny procurement market access to U.S. contractors.

q. 49 CFR Part 32 – Government-wide Requirements for Drug-Free Workplace (Financial Assistance).

r. 49 CFR Part 37 – Transportation Services for Individuals with Disabilities (ADA).

s. 49 CFR Part 41 – Seismic safety of Federal and Federally assisted or regulated new building construction.

FOOTNOTES TO ASSURANCE ACRGP ASSURANCE B.1.

[1] These laws do not apply to airport planning sponsors.
[2] These laws do not apply to private sponsors.
[3] Cost principles established in 2 CFR Part 200 subpart E must be used as guidelines for determining the eligibility of specific types of expenses
[4] Audit requirements established in 2 CFR Part 200 subpart F are the guidelines for audits.

SPECIFIC ASSURANCES

Specific assurances required to be included in grant agreements by any of the above laws, regulations, or circulars are incorporated by reference in this Grant Agreement.

1. Purpose Directly Related to the Airport

It certifies that the reimbursement sought is for a purpose directly related to the airport.

2. Responsibility and Authority of the Sponsor.

a. Public Agency Sponsor:

It has legal authority to apply for this Grant, and to finance and carry out the proposed grant; that an official decision has been made by the applicant's governing body authorizing the filing of the application, including all understandings and assurances contained therein, and directing

and authorizing the person identified as the official representative of the applicant to act in connection with the application and to provide such additional information as may be required.

b. Private Sponsor:

It has legal authority to apply for this Grant and to finance and carry out the proposed Grant and comply with all terms, conditions, and assurances of this Grant Agreement. It shall designate an official representative and shall in writing direct and authorize that person to file this application, including all understandings and assurances contained therein; to act in connection with this application; and to provide such additional information as may be required.

3. Good Title.

It, a public agency or the Federal government, holds good title, satisfactory to the Secretary, to the landing area of the airport or site thereof, or will give assurance satisfactory to the Secretary that good title will be acquired.

4. Preserving Rights and Powers.

a. It will not take or permit any action which would operate to deprive it of any of the rights and powers necessary to perform any or all of the terms, conditions, and assurances in this Grant Agreement without the written approval of the Secretary, and will act promptly to acquire, extinguish, or modify any outstanding rights or claims of right of others which would interfere with such performance by the sponsor. This shall be done in a manner acceptable to the Secretary.

b. If the sponsor is a private sponsor, it will take steps satisfactory to the Secretary to ensure that the airport will continue to function as a public-use airport in accordance with this Grant Agreement.

c. If an arrangement is made for management and operation of the airport by any agency or person other than the sponsor or an employee of the sponsor, the sponsor will reserve sufficient rights and authority to insure that the airport will be operated and maintained in accordance Title 49, United States Code, the regulations, and the terms and conditions of this Grant Agreement.

5. Consistency with Local Plans.

Any project undertaken by this Grant Agreement is reasonably consistent with plans (existing at the time of submission of the ACGRP application) of public agencies that are authorized by the State in which the project is located to plan for the development of the area surrounding the airport.

6. Consideration of Local Interest.

It has given fair consideration to the interest of communities in or near where any project undertaken by this Grant Agreement may be located.

7. Consultation with Users.

In making a decision to undertake any airport development project undertaken by this Grant Agreement, it has undertaken reasonable consultations with affected parties using the airport at which project is proposed.

8. Pavement Preventative Maintenance.

With respect to a project undertaken by this Grant Agreement for the replacement or reconstruction of pavement at the airport, it assures or certifies that it has implemented an effective airport pavement maintenance-management program and it assures that it will use such program for the useful life of any pavement constructed, reconstructed, or repaired with Federal financial assistance at the airport, including ACRGP funds provided under this Grant Agreement. It will provide such reports on pavement condition and pavement management programs as the Secretary determines may be useful.

9. Accounting System, Audit, and Record Keeping Requirements.

a. It shall keep all Grant accounts and records which fully disclose the amount and disposition by the recipient of the proceeds of this Grant, the total cost of the Grant in connection with which this Grant is given or used, and the amount or nature of that portion of the cost of the Grant supplied by other sources, and such other financial records pertinent to the Grant. The accounts and records shall be kept in accordance with an accounting system that will facilitate an effective audit in accordance with the Single Audit Act of 1984.

b. It shall make available to the Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, for the purpose of audit and examination, any books, documents, papers, and records of the recipient that are pertinent to this Grant. The Secretary may require that an appropriate audit be conducted by a recipient. In any case in which an independent audit is made of the accounts of a sponsor relating to the disposition of the proceeds of a Grant or relating to the Grant in connection with which this Grant was given or used, it shall file a certified copy of such audit with the Comptroller General of the United States not later than six (6) months following the close of the fiscal year for which the audit was made.

10. Minimum Wage Rates.

It shall include, in all contracts in excess of $2,000 for work on any projects funded under this grant agreement which involve labor, provisions establishing minimum rates of wages, to be predetermined by the Secretary of Labor, in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a-276a-5), which contractors shall pay to skilled and unskilled labor, and such minimum rates shall be stated in the invitation for bids and shall be included in proposals or bids for the work.

11. Veteran's Preference.

It shall include in all contracts for work on any project funded under this grant agreement which involve labor, such provisions as are necessary to insure that, in the employment of labor (except in executive, administrative, and supervisory positions), preference shall be given to Vietnam era veterans, Persian Gulf veterans, Afghanistan-Iraq war veterans, disabled veterans, and small business concerns owned and controlled by disabled veterans as defined in Section 47112 of Title 49, United States Code. However, this preference shall apply only where the individuals are available and qualified to perform the work to which the employment relates.

12. Operation and Maintenance.

a. The airport and all facilities which are necessary to serve the aeronautical users of the airport, other than facilities owned or controlled by the United States, shall be operated at all times in a safe and serviceable condition and in accordance with the minimum standards as may be required or prescribed by applicable Federal, state and local agencies for maintenance and

operation. It will not cause or permit any activity or action thereon which would interfere with its use for airport purposes. It will suitably operate and maintain the airport and all facilities thereon or connected therewith, with due regard to climatic and flood conditions. Any proposal to temporarily close the airport for non-aeronautical purposes must first be approved by the Secretary. In furtherance of this assurance, the sponsor will have in effect arrangements for-

1. Operating the airport's aeronautical facilities whenever required;
2. Promptly marking and lighting hazards resulting from airport conditions, including temporary conditions; and
3. Promptly notifying airmen of any condition affecting aeronautical use of the airport. Nothing contained herein shall be construed to require that the airport be operated for aeronautical use during temporary periods when snow, flood or other climatic conditions interfere with such operation and maintenance. Further, nothing herein shall be construed as requiring the maintenance, repair, restoration, or replacement of any structure or facility which is substantially damaged or destroyed due to an act of God or other condition or circumstance beyond the control of the sponsor.

b. It will suitably operate and maintain noise compatibility program items that it owns or controls upon which Federal funds have been expended.

13. Hazard Removal and Mitigation.

It will take appropriate action to assure that such terminal airspace as is required to protect instrument and visual operations to the airport (including established minimum flight altitudes) will be adequately cleared and protected by removing, lowering, relocating, marking, or lighting or otherwise mitigating existing airport hazards and by preventing the establishment or creation of future airport hazards.

14. Compatible Land Use.

It will take appropriate action, to the extent reasonable, including the adoption of zoning laws, to restrict the use of land adjacent to or in the immediate vicinity of the airport to activities and purposes compatible with normal airport operations, including landing and takeoff of aircraft.

15. Exclusive Rights.

The sponsor shall not grant an exclusive right to use an air navigation facility on which this Grant has been expended. However, providing services at an airport by only one fixed-based operator is not an exclusive right if—

a. it is unreasonably costly, burdensome, or impractical for more than one fixed-based operator to provide the services; and

b. allowing more than one fixed-based operator to provide the services requires a reduction in space leased under an agreement existing on September 3, 1982, between the operator and the airport.

16. Airport Revenues.

a. This Grant shall be available for any purpose for which airport revenues may lawfully be used to prevent, prepare for, and respond to coronavirus. Funds provided under this ACRGP Grant Agreement will only be expended for the capital or operating costs of the airport; the local airport system; or other local facilities which are owned or operated by the owner or operator of the airport(s) subject to this agreement and all applicable addendums for costs related to

operations, personnel, cleaning, sanitization, janitorial services, combating the spread of pathogens at the airport, and debt service payments as prescribed in the Act

b. For airport development, 49 U.S.C. § 47133 applies.

17. Reports and Inspections.

It will:

a. submit to the Secretary such annual or special financial and operations reports as the Secretary may reasonably request and make such reports available to the public; make available to the public at reasonable times and places a report of the airport budget in a format prescribed by the Secretary;

b. in a format and time prescribed by the Secretary, provide to the Secretary and make available to the public following each of its fiscal years, an annual report listing in detail:

1. all amounts paid by the airport to any other unit of government and the purposes for which each such payment was made; and

2. all services and property provided by the airport to other units of government and the amount of compensation received for provision of each such service and property.

18. Land for Federal Facilities.

It will furnish without cost to the Federal Government for use in connection with any air traffic control or air navigation activities, or weather-reporting and communication activities related to air traffic control, any areas of land or water, or estate therein, or rights in buildings of the sponsor as the Secretary considers necessary or desirable for construction, operation, and maintenance at Federal expense of space or facilities for such purposes. Such areas or any portion thereof will be made available as provided herein within four months after receipt of a written request from the Secretary.

19. Airport Layout Plan.

a. Subject to the FAA Reauthorization Act of 2018, Public Law 115-254, Section 163, it will keep up to date at all times an airport layout plan of the airport showing:

1. boundaries of the airport and all proposed additions thereto, together with the boundaries of all offsite areas owned or controlled by the sponsor for airport purposes and proposed additions thereto;

2. the location and nature of all existing and proposed airport facilities and structures (such as runways, taxiways, aprons, terminal buildings, hangars and roads), including all proposed extensions and reductions of existing airport facilities;

3. the location of all existing and proposed non-aviation areas and of all existing improvements thereon; and

4. all proposed and existing access points used to taxi aircraft across the airport's property boundary. Such airport layout plans and each amendment, revision, or modification thereof, shall be subject to the approval of the Secretary which approval shall be evidenced by the signature of a duly authorized representative of the Secretary on the face of the airport layout plan. The sponsor will not make or permit any changes or alterations in the airport or any of its facilities which are not in conformity with the airport layout plan

as approved by the Secretary and which might, in the opinion of the Secretary, adversely affect the safety, utility or efficiency of the airport.

b. Subject to the FAA Reauthorization Act of 2018, Public Law 115-254, Section 163, if a change or alteration in the airport or the facilities is made which the Secretary determines adversely affects the safety, utility, or efficiency of any federally owned, leased, or funded property on or off the airport and which is not in conformity with the airport layout plan as approved by the Secretary, the owner or operator will, if requested, by the Secretary (1) eliminate such adverse effect in a manner approved by the Secretary; or (2) bear all costs of relocating such property (or replacement thereof) to a site acceptable to the Secretary and all costs of restoring such property (or replacement thereof) to the level of safety, utility, efficiency, and cost of operation existing before the unapproved change in the airport or its facilities except in the case of a relocation or replacement of an existing airport facility due to a change in the Secretary's design standards beyond the control of the airport sponsor.

20. Civil Rights.

It will promptly take any measures necessary to ensure that no person in the United States shall, on the grounds of race, creed, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination in any activity conducted with, or benefiting from, funds received from this Grant.

a. Using the definitions of activity, facility, and program as found and defined in §§ 21.23 (b) and 21.23 (e) of 49 CFR Part 21, the sponsor will facilitate all programs, operate all facilities, or conduct all programs in compliance with all non-discrimination requirements imposed by or pursuant to these assurances.

b. Applicability

1. Programs and Activities. If the sponsor has received a grant (or other Federal assistance) for any of the sponsor's program or activities, these requirements extend to all of the sponsor's programs and activities

2. Facilities. Where it receives a grant or other Federal financial assistance to construct, expand, renovate, remodel, alter, or acquire a facility, or part of a facility, the assurance extends to the entire facility and facilities operated in connection therewith.

3. Real Property. Where the sponsor receives a grant or other Federal financial assistance in the form of, or for the acquisition of, real property or an interest in real property, the assurance will extend to rights to space on, over, or under such property.

c. Duration

The sponsor agrees that it is obligated to this assurance for the period during which Federal financial assistance is extended to the program, except where the Federal financial assistance is to provide, or is in the form of, personal property, or real property, or interest therein, or structures or improvements thereon, in which case the assurance obligates the sponsor, or any transferee for the longer of the following periods:

1. So long as the airport is used as an airport, or for another purpose involving the provision of similar services or benefits; or

2. So long as the sponsor retains ownership or possession of the property.

d. Required Solicitation Language

It will include the following notification in all solicitations for bids, Requests for Proposals for work, or material under this Grant and in all proposals for agreements, including airport concessions, regardless of funding source:

"The **County of Itasca and City of Grand Rapids**, in accordance with the provisions of Title VI of the Civil Rights Act of 1964 (78 Stat. 252, 42 U.S.C. §§ 2000d to 2000d-4) and the Regulations, hereby notifies all bidders that it will affirmatively ensure that for any contract entered into pursuant to this advertisement, disadvantaged business enterprises and airport concession disadvantaged business enterprises will be afforded full and fair opportunity to submit bids in response to this invitation and will not be discriminated against on the grounds of race, color, or national origin in consideration for an award."

e. Required Contract Provisions.

1. It will insert the non-discrimination contract clauses requiring compliance with the acts and regulations relative to non-discrimination in Federally-assisted programs of the DOT, and incorporating the acts and regulations into the contracts by reference in every contract or agreement subject to the non-discrimination in Federally-assisted programs of the DOT Acts and regulations.
2. It will include a list of the pertinent non-discrimination authorities in every contract that is subject to the non-discrimination acts and regulations.
3. It will insert non-discrimination contract clauses as a covenant running with the land, in any deed from the United States effecting or recording a transfer of real property, structures, use, or improvements thereon or interest therein to a sponsor.
4. It will insert non-discrimination contract clauses prohibiting discrimination on the basis of race, color, national origin, creed, sex, age, or handicap as a covenant running with the land, in any future deeds, leases, license, permits, or similar instruments entered into by the sponsor with other parties:

    A. For the subsequent transfer of real property acquired or improved under the applicable activity, grant, or program; and

    B. For the construction or use of, or access to, space on, over, or under real property acquired or improved under the applicable activity, grant, or program.

    C. It will provide for such methods of administration for the program as are found by the Secretary to give reasonable guarantee that it, other recipients, sub-recipients, sub-grantees, contractors, subcontractors, consultants, transferees, successors in interest, and other participants of Federal financial assistance under such program will comply with all requirements imposed or pursuant to the acts, the regulations, and this assurance.

    D. It agrees that the United States has a right to seek judicial enforcement with regard to any matter arising under the acts, the regulations, and this assurance.

21. Foreign Market Restrictions.

It will not allow funds provided under this Grant to be used to fund any activity that uses any product or service of a foreign country during the period in which such foreign country is listed by the United States Trade Representative as denying fair and equitable market opportunities for products and suppliers of the United States in procurement and construction.

22. Policies, Standards and Specifications.

It will carry out any project funded under an Airport Coronavirus Relief Program Grant in accordance with policies, standards, and specifications approved by the Secretary including, but not limited to, current FAA Advisory Circulars for AIP projects, as of February 16, 2021, included in this grant, and in accordance with applicable state policies, standards, and specifications approved by the Secretary.

23. Access By Intercity Buses.

The airport owner or operator will permit, to the maximum extent practicable, intercity buses or other modes of transportation to have access to the airport; however, it has no obligation to fund special facilities for intercity buses or for other modes of transportation.

24. Disadvantaged Business Enterprises.

The sponsor shall not discriminate on the basis of race, color, national origin or sex in the award and performance of any DOT-assisted contract covered by 49 CFR Part 26, or in the award and performance of any concession activity contract covered by 49 CFR Part 23. In addition, the sponsor shall not discriminate on the basis of race, color, national origin or sex in the administration of its Disadvantaged Business Enterprise (DBE) and Airport Concessions Disadvantaged Business Enterprise (ACDBE) programs or the requirements of 49 CFR Parts 23 and 26. The sponsor shall take all necessary and reasonable steps under 49 CFR Parts 23 and 26 to ensure nondiscrimination in the award and administration of DOT-assisted contracts, and/or concession contracts. The sponsor's DBE and ACDBE programs, as required by 49 CFR Parts 26 and 23, and as approved by DOT, are incorporated by reference in this agreement. Implementation of these programs is a legal obligation and failure to carry out its terms shall be treated as a violation of this agreement. Upon notification to the sponsor of its failure to carry out its approved program, the Department may impose sanctions as provided for under Parts 26 and 23 and may, in appropriate cases, refer the matter for enforcement under 18 U.S.C. 1001 and/or the Program Fraud Civil Remedies Act of 1936 (31 U.S.C. 3801).

25. Acquisition Thresholds.

The FAA deems equipment to mean tangible personal property having a useful life greater than one year and a per-unit acquisition cost equal to or greater than $5,000. Procurements by micro-purchase means the acquisition of goods or services for which the aggregate dollar amount does not exceed $10,000, unless authorized in accordance with 2 CFR § 200.320. Procurement by small purchase procedures means those relatively simple and informal procurement methods for securing goods or services that do not exceed the $250,000 threshold for simplified acquisitions.

Current FAA Advisory Circulars Required for Use in AIP Funded and PFC Approved Projects

View the most current Series 150 Advisory Circulars (ACs) for Airport Projects at
http://www.faa.gov/airports/resources/advisory_circulars and
http://www.faa.gov/regulations_policies/advisory_circulars

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1501

DEPARTMENT: Health & Human Services
TIME REQUESTED: < 5 Minutes
PRESENTER: Sarah Anderson

AGENDA ITEM:
IMCare Provider Participation Agreement with The Woods Therapy and Counseling Services, PLLC

BOARD ACTION REQUESTED:
Authorize IMCare Director and County Board Chair to sign the contract between IMCare and The Woods Therapy and Counseling Services, PLLC.

BACKGROUND:
The Woods Therapy and Counseling Services, PLLC is a Behavioral Health Provider.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1526

DEPARTMENT: Management Information Services **TIME REQUESTED:**
PRESENTER: Chris Gunderson

AGENDA ITEM:
2021 ESRI Enterprise Agreement Renewal

BOARD ACTION REQUESTED:
Authorize the IT Director to sign the 2021 Enterprise Agreement with ESRI to renew services for a further three years and authorize payment of the agreement from the Recorder's Compliance Fund.

BACKGROUND:
ESRI provides the GIS software that geographically represents land data. The Enterprise Agreement will extend our licensing support for a further three years. Cost of the agreement is $39,250/year for the next three years for a total of $117,750.

COUNTY ATTORNEY REVIEW: Yes and/or Pending

SUPPORTING DOCUMENTATION:
1. Q-427636-20210311-1058
2. Compliance Fund Request_2021 ESRI EA Renewal_signed

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

March 11, 2021

Mr. Jeff Braaten
County of Itasca
123 NE 4th St
Grand Rapids, MN 55744-2600

Dear Jeff,

The Esri Small Municipal and County Government Enterprise Agreement (SGEA) is a three-year agreement that will grant your organization access to Esri term license software. The EA will be effective on the date executed and will require a firm, three-year commitment.

Based on Esri's work with several organizations similar to yours, we know there is significant potential to apply Geographic Information System (GIS) technology in many operational and technical areas within your organization. For this reason, we believe that your organization will greatly benefit from an Enterprise Agreement (EA).

An EA will provide your organization with numerous benefits including:

- A lower cost per unit for licensed software
- Substantially reduced administrative and procurement expenses
- Complete flexibility to deploy software products when and where needed

The following business terms and conditions will apply:

- All current departments, employees, and in-house contractors of the organization will be eligible to use the software and services included in the EA.

- If your organization wishes to acquire and/or maintain any Esri software during the term of the agreement that is not included in the EA, it may do so separately at the Esri pricing that is generally available for your organization for software and maintenance.

- The organization will establish a single point of contact for orders and deliveries and will be responsible for redistribution to eligible users.

- The organization will establish a Tier 1 support center to field calls from internal users of Esri software. The organization may designate individuals as specified in the EA who may directly contact Esri for Tier 2 technical support.

- The organization will provide an annual report of installed Esri software to Esri.

- Esri software and updates that the organization is licensed to use will be automatically available for downloading.

- The fee and benefits offered in this EA proposal are contingent upon your acceptance of Esri's Small Municipal and County Government EA terms and conditions.

- Licenses are valid for the term of the EA.

This program offer is valid for 90 days. To complete the agreement within this time frame, please contact me within the next seven days to work through any questions or concerns you may have.

To expedite your acceptance of this EA offer:

1. Sign and return the EA contract with a Purchase Order or issue a Purchase Order that references this EA Quotation and includes the following statement on the face of the Purchase Order:

   "THIS PURCHASE ORDER IS GOVERNED BY THE TERMS AND CONDITIONS OF THE ESRI SMALL MUNICIPAL AND COUNTY GOVERNMENT EA, AND ADDITIONAL TERMS AND CONDITIONS IN THIS PURCHASE ORDER WILL NOT APPLY."

   Have it signed by an authorized representative of the organization.

2. On the first page of the EA, identify the central point of contact/agreement administrator. The agreement administrator is the party that will be the contact for management of the software, administration issues, and general operations. Information should include name, title (if applicable), address, phone number, and e-mail address.

3. In the purchase order, identify the "Ship to" and "Bill to" information for your organization.

4. Send the purchase order and agreement to the address, email or fax noted below:

   Esri
   Attn: Customer Service SG-EA
   380 New York Street
   Redlands, CA 92373-8100

   e-mail: service@esri.com
   fax documents to: 909-307-3083

I appreciate the opportunity to present you with this proposal, and I believe it will bring great benefits to your organization.

Thank you very much for your consideration.

Best Regards,

Angela Bramer

Quotation # Q-427636

Date: March 11, 2021

Environmental Systems Research Institute, Inc.
380 New York St
Redlands, CA 92373-8100
Phone: (909) 793-2853 Fax: (909) 307-3049
DUNS Number: 06-313-4175 CAGE Code: 0AMS3

To expedite your order, please attach a copy of this quotation to your purchase order.
Quote is valid from: 3/11/2021 To: 6/9/2021

Customer # 10420 **Contract #**

County of Itasca
Surveying & Mapping Dept
123 NE 4th St
Grand Rapids, MN 55744-2600

ATTENTION: Jeff Braaten
PHONE: (218) 327-7388
EMAIL: jeff.braaten@co.itasca.mn.us

Material	Qty	Term	Unit Price	Total
168178	1	Year 1	$38,500.00	$38,500.00
Populations of 25,001 to 50,000 Small Government Term Enterprise License Agreement				
168178	1	Year 2	$38,500.00	$38,500.00
Populations of 25,001 to 50,000 Small Government Term Enterprise License Agreement				
168178	1	Year 3	$38,500.00	$38,500.00
Populations of 25,001 to 50,000 Small Government Term Enterprise License Agreement				
168199	1	Year 1	$750.00	$750.00
ArcPad Populations of 25,001 to 50,000 Small Government Term Enterprise Agreement				
168199	1	Year 2	$750.00	$750.00
ArcPad Populations of 25,001 to 50,000 Small Government Term Enterprise Agreement				
168199	1	Year 3	$750.00	$750.00
ArcPad Populations of 25,001 to 50,000 Small Government Term Enterprise Agreement				

Esri may charge a fee to cover expenses related to any customer requirement to use a proprietary vendor management, procurement, or invoice program.

For questions contact:	**Email:**	**Phone:**
Chad Anderson	canderson@esri.com	(651) 454-0600 x8319

ANDERSONC **This offer is limited to the terms and conditions incorporated and attached herein.**

Quotation # Q-427636

Date: March 11, 2021

Environmental Systems Research Institute, Inc.
380 New York St
Redlands, CA 92373-8100
Phone: (909) 793-2853 Fax: (909) 307-3049
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County of Itasca
Surveying & Mapping Dept
123 NE 4th St
Grand Rapids, MN 55744-2600

ATTENTION: Jeff Braaten
PHONE: (218) 327-7388
EMAIL: jeff.braaten@co.itasca.mn.us

Subtotal:	$117,750.00
Sales Tax:	$0.00
Estimated Shipping and Handling (2 Day Delivery):	$0.00
Contract Price Adjust:	$0.00
Total:	$117,750.00

Esri may charge a fee to cover expenses related to any customer requirement to use a proprietary vendor management, procurement, or invoice program.

For questions contact:	**Email:**	**Phone:**
Chad Anderson	canderson@esri.com	(651) 454-0600 x8319

ANDERSONC **This offer is limited to the terms and conditions incorporated and attached herein.**

Esri Use Only:
Cust. Name _____
Cust. # _____
PO # _____
Esri Agreement # _____

SMALL ENTERPRISE AGREEMENT
COUNTY AND MUNICIPALITY GOVERNMENT
(E214-2)

This Agreement is by and between the organization identified in the Quotation (**"Customer"**) and **Environmental Systems Research Institute, Inc.** (**"Esri"**).

This Agreement sets forth the terms for Customer's use of Products and incorporates by reference (i) the Quotation and (ii) the Master Agreement. Should there be any conflict between the terms and conditions of the documents that comprise this Agreement, the order of precedence for the documents shall be as follows: (i) the Quotation, (ii) this Agreement, and (iii) the Master Agreement. This Agreement shall be governed by and construed in accordance with the laws of the state in which Customer is located without reference to conflict of laws principles, and the United States of America federal law shall govern in matters of intellectual property. The modifications and additional rights granted in this Agreement apply only to the Products listed in Table A.

Table A
List of Products

Uncapped Quantities

Desktop Software and Extensions (Single Use)
ArcGIS Desktop Advanced
ArcGIS Desktop Standard
ArcGIS Desktop Basic
ArcGIS Desktop Extensions: ArcGIS 3D Analyst, ArcGIS Spatial Analyst, ArcGIS Geostatistical Analyst, ArcGIS Publisher, ArcGIS Network Analyst, ArcGIS Schematics, ArcGIS Workflow Manager, ArcGIS Data Reviewer

Enterprise Software and Extensions
ArcGIS Enterprise and Workgroup (Advanced and Standard)
ArcGIS Monitor
ArcGIS Enterprise Extensions: ArcGIS 3D Analyst, ArcGIS Spatial Analyst, ArcGIS Geostatistical Analyst, ArcGIS Network Analyst, ArcGIS Schematics, ArcGIS Workflow Manager

Enterprise Additional Capability Servers
ArcGIS Image Server

Developer Tools
ArcGIS Engine
ArcGIS Engine Extensions: ArcGIS 3D Analyst, ArcGIS Spatial Analyst, ArcGIS Engine Geodatabase Update, ArcGIS Network Analyst, ArcGIS Schematics
ArcGIS Runtime (Standard)
ArcGIS Runtime Analysis Extension

Limited Quantities
One (1) Professional subscription to ArcGIS Developer
Two (2) ArcGIS CityEngine Single Use Licenses
100 ArcGIS Online Viewers
100 ArcGIS Online Creators
17,500 ArcGIS Online Service Credits
100 ArcGIS Enterprise Creators
3 ArcGIS Insights in ArcGIS Enterprise
3 ArcGIS Insights in ArcGIS Online
10 ArcGIS Tracker for ArcGIS Enterprise
10 ArcGIS Tracker for ArcGIS Online
3 ArcGIS Parcel Fabric User Type Extensions (Enterprise)
3 ArcGIS Utility Network User Type Extensions (Enterprise)

OTHER BENEFITS

Number of Esri User Conference registrations provided annually	**3**
Number of Tier 1 Help Desk individuals authorized to call Esri	**3**
Maximum number of sets of backup media, if requested*	**2**
Five percent (5%) discount on all individual commercially available instructor-led training classes at Esri facilities purchased outside this Agreement	

*Additional sets of backup media may be purchased for a fee

Customer may accept this Agreement by signing and returning the whole Agreement with (i) the Quotation attached, (ii) a purchase order, or (iii) another document that matches the Quotation and references this Agreement ("**Ordering Document**"). **ADDITIONAL OR CONFLICTING TERMS IN CUSTOMER'S PURCHASE ORDER OR OTHER DOCUMENT WILL NOT APPLY, AND THE TERMS OF THIS AGREEMENT WILL GOVERN.** This Agreement is effective as of the date of Esri's receipt of an Ordering Document, unless otherwise agreed to by the parties ("**Effective Date**").

Term of Agreement: Three (3) years

This Agreement supersedes any previous agreements, proposals, presentations, understandings, and arrangements between the parties relating to the licensing of the Products. Except as provided in Article 4—Product Updates, no modifications can be made to this Agreement.

Accepted and Agreed:

_____
(Customer)

By: _____
Authorized Signature

Printed Name: _____

Title: _____

Date: _____

CUSTOMER CONTACT INFORMATION

Contact: _____

Address: _____

City, State, Postal Code: _____

Country: _____

Quotation Number (if applicable): _____

Telephone: _____

Fax: _____

E-mail: _____

1.0—Additional Definitions

In addition to the definitions provided in the Master Agreement, the following definitions apply to this Agreement:

"Case" means a failure of the Software or Online Services to operate according to the Documentation where such failure substantially impacts operational or functional performance.

"Deploy", "Deployed" and "Deployment" mean to redistribute and install the Products and related Authorization Codes within Customer's organization(s).

"Fee" means the fee set forth in the Quotation.

"Maintenance" means Tier 2 Support, Product updates, and Product patches provided to Customer during the Term of Agreement.

"Master Agreement" means the applicable master agreement for Esri Products incorporated by this reference that is (i) found at https://www.esri.com/en-us/legal/terms/full-master-agreement and available in the installation process requiring acceptance by electronic acknowledgment or (ii) a signed Esri master agreement or license agreement that supersedes such electronically acknowledged master agreement.

"Product(s)" means the products identified in Table A—List of Products and any updates to the list Esri provides in writing.

"Quotation" means the offer letter and quotation provided separately to Customer.

"Technical Support" means the technical assistance for attempting resolution of a reported Case through error correction, patches, hot fixes, workarounds, replacement deliveries, or any other type of Product corrections or modifications.

"Tier 1 Help Desk" means Customer's point of contact(s) to provide all Tier 1 Support within Customer's organization(s).

"Tier 1 Support" means the Technical Support provided by the Tier 1 Help Desk.

"Tier 2 Support" means the Esri Technical Support provided to the Tier 1 Help Desk when a Case cannot be resolved through Tier 1 Support.

2.0—Additional Grant of License

2.1 Grant of License. Subject to the terms and conditions of this Agreement, Esri grants to Customer a personal, nonexclusive, nontransferable license solely to use, copy, and Deploy quantities of the Products listed in Table A—List of Products for the Term of Agreement (i) for the applicable Fee and (ii) in accordance with the Master Agreement.

2.2 Consultant Access. Esri grants Customer the right to permit Customer's consultants or contractors to use the Products exclusively for Customer's benefit. Customer will be solely responsible for compliance by consultants and contractors with this Agreement and will ensure that the consultant or contractor discontinues use of Products upon completion of work for Customer. Access to or use of Products by consultants or contractors not exclusively for Customer's benefit is prohibited. Customer may not permit its consultants or contractors to install Software or Data on consultant, contractor, or third-party computers or remove Software or Data from Customer locations, except for the purpose of hosting the Software or Data on Contractor servers for the benefit of Customer.

3.0—Term, Termination, and Expiration

3.1 Term. This Agreement and all licenses hereunder will commence on the Effective Date and continue for the duration identified in the Term of Agreement, unless this Agreement is terminated earlier as provided herein. Customer is only authorized to use Products during the Term of Agreement. For an Agreement with a limited term, Esri does not grant Customer an indefinite or a perpetual license to Products.

3.2 No Use upon Agreement Expiration or Termination. All Product licenses, all Maintenance, and Esri User Conference registrations terminate upon expiration or termination of this Agreement.

3.3 Termination for a Material Breach. Either party may terminate this Agreement for a material breach by the other party. The breaching party will have thirty (30) days from the date of written notice to cure any material breach.

3.4 Termination for Lack of Funds. For an Agreement with government or government-

owned entities, either party may terminate this Agreement before any subsequent year if Customer is unable to secure funding through the legislative or governing body's approval process.

3.5 Follow-on Term. If the parties enter into another agreement substantially similar to this Agreement for an additional term, the effective date of the follow-on agreement will be the day after the expiration date of this Agreement.

4.0—Product Updates

4.1 Future Updates. Esri reserves the right to update the list of Products in Table A—List of Products by providing written notice to Customer. Customer may continue to use all Products that have been Deployed, but support and upgrades for deleted items may not be available. As new Products are incorporated into the standard program, they will be offered to Customer via written notice for incorporation into the Products schedule at no additional charge. Customer's use of new or updated Products requires Customer to adhere to applicable additional or revised terms and conditions in the Master Agreement.

4.2 Product Life Cycle. During the Term of Agreement, some Products may be retired or may no longer be available to Deploy in the identified quantities. Maintenance will be subject to the individual Product Life Cycle Support Status and Product Life Cycle Support Policy, which can be found at https://support.esri.com/en/other-resources/product-life-cycle. Updates for Products in the mature and retired phases may not be available. Customer may continue to use Products already Deployed, but Customer will not be able to Deploy retired Products.

5.0—Maintenance

The Fee includes standard maintenance benefits during the Term of Agreement as specified in the most current applicable Esri Maintenance and Support Program document (found at https://www.esri.com/en-us/legal/terms/maintenance). At Esri's sole discretion, Esri may make patches, hot fixes, or updates available for download. No Software other than the defined Products will receive Maintenance. Customer may acquire maintenance for other Software outside this Agreement.

a. Tier 1 Support

1. Customer will provide Tier 1 Support through the Tier 1 Help Desk to all Customer's authorized users.

2. The Tier 1 Help Desk will be fully trained in the Products.

3. At a minimum, Tier 1 Support will include those activities that assist the user in resolving how-to and operational questions as well as questions on installation and troubleshooting procedures.

4. The Tier 1 Help Desk will be the initial point of contact for all questions and reporting of a Case. The Tier 1 Help Desk will obtain a full description of each reported Case and the system configuration from the user. This may include obtaining any customizations, code samples, or data involved in the Case.

5. If the Tier 1 Help Desk cannot resolve the Case, an authorized Tier 1 Help Desk individual may contact Tier 2 Support. The Tier 1 Help Desk will provide support in such a way as to minimize repeat calls and make solutions to problems available to Customer’s organization.

6. Tier 1 Help Desk individuals are the only individuals authorized to contact Tier 2 Support. Customer may change the Tier 1 Help Desk individuals by written notice to Esri.

b. Tier 2 Support

1. Tier 2 Support will log the calls received from Tier 1 Help Desk.

2. Tier 2 Support will review all information collected by and received from the Tier 1 Help Desk including preliminary documented troubleshooting provided by the Tier 1 Help Desk when Tier 2 Support is required.

3. Tier 2 Support may request that Tier 1 Help Desk individuals provide verification of information, additional information, or answers to additional questions to

supplement any preliminary information gathering or troubleshooting performed by Tier 1 Help Desk.

4. Tier 2 Support will attempt to resolve the Case submitted by Tier 1 Help Desk.

5. When the Case is resolved, Tier 2 Support will communicate the information to Tier 1 Help Desk, and Tier 1 Help Desk will disseminate the resolution to the user(s).

6.0—Endorsement and Publicity

This Agreement will not be construed or interpreted as an exclusive dealings agreement or Customer's endorsement of Products. Either party may publicize the existence of this Agreement.

7.0—Administrative Requirements

7.1 OEM Licenses. Under Esri's OEM or Solution OEM programs, OEM partners are authorized to embed or bundle portions of Esri products and services with their application or service. OEM partners' business model, licensing terms and conditions, and pricing are independent of this Agreement. Customer will not seek any discount from the OEM partner or Esri based on the availability of Products under this Agreement. Customer will not decouple Esri products or services from the OEM partners' application or service.

7.2 Annual Report of Deployments. At each anniversary date and ninety (90) calendar days prior to the expiration of this Agreement, Customer will provide Esri with a written report detailing all Deployments. Upon request, Customer will provide records sufficient to verify the accuracy of the annual report.

8.0—Ordering, Administrative Procedures, Delivery, and Deployment

8.1 Orders, Delivery, and Deployment

a. Upon the Effective Date, Esri will invoice Customer and provide Authorization Codes to activate the nondestructive copy protection program that enables Customer to download, operate, or allow access to the Products. If this is a multi-year Agreement, Esri may invoice the Fee up to thirty (30) calendar days before the annual anniversary date for each year.

b. Undisputed invoices will be due and payable within thirty (30) calendar days from the date of invoice. Esri reserves the right to suspend Customer's access to and use of Products if Customer fails to pay any undisputed amount owed on or before its due date. Esri may charge Customer interest at a monthly rate equal to the lesser of one percent (1.0%) per month or the maximum rate permitted by applicable law on any overdue fees plus all expenses of collection for any overdue balance that remains unpaid ten (10) days after Esri has notified Customer of the past-due balance.

c. Esri's federal ID number is 95-2775-732.

d. If requested, Esri will ship backup media to the ship-to address identified on the Ordering Document, FOB Destination, with shipping charges prepaid. Customer acknowledges that should sales or use taxes become due as a result of any shipments of tangible media, Esri has a right to invoice and Customer will pay any such sales or use tax associated with the receipt of tangible media.

8.2 Order Requirements. Esri does not require Customer to issue a purchase order. Customer may submit a purchase order in accordance with its own process requirements, provided that if Customer issues a purchase order, Customer will submit its initial purchase order on the Effective Date. If this is a multi-year Agreement, Customer will submit subsequent purchase orders to Esri at least thirty (30) calendar days before the annual anniversary date for each year.

a. All orders pertaining to this Agreement will be processed through Customer's centralized point of contact.

b. The following information will be included in each Ordering Document:

(1) Customer name; Esri customer number, if known; and bill-to and ship-to addresses
(2) Order number
(3) Applicable annual payment due

9.0—MERGERS, ACQUISITIONS, OR DIVESTITURES

If Customer is a commercial entity, Customer will notify Esri in writing in the event of (i) a consolidation, merger, or reorganization of Customer with or into another corporation or entity; (ii) Customer's acquisition of another entity; or (iii) a transfer or sale of all or part of Customer's organization (subsections i, ii, and iii, collectively referred to as "**Ownership Change**"). There will be no decrease in Fee as a result of any Ownership Change.

9.1 If an Ownership Change increases the cumulative program count beyond the maximum level for this Agreement, Esri reserves the right to increase the Fee or terminate this Agreement and the parties will negotiate a new agreement.

9.2 If an Ownership Change results in transfer or sale of a portion of Customer's organization, that portion of Customer's organization will transfer the Products to Customer or uninstall, remove, and destroy all copies of the Products.

9.3 This Agreement may not be assigned to a successor entity as a result of an Ownership Change unless approved by Esri in writing in advance. If the assignment to the new entity is not approved, Customer will require any successor entity to uninstall, remove, and destroy the Products. This Agreement will terminate upon such Ownership Change.

RECORDER'S COMPLIANCE FUND

REQUISITION FOR FUNDING

Name(s) of requesting Department/Individual:

Chris Gunderson – MIS Department

Guy Carlson – Department of Surveying and Mapping

Description of Project/Items Requested:

2021 Enterprise License Agreement with ESRI to continue using our GIS products

Detail of Costs of Requested Project/Item:

$39,250/year for the next three years for a total of $117,750.00. This is an increase of $10,500 over the 2018 – 2021 agreement

Describe Use and How Project/Item Requested Complies with MS 357.182

ESRI provides the software that geographically represents various types of data related to the land.

Compliance Fund Designee: Nicolle Zuehlke/County Recorder/Registrar

Date of Review: 4.15.2021

Approved: ✓ **Denied:** _____

Signed: Nicolle Zuehlke

MS 357.182 Subd. 7 – Restriction on use of recording fees.

Notwithstanding any law to the contrary, for county budgets adopted after January 1, 2006, each county shall segregate the additional unallocated fee authorized by sections 357.18, 508.82, and 508A.82 from the application of the provisions of chapters 386, 507, 508, and 508A, in an appropriate account. **This money is available as authorized by the Board of County Commissioners for supporting enhancements to the recording process, including electronic recording, to fund compliance efforts specified in subdivision 5 and for use in undertaking data integration and aggregation projects.** Money remains in the account until expended for any of the authorized purposes set forth in this subdivision. This money must not be used to supplant the normal operating expenses for the office of county recorder or registrar of titles.

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1504

DEPARTMENT: Transportation
PRESENTER: Kory Johnson

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:
Propane, Diesel Fuel, and Gasoline for County Garages and Gasoline for Courthouse

BOARD ACTION REQUESTED:
Award bids for Propane, Diesel Fuel, and Gasoline for a one (1) year period from May 1, 2021 through April 30, 2022 to the lowest responsible bidders, as follows, and authorize the county engineer to sign the service agreement: Propane: Edwards Oil Inc. - Swan River, Togo, Old Balsam, Deer River, Arbo, Balsam, Max, Nashwauk; Diesel Fuel: Edwards Oil Inc. - Cohasset, Arbo, Bigfork, Balsam, Swan River, Nashwauk and Davis Oil Inc. - Togo; and Gasoline: Edwards Oil Inc. - Courthouse, Deer River, Cohasset, Balsam, Bigfork, Nashwauk, Swan River.

BACKGROUND:
Bids were opened April 7, 2021

COUNTY ATTORNEY REVIEW: Yes and/or Pending; This will use a standard service contract that has been previously approved by the County Attorney's Office.

SUPPORTING DOCUMENTATION: None

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1522

DEPARTMENT: Transportation
PRESENTER: Ryan Sutherland

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:
Annual Road Maintenance Agreements with Townships and Cities

BOARD ACTION REQUESTED:
Approve the 2021/2022 Annual Road Maintenance Agreements and authorize the County Board Chairperson and the Clerk to the County Board to sign Agreements and authorize the County Engineer to modify Attachment "A" to Agreements as needed and upon mutual agreement with the Township or City.

BACKGROUND:
Annually, the Itasca County Transportation Department offers the opportunity for Townships and Cities to contract for snowplowing, grading, and dust control services offered by the County. 33 Townships and 4 Cities wish to enter into agreements with Itasca County for these services in 2021/2022. Attached is a copy of the Arbo Township "Agreement for Work on Township Roads" and Attachment "A" which serves as a sample of the agreements.

COUNTY ATTORNEY REVIEW: Yes and/or Pending

SUPPORTING DOCUMENTATION:
1. Arbo (RBA Sample)

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

(Rev. 02/08/2018)

AGREEMENT FOR WORK ON TOWNSHIP ROADS

This Agreement made this ____ day of _____, 2021, by and between the County of Itasca, hereinafter referred to as the "County" or "Itasca County", and the Township of _____, hereinafter referred to as the "Township".

Whereas, pursuant to the laws of Minnesota, the governing body of any Township may contract with Itasca County, in which the Township is situated, for the use of County equipment and operators, for snow removal from, for the blading of, and for application of dust control materials on any or all Township roads within the Township.

Whereas, pursuant to the laws of Minnesota, the contract price to be paid by the Township to Itasca County, shall not be less than the actual cost to the Transportation Department for the use of such equipment, operator, materials or contracted cost.

Now, wherefore, in consideration for such work the Township agrees to pay Itasca County at the rates shown in Attachment "A", for the said twelve-month period for snowplowing, grading and/or dust control application, subject to the following:

1. Term
   This Agreement for grading, snowplowing and/or dust control application shall commence on the first day of May, 2021, and shall continue for a twelve (12) month period. This Agreement may be extended for additional twelve month periods upon the mutual consent of the Transportation Department and the Township.

2. Termination
   Either party may cancel this Agreement upon Thirty (30) days notice, with or without cause. Notice shall be in writing served by mail or in person by the Township to the Itasca County Engineer, and by the Transportation Department to the Township Clerk. In the case of dust control, notice must be received by May 15 for the year of the agreement.

3. Employees
   Transportation Department employees performing the work on Township roads as described in this Agreement shall be deemed Transportation Department employees for all purposes while so engaged. Dust control application shall be through an Itasca County contract.

4. Billing
   The Township shall pay Itasca County upon receipt of invoice for services, snowplowing services are billed in January, grading services are billed in July, and dust control services are billed in August.

5. Attachment "A"
   Attachment "A" shall be considered a part of this "Agreement for Work on Township Roads" and shall provide the information as follows:

   a.) Annual rates (per mile) for grading gravel roads once per month and twice per month. The annual rates will be set by Itasca County.

   b.) Annual rate (per mile) for snowplowing. The annual rates will be set by Itasca County.

   c.) Application rate (per mile, 18 foot width, single application) of dust control. The dust control rates will be based on supplier pricing for the Itasca County wide chloride application.

   d.) Township shall indicate which roads are included in this agreement, along with the length of each road.

   e.) Maps of roads as required. Itasca County will provide maps of the Township roads as part of this agreement.

6. Time and Manner of Work

A. The Transportation Department reserves the right to do the work described in this Agreement on Township roads at such time and in such manner so as to not interfere with, nor delay, the work schedule of County roads. The Transportation Department has an obligation to provide services first to Itasca County Roads. As it is likely that the services provided herein may be also needed at more than one location at any time, it shall be at the sole discretion of the County Highway Engineer or his designee to determine the allocation of resources available to provide services under this agreement. This determination shall be final. The Township hereby absolves and agrees to indemnify and hold harmless Itasca County, its agents, servants or employees from any liability arising from such decisions.

B. Snowplowing will not be performed before November 1st, or after March 31st; unless determined to be necessary by the District Maintenance Supervisor, the Highway Maintenance Engineer, or the County Highway Engineer.

C. Snowplowing for emergency situations will only be performed when the Sheriff's Office makes the request. For emergencies, call 911.

7. Unavoidable Delays

Itasca County shall not be held liable in accordance with this contract for unavoidable delays. Unavoidable delays can include delays which were beyond the power of Itasca County to control, with no fault or negligence on its part. Such delays can include acts of nature, i.e. severely inclement weather, floods, tornadoes and strikes.

8. Special Covenants

A. Township covenants that each road identified in attachment "A", is a public highway which is open for public use, and which is subject to the jurisdiction and control of the Township.

B. For each road identified in attachment "A", the Township shall:

1. Erect and maintain appropriate signs at the point of termination of each road.
2. Provide a suitable turnaround site as close to the point of termination of said road as practical. The location and size of the turnaround space shall be subject to approval by the Itasca County Engineer in his/her exclusive discretion.

C. Township covenants that any and all necessary consents have been obtained and remain in effect enabling entry of Itasca County equipment to land beyond the point of termination of any road identified in attachment "A", where such entry is necessary to reach the designated turnaround area.

D. Township shall defend, indemnify, and save Itasca County harmless from any and all claims, demands and judgments based upon, right of way claims or arising under Minnesota Statute 160.05, with respect to any road identified in attachment "A", and further including any turnaround area and road leading thereto beyond the designated termination point of road.

E. Nothing herein shall alter, limit, or diminish the duties and responsibilities of the Township with respect to the roads identified in attachment "A".

9. Indemnification and Hold Harmless

Except as otherwise set forth above in sections 6 and 8 each party shall fully indemnify and hold harmless the other against all claims losses, damages, liability, suits, judgments, costs and expenses by reason of the action, inaction, errors, omissions, or negligence of its employees. This agreement to indemnify and hold harmless does not constitute a waiver by either party of the limitations on liability provided by Minnesota Statutes Chapter 466 or of any defenses or governmental immunities as to third parties. Each party is responsible to maintain liability insurance in at least the amount of its maximum liability under Minnesota Statutes Chapter 466.

To the full extent permitted by law, actions by the Parties pursuant to this Agreement are intended to be and shall be construed as a "cooperative activity" and it is the intent of the Parties that they shall be deemed a "single government unit" for the purpose of liability, as set forth in Minnesota Statutes, Section 471.59, Subd. 1a; provided further that for purposes of that statute, each Party to this Agreement expressly declines responsibility for the acts or omissions of the other Party.

IN WITNESS WHEREOF, the parties hereunto have each caused this Agreement to be executed by their respective officers, hereby duly authorized, as of the date and year first above written.

I have reviewed the foregoing Agreement and I recommend that the Itasca County Board approve the same.

By: _____ Date: _____
Itasca County Highway Engineer

APPROVAL BY COUNTY OF ITASCA

_____
County Board Chairperson

Date: _____

APPROVAL BY _____TOWNSHIP
Motion
By: _____
TWP Board Member
Second
By: _____
TWP Board Member
Motion Passed:

_____ Date: _____
TWP Board Chairperson

I, the undersigned, am the duly appointed Clerk or Deputy Clerk of the above referenced unit of government and attest that on the above referenced date, at a duly convened meeting of the Board, a resolution was duly adopted by the Board approving the agreement set forth above.

By: _____
Clerk/Deputy Clerk
Itasca County Board

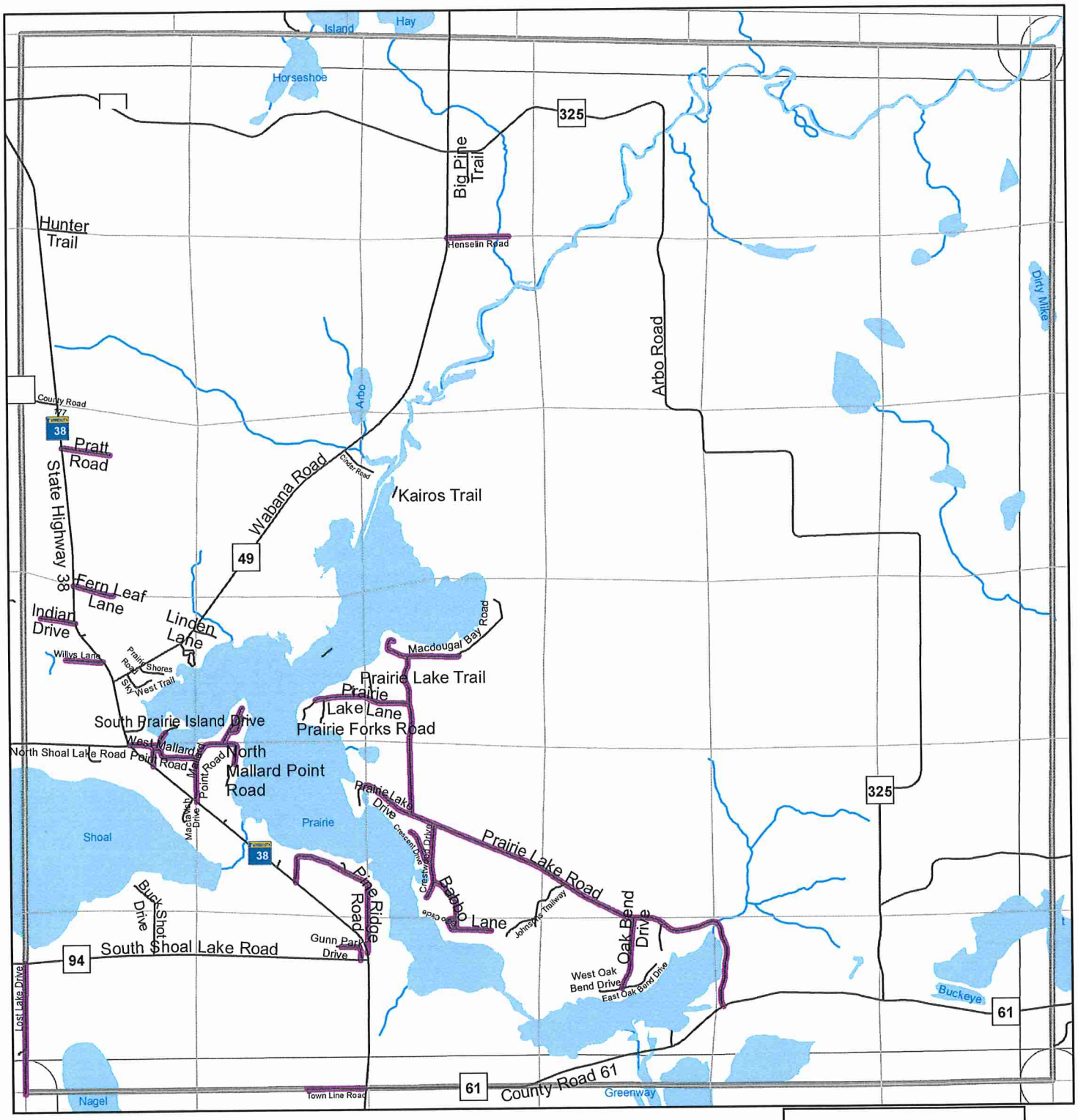
By: _____
Clerk/Deputy Clerk
Township

Your Town/Township is currently under contract with Itasca County for the services shown below. This contract expires **April 30th, 2021**. Your Town/Township must authorize continuance of this contract for the period **May 1, 2021 to April 30th, 2022**. If there are changes, please note them in the comments section and we will adjust new contract. Rates for 2021 Grading are: $700/Mile for one trip per month; and $1400/Mile for two trips per month. Rate for 2021-2022 Snowplowing is: $700/Mile. **Estimated rate** for 2021 Dust Control: $2100/Mile (18 foot width, single application). **Final rate** for 2021 Dust Control will be determined by contract between Itasca County/Supplier and will include grading to prepare road for application.

ARBO TWP - Attachment "A"

	Road Name	length of road	grading once per month	grading twice per month	snowplowing	dust control	Comments
		miles	miles	miles	miles	miles	
1	Arbo Hall Road	0.25			0.25		
2	Crescent Drive	0.20	0.20		0.20		
3	Crestwood Drive	0.45	0.10		0.45		
4	Fern Leaf Lane	0.25	0.25		0.25		
5	Macdougal Bay Rd.	0.50			0.50		Removed Grading 2019 (paved)
6	Gunn Park Drive	0.20			0.20		
7	Henselin Road	0.35	0.35		0.35		
8	Indian Drive	0.20	0.20		0.20		
9	Lost Lake Drive	0.80	0.80		0.80		
10	Mallard Pt. Road	0.60			0.60		
11	N. Mallard Pt. Road	0.25			0.25		
12	W. Mallard Pt. Road	0.30	0.30		0.30		
13	E. Mallard Pt. Road	0.15			0.15		
14	Oak Bend Drive	0.40			0.40		Removed Grading 2019 (paved)
16	Pine Ridge Road	1.00			1.00		
17	S. Prairie Island Dr.	0.10			0.10		
18	Prairie Lake Drive	0.35			0.35		
19	Prairie Lake Lane	0.55			0.55		
20	Prairie Lake Road	3.50			3.50		
21	Pratt Road	0.25	0.25		0.25		
23	Town Line Road	0.30			0.30		
24	Willy's Lane	0.20	0.20		0.20		
25	Babbo Lane	0.55			0.55		Paved summer of 2008
26	Bello Circle	0.10			0.10		Added Snowplowing 2019
27	Town Hall				XXX		As Requested
28							
29							
30							
31							
32							
	Totals-	11.80	2.65	0.00	11.80	0.00	last updated: March 11, 2019

Arbo Township



0 0.5 1 2 Miles

N
W E
S

Township Road Maintenance
Snow Plowing
Last Updated: 1/10/2019

Legend

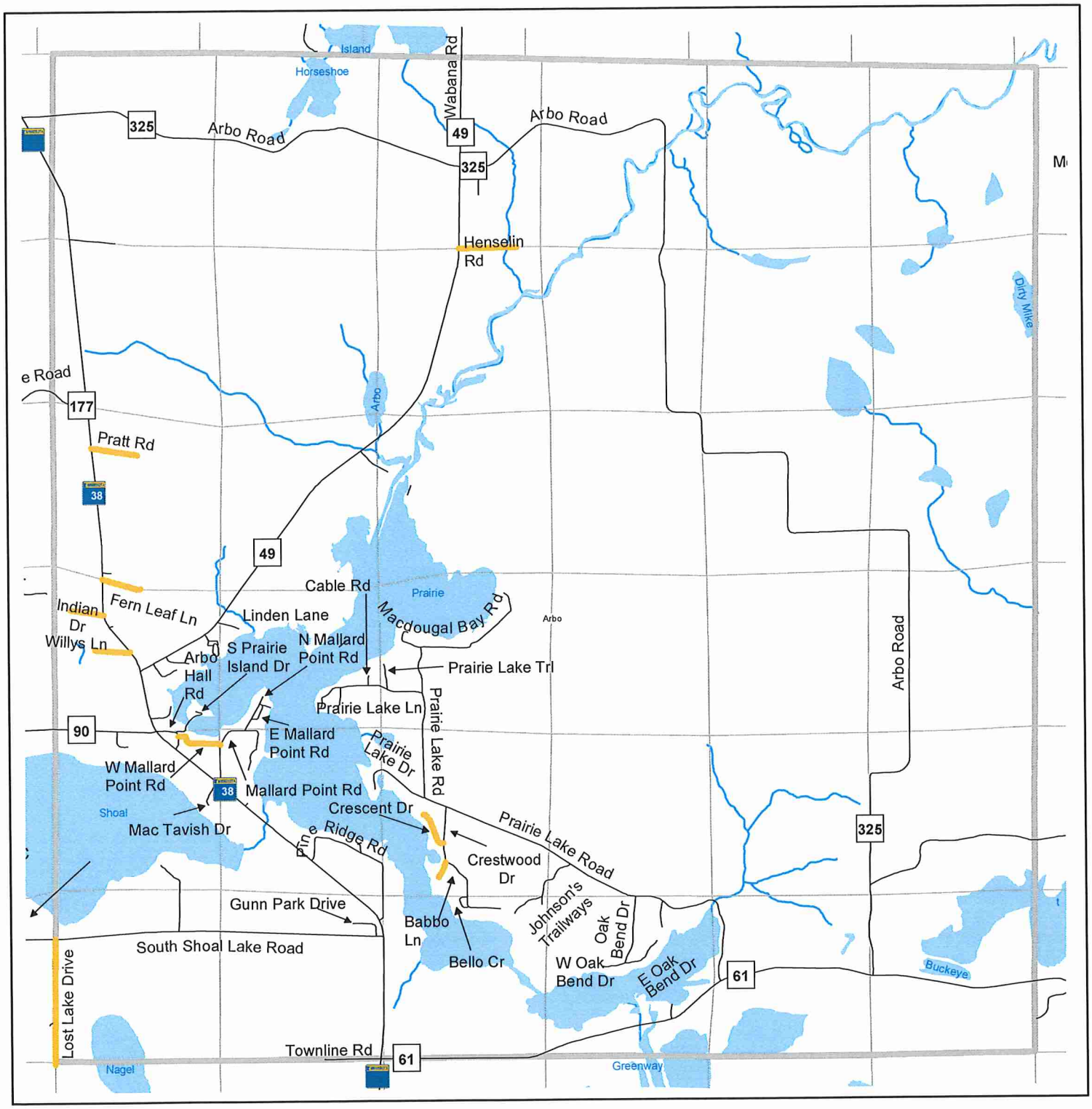
- Vector.GIS.Roads
- Roads Snowplowed Under Contract
- All Other Roads
- Section Lines
- Township Line
- Lakes
- Rivers
- Twp_Snow_Updated_Date

Itasca Geographic Information System
"decision support through automation"

This information is a compilation of data from different sources with varying degrees of accuracy and requires a qualified field survey to verify.

N:\MAINTENANCE\Maintenance Contracts\Twp-City Maintenance \Township Maintenance Agreement Maps\2019-2020 Maps

Arbo Township



0 0.5 1 2 Miles

N
W E
S

Township Road Maintenance
Grading Once Per Month
Last Updated: 3/11/2019

Legend

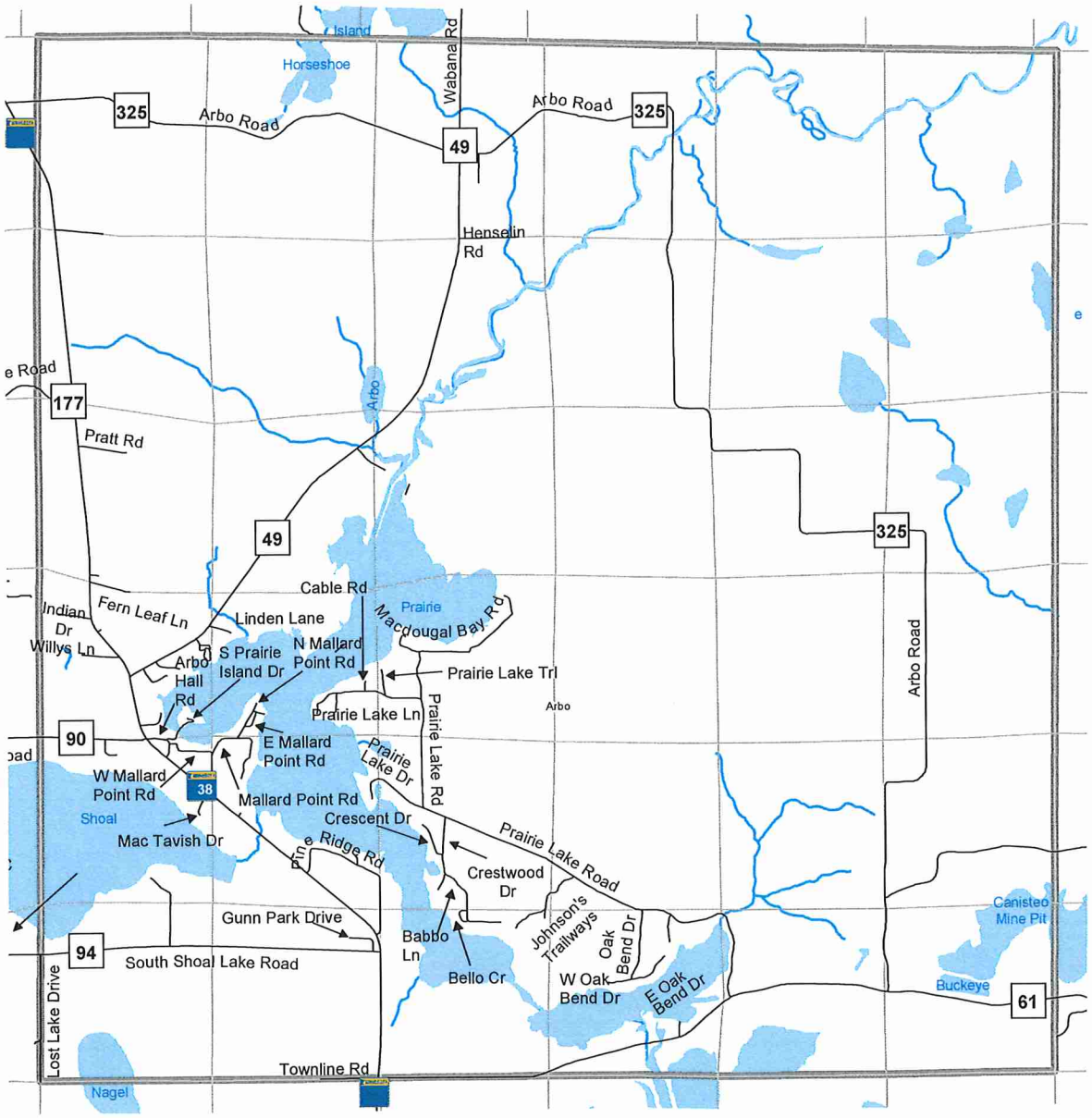
- Roads Graded Once Per Month Under Contract
- All Other Roads
- Section Lines
- Township Line
- Lakes
- Rivers

Itasca Geographic Information System
"decision support through automation"

This information is a compilation of data from different sources with varying degrees of accuracy and requires a qualified field survey to verify.

N:\MAINTENANCE\Maintenance Contracts\Twp-City Maintenance \Township Maintenance Agreement Maps\2019-2020 Maps

Arbo Township



0 0.5 1 2 Miles

N
W E
S

Township Road Maintenance
Grading Twice Per Month
Last Updated: 5/01/2018

Legend

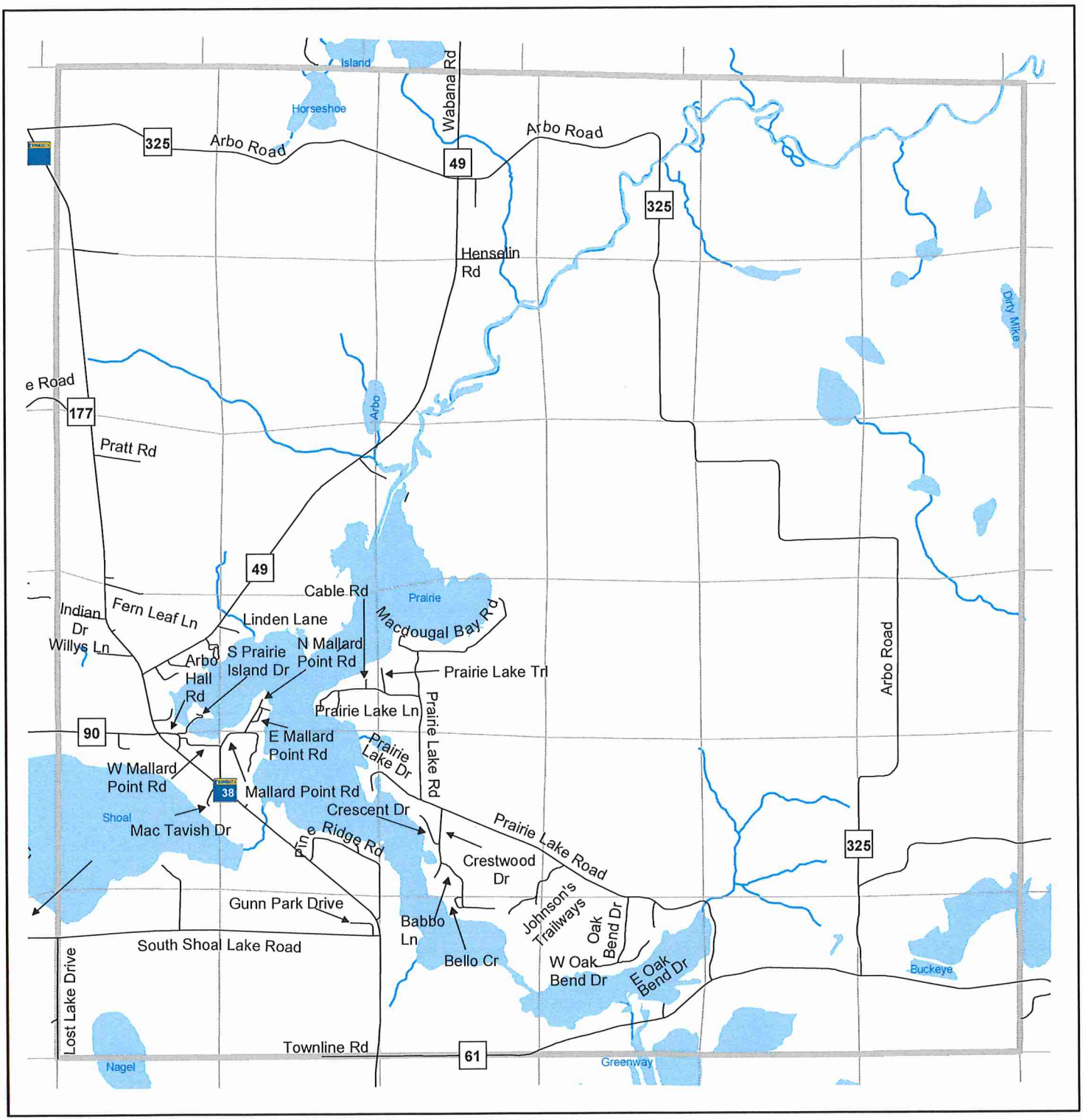
- Roads Graded Twice Per Month Under Contract
- All Other Roads
- Section Lines
- Township Line
- Lakes
- Rivers

Itasca Geographic Information System
"decision support through automation"

This information is a compilation of data from different sources with varying degrees of accuracy and requires a qualified field survey to verify.

N:\MAINTENANCE\Maintenance Contracts\Twp-City Maintenance \Township Maintenance Agreement Maps\2019-2020 Maps

Arbo Township



0 0.5 1 2 Miles

Township Road Maintenance
Dust Control
Last Updated: 5/01/2018

Legend

- Roads With Dust Control Applied Under Contract
- All Other Roads
- Section Lines
- Township Line
- Lakes
- Rivers

Itasca Geographic Information System
"decision support through automation"

This information is a compilation of data from different sources with varying degrees of accuracy and requires a qualified field survey to verify.

N:\MAINTENANCE\Maintenance Contracts\Twp-City Maintenance \Township Maintenance Agreement Maps\2019-2020 Maps

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1498

DEPARTMENT: Land Department
PRESENTER: Michael Gibbons

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:
Notice of Oral Timber Auction

BOARD ACTION REQUESTED:
Authorize notice of intermediate and regular oral bid auction of timber be given by publication in the official newspaper of the County as provided by law and that Land Commissioner offers such tracts of timber associated with said notice of sale, and the auction shall commence at 10:00 AM on Wednesday, June 9th, 2021 at the Gunn Park Pavilion in Grand Rapids, MN. Special COVID-19 public safety guidelines and precautious shall apply.

BACKGROUND:

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:
1. Notice of Intermediate and Regular Timber Auction_6_09_21

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

NOTICE OF ITASCA COUNTY INTERMEDIATE AND REGULAR TIMBER AUCTION

Itasca County Forest Lands are FSC Certified by NEPCon
NC-FM/COC-001709; FSC 100%

Pursuant to the April 27, 2021 official action of the Itasca County Board of Commissioners and under the provisions of Minnesota Statute 282.04, as amended, timber on tax-forfeited land within Itasca County will be offered for sale WITHOUT the sale of land at an Intermediate and Regular Timber Auction sale at **10:00 A.M. on Wednesday, June 9, 2021, at the Gunn Park Pavilion, 4680 MN HWY 38, Grand Rapids, MN.** Timber will be sold to the highest bidder at not less than the appraised value listed on the Timber Appraisal Report. BIDDING SHALL BE BY ORAL BID ONLY. Bid up shall be by two percent (2%) increments, the percent bid up to be added to the appraised price. Itasca County reserves the right to accept or reject any or all bids. SIGNING A ONE TIME AFFIDAVIT OF COMPLIANCE IS REQUIRED PRIOR TO BEING ABLE TO BID ON COUNTY TIMBER AUCTIONS. **All bidders who have not previously registered (i.e. signed Affidavit of Compliance) must register prior to 4:30 p.m. on Tuesday, June 8, 2021.** Interested bidders are responsible to know and comply with all permit regulations and eligibility limits. Bidders must be 18 years and older and in good standing with Itasca County. No bidder can act in any capacity on behalf of a non-qualifying operation for the purpose of procuring rights to timber from Itasca County. No bid will be accepted from any bidder having a delinquent or uncollectible timber permit account or a pending timber trespass with a county, state or federal agency. Violation of eligibility limits will result in loss of down payment and/or loss of privilege to purchase stumpage from Itasca County.

COVID-19 SAFETY GUIDELINES WILL ALLOW HOLDING AN OUTDOOR PUBLIC ORAL TIMBER AUCTION WITH THE FOLLOWING PRECAUTIONS.

- **Do not attend the auction if you are sick or have any symptoms related to COVID-19.**
- **Auction will be held in compliance with state health guidelines and executive orders which require attendees to wear a face covering and to maintain a distance of 6 feet between attendees.**
- **Auction will be held at Gunn Park an outside facility allowing for more room to distance between attendees. Chairs will be provided and spaced appropriately; attendees are asked to not move them.**
- **Bidders are asked to maintain distancing when entering the facility, to go directly to their seat with their bidder card and to leave immediately following the auction.**
- **Disposable bidding cards will be mailed to recent bidders, available at Land Department offices through 6/7/2021, and will also be available for eligible bidders at the auction.**
- **It is requested that only one representative from your organization attend the auction to limit the number of total attendees.**
- **Those who are in the high-risk health category should consider sending someone else to the auction to represent your organization.**
- **Face coverings and hand sanitizer will be available for use at the auction, refreshments will not be provided at this auction.**
- **Successful bidders will be mailed a timber contract and invoice for down payment(s) which will be due within 14 days. Down payments and signing contracts will not occur at the auction.**
- **This oral auction may be cancelled at any time if auction safety guidelines are not followed by attendees, or if COVID-19 infection rates or local/state/federal guidelines dictate.**

All sizes of operations are eligible to purchase timber through Intermediate Auction sale. Each purchaser, including their affiliates as defined in MN Statute 90.01, may have no more than four (4) permits purchased through Intermediate Auction sale in possession at any time. During Intermediate

Auction sales an operation may purchase only one (1) permit in the first round of bidding. An operation may purchase more than one (1) permit in the second round of bidding but may not exceed the possession limit of four (4) intermediate permits. Intermediate Auction permits will have the duration of three (3) years, unless stated otherwise. Intermediate Auction permits may be granted one (1) extension, not to exceed one (1) year, upon payment of 10% of the uncut "bid up value" balance. The minimum extension fee shall be $50. Extensions will be granted at the discretion of the District Forester. Intermediate Auction permits are non-transferable, except in case of hardship. Remaining unsold Intermediate Auction tracts may be re-offered through Regular Auction subject to their Intermediate Auction permit terms but will not be counted towards the Intermediate Auction sale permit limit of four (4) sales.

The Regular Auction sale will immediately follow the Intermediate Auction. There is no limit on how many permits may be purchased through Regular Auction. Regular Auction permits will have the duration of three (3) years, unless stated otherwise. Regular Auction permits may be granted one (1) regular extension, not to exceed one (1) year, upon payment of 10% of the uncut "bid up value" balance. The minimum extension fee shall be $50. Regular extensions will be granted at the discretion of the District Forester. Regular Auction permits may be transferred upon written approval from the Land Commissioner. Each tract not sold at the auction will be available over the counter at the appraised value subject to its "auction permit terms" until withdrawn from sale.

After the sale, the successful bidder for each tract will be mailed an invoice and must pay a minimum non-refundable down payment of 15% of the APPRAISED value for that tract within 14 days. Two thirds of this payment (10% of the appraised value) will be held as a performance bond, and the remaining amount (5% of the appraised value) as a stumpage advance. The Performance Bond will be kept on deposit by the County and will be refunded upon satisfactory completion of the permit requirements, as judged by the District Forester. A permit to cut and remove the timber from the land will be issued to the purchaser in whose name the bid is made. The price of each species subject to bid will be increased by the bid-up percent of the successful bid for that tract. The purchaser must pay for all stumpage prior to cutting. All cut products shall be scaled by Itasca County before being removed from the permit area unless specified otherwise. In the case of tracts that are partitioned into pre-determined cutting blocks, the total down payment is to be 15% of the APPRAISED value of the ENTIRE permit. A performance bond of 10% of the APPRAISED value of the ENTIRE permit will be deducted from the down payment. The remaining 5% will be applied to the first cutting block that is opened. The stumpage value in each block must be paid in full before any cutting may begin in that block. With the permission of the District Forester, the purchaser may enter unpaid blocks and cut necessary timber incidental to developing logging roads as may be needed to log other blocks, provided that no timber may be removed from an unpaid block until separately scaled and paid for.

Within five (5) business days prior to beginning sale operations, the Purchaser has the option to furnish security for the remaining stumpage value. Under this option, the Purchaser may pay for stumpage after the wood is felled or scaled, rather than paying prior to harvest. Security can be furnished in one of the following forms: Corporate surety bond, cash, certified check, cashier's check, money order, assignable bonds or notes of the United States, an assignment of a bank savings account or investment certificate, or an irrevocable bank letter of credit. No harvesting is permitted until proper security has been furnished or payment in full is received for the remaining stumpage balance. Should the Purchaser default on the permit under the security option prior to when logging begins, the Purchaser shall, at a minimum, lose the 15% down payment as a penalty for not completing the permit requirements. Additionally, the Purchaser may be liable for costs and losses incurred by Itasca County on that permit in excess of the 15% down payment. Costs and losses to Itasca County may include but are not limited to decreases in stumpage upon re-sale of the timber, additional permit layout and sale costs required for re-sale, and loss of timber due to blowdown or disease after the permit has forfeited to Itasca County until the permit is harvested.

It is the responsibility of the bidder to arrange access to the permit area, examine each tract, and know the timber permit requirements as stated in the Timber Report and in the Itasca County Forest Management Guidelines & Specifications. Copies of these requirements are available at the Itasca County Land Department upon request. Submission of bid reflects that Bidder has inspected the tract and its permit requirements. Copies of permit requirements for each tract offered for sale, and further information relative to the bidding specifications, are available at the Land Commissioner's Office, 1177 LaPrairie Ave, Grand Rapids, Minnesota (Telephone number: 218-327-2855; TDD numbers: 218-326- 0316 or 218-327-2941).

Itasca County does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment and the provision of services. Prospective bidders who require special accommodations to participate in this sale should inform the Land Department as soon as possible and more than three working days before the sale. Permits can only be awarded to bidders who comply with the Americans with Disabilities Act.

Kory Cease

Itasca County Land Commissioner

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1502

DEPARTMENT: Land Department
PRESENTER: Cindy Shevich

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:
Application for Repurchase of Tax-Forfeited Parcel by Allen Wayne Chastan

BOARD ACTION REQUESTED:
Adopt the Resolution Re: Repurchase of the South Four hundred Sixty-two feet (S. 462') of the Northeast Quarter of the Southeast Quarter (NE1/4 SE1/4), Section Nine (9), Township Fifty-seven (57), Range Twenty-four (24) to Allen Wayne Chastan.

BACKGROUND:
This property forfeited October 31, 2020 for non-payment of property taxes. Itasca County has received payment for all delinquent taxes, penalties, interest and associated costs.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:
1. Application Chastan
2. 23-009-4102 Chastan map

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

ITASCA COUNTY
BOARD OF COMMISSIONERS

Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

RESOLUTION

RE: REPURCHASE OF THE SOUTH FOUR HUNDRED SIXTY-TWO FEET (S. 462') OF THE NORTHEAST QUARTER OF THE SOUTHEAST QUARTER (NE1/4 SE1/4), SECTION NINE (9), TOWNSHIP FIFTY-SEVEN (57), RANGE TWENTY-FOUR (24)

WHEREAS, Minn. Stat. 282.241 provides that the State of Minnesota held in trust for the taxing districts may be repurchased by the owner at the time of forfeiture, or the owner's heir, devisee, or representative, or any person to whom the right to pay taxes was given by statute, mortgage, or other agreement, subject to adoption of a resolution by the County board and payment of the sum of all delinquent taxes, penalties, interest and associated costs, and

WHEREAS, the applicant, Allen Wayne Chastan, has applied to repurchase State of Minnesota land held in trust for the taxing districts legally described as: the South Four hundred Sixty-two feet (S. 462') of the Northeast Quarter of the Southeast Quarter (NE1/4 SE1/4), Section Nine (9), Township Fifty-seven (57), Range Twenty-four (24), and

WHEREAS, the applicant is eligible to repurchase the property, and

WHEREAS, approving the repurchase will promote the use of lands that will best serve the public interest.

NOW THEREFORE BE IT RESOLVED, the Itasca County Board approves the repurchase application by Allen Wayne Chastan, subject to payment including taxes, penalties and interest of $2,556.94; deed tax $1.65; deed fee $25.00; recording fee $46.00; repurchase application fee $300.00 for a total of $2,929.59.

APPLICATION FOR REPURCHASE OF FORFEITED LANDS

Pursuant to Minnesota, Statutes Section 282.241

To The Board of County Commissioners and The County Auditor of Itasca County, Minnesota:

The undersigned **Allen Wayne Chastan,** *hereby makes application to repurchase from the State of Minnesota the following described land, pursuant to Minnesota Statutes, Section 282.241, Said land is situated in said* **Itasca** *County, Minnesota, and more particularly described as follows:*

South Four hundred Sixty-two feet (S. 462') of the Northeast Quarter of the Southeast Quarter (NE1/4 SE1/4), Section Nine (9), Township Fifty-seven (57), Range Twenty-four (24)

Applicant states and shows that at the time of the forfeiture to the State of the said land for taxes hereinafter set out, he was ***the owner by statute, to-wit:***

That said land forfeited to the State on the 31st *day of* **October, 2020**

That such taxes became delinquent **2016** *and remained delinquent*

and unpaid for the subsequent years of **2017 thru 2020**

That the aggregate of all delinquent taxes and assessments, with penalties, costs and interest, exclusive of taxes and assessments to be reinstated as provided by Minnesota Statutes, Section 282.251, is the sum of **Two Thousand Nine Hundred Twenty-nine and 59/100ths dollars ($2,929.59), which includes (taxes, penalties & interest $2,556.94; plus deed tax $1.65; deed issuance fee $25.00; recording fee $46.00; application fee $300.00***)*

That permission to repurchase said land is hereby requested for the reasons stated as follows:

I don't want to loose this land and now am able to pay for all necessary fee's and penalties.

This applicant offers to pay upon such repurchase not less than one-tenth of the aggregate sum of said delinquent taxes and assessments together with penalties and costs, with interest at the rate fixed by law for the respective years computed to the date of repurchase from the time such taxes and as-assessments became delinquent, and also the sum of taxes and assessments with penalties and costs, with interest at the rate fixed by law for the respective years to the date of repurchase from the time such taxes and assessments would have been delinquent that would have been levied and assessed against such parcel between the date of forfeiture and the date of repurchase, all due and to be computed as set out in the Minnesota Statutes, Section 282.251, and to pay the remaining portion of repurchase price in ten equal annual installments, with the privilege of paying the unpaid balance in full at any time with interest at four percent per annum on the balance remaining unpaid each year.

Dated 4-6 ,20 21

Allen Chastan
Applicant

Applicant

State of Minnesota, }ss.

County of Itasca

Allen Wayne Chastan, being duly sworn, deposes and says: that ..he is the applicant and petitioner in the forgoing petition; that ....he has read said petition and knows the contents thereof; that the same is true of his...own knowledge save as to the matters therein stated on information and belief and as to those matters ...he believes it to be true.

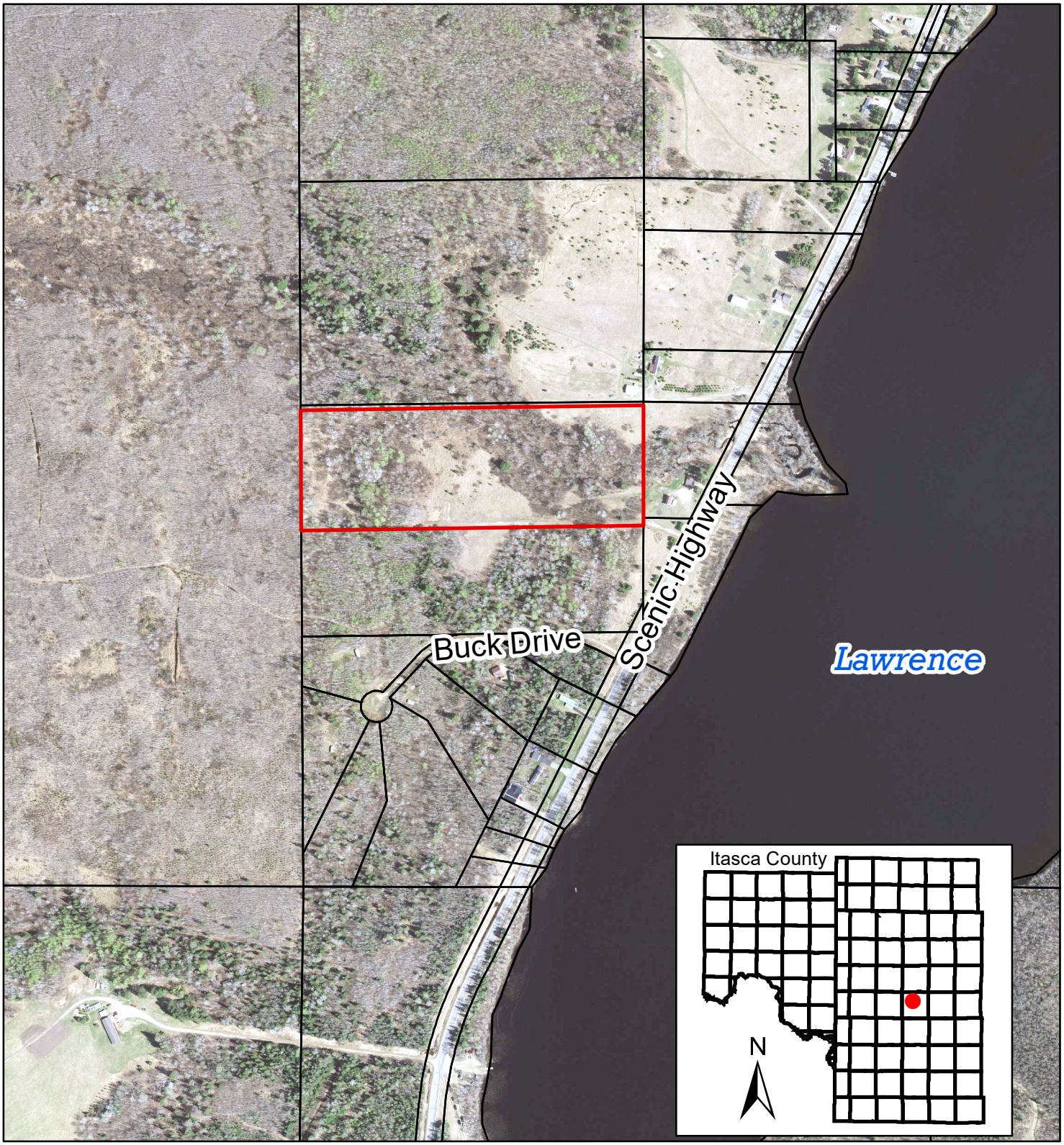
Subscribed and sworn to before me this

6th ***day of*** April ,20 21

Bonita K. Lentz

BONITA KAREN LENTZ
NOTARY PUBLIC-MINNESOTA
My Comm. Exp. Jan. 31, 2022

Repurchase Application by Allen Wayne Chastan



0 310 620 1,240 Feet

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1503

DEPARTMENT: Land Department
PRESENTER: Cindy Shevich

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:
Application for Repurchase of Tax-Forfeited Parcel by Steven Keske

BOARD ACTION REQUESTED:
Adopt the Resolution Re: Repurchase of Lot Five (5), Block One (1), Third Addition to Marble to Steven Keske.

BACKGROUND:
This property forfeited October 31, 2020 for non-payment of property taxes. Itasca County has received payment for all delinquent taxes, penalties, interest and associated costs.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:
1. Application Keske
2. 94-440-0150 Keske map

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

ITASCA COUNTY
BOARD OF COMMISSIONERS

Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

RESOLUTION

RE: REPURCHASE OF LOT FIVE (5), BLOCK ONE (1), THIRD ADDITION TO MARBLE

WHEREAS, Minn. Stat. 282.241 provides that the State of Minnesota held in trust for the taxing districts may be repurchased by the owner at the time of forfeiture, or the owner's heir, devisee, or representative, or any person to whom the right to pay taxes was given by statute, mortgage, or other agreement, subject to adoption of a resolution by the County board and payment of the sum of all delinquent taxes, penalties, interest and associated costs, and

WHEREAS, the applicant, Steven Keske, has applied to repurchase State of Minnesota land held in trust for the taxing districts legally described as: Lot Five (5), Block One (1), Third Addition to Marble, and

WHEREAS, the applicant is eligible to repurchase the property, and

WHEREAS, approving the repurchase will promote the use of lands that will best serve the public interest.

NOW THEREFORE BE IT RESOLVED, the Itasca County Board approves the repurchase application by Steven Keske, subject to payment including taxes, penalties and interest of $1,071.58; deed tax $1.65; deed fee $25.00; recording fee $46.00; repurchase application fee $300.00 for a total of $1,444.23.

APPLICATION FOR REPURCHASE OF FORFEITED LANDS

Pursuant to Minnesota, Statutes Section 282.241

To The Board of County Commissioners and The County Auditor of Itasca County, Minnesota:

The undersigned **Steven David Keske and Kassandra Lee Keske** *hereby makes application to repurchase from the State of Minnesota the following described land, pursuant to Minnesota Statutes, Section 282.241, Said land is situated in said* **Itasca** *County, Minnesota, and more particularly described as follows:*

Lot Five (5), Block One (1), Third Addition to Marble
located in Itasca County
SECTION 19, TOWNSHIP 56, RANGE 23

Applicant states and shows that at the time of the forfeiture to the State of the said land for taxes hereinafter set out, they were the owners and taxpayers.

That said land forfeited to the State on the 31st *day of* **October, 2020**

That such taxes became delinquent **2012** *and remained delinquent*

and unpaid for the subsequent years of **2012-2017 and 2019**

That the aggregate of all delinquent taxes and assessments, with penalties, costs and interest, exclusive of taxes and assessments to be reinstated as provided by Minnesota Statutes, Section 282.251, is the sum of **One Thousand Four Hundred Forty-four and 23/100ths Dollars($1,444.23), which includes *(*taxes, penalties & interest $1,071.58; plus deed tax $1.65; deed issuance fee $25.00; recording fee $46.00; application fee $300.00*)***

That permission to repurchase said land is hereby requested for the reasons stated as follows:

This applicant offers to pay upon such repurchase not less than one-tenth of the aggregate sum of said delinquent taxes and assessments together with penalties and costs, with interest at the rate fixed by law for the respective years computed to the date of repurchase from the time such taxes and as-assessments became delinquent, and also the sum of taxes and assessments with penalties and costs, with interest at the rate fixed by law for the respective years to the date of repurchase from the time such taxes and assessments would have been delinquent that would have been levied and assessed against such parcel between the date of forfeiture and the date of repurchase, all due and to be computed as set out in the Minnesota Statutes, Section 282.251, and to pay the remaining portion of repurchase price in ten equal annual installments, with the privilege of paying the unpaid balance in full at any time with interest at four percent per annum on the balance remaining unpaid each year.

*Dated*_____ *,20__*

_____
Applicant

_____
Applicant

State of Minnesota, }ss.
County of Itasca

Steven David Keske and Kassandra Lee Keske, ***being duly sworn, deposes and says: that they are the applicants and petitioners in the forgoing petition; that they have read said petition and knows the contents thereof; that the same is true of their own knowledge save as to the matters therein stated on information and belief and as to those matters they believe it to be true.***

Subscribed and sworn to before me this

_____

_____ ***day of*** _____,***20__***

_____

_____

RESOLUTION OF COUNTY BOARD

Resolved by the Board of County Commissioners of _____ County, Minnesota, that the forgoing application is hereby approved for the reasons stated as follows:

Adopted this _____ day of _____ 20__

_____
Chairman County Board

Attest;

_____
County Auditor

*No.*_____

State of Minnesota,

*County of*_____

Petition of

_____

_____

_____

For Repurchase of Land Forfeited to the State of Minnesota for Delinquent Taxes

_____

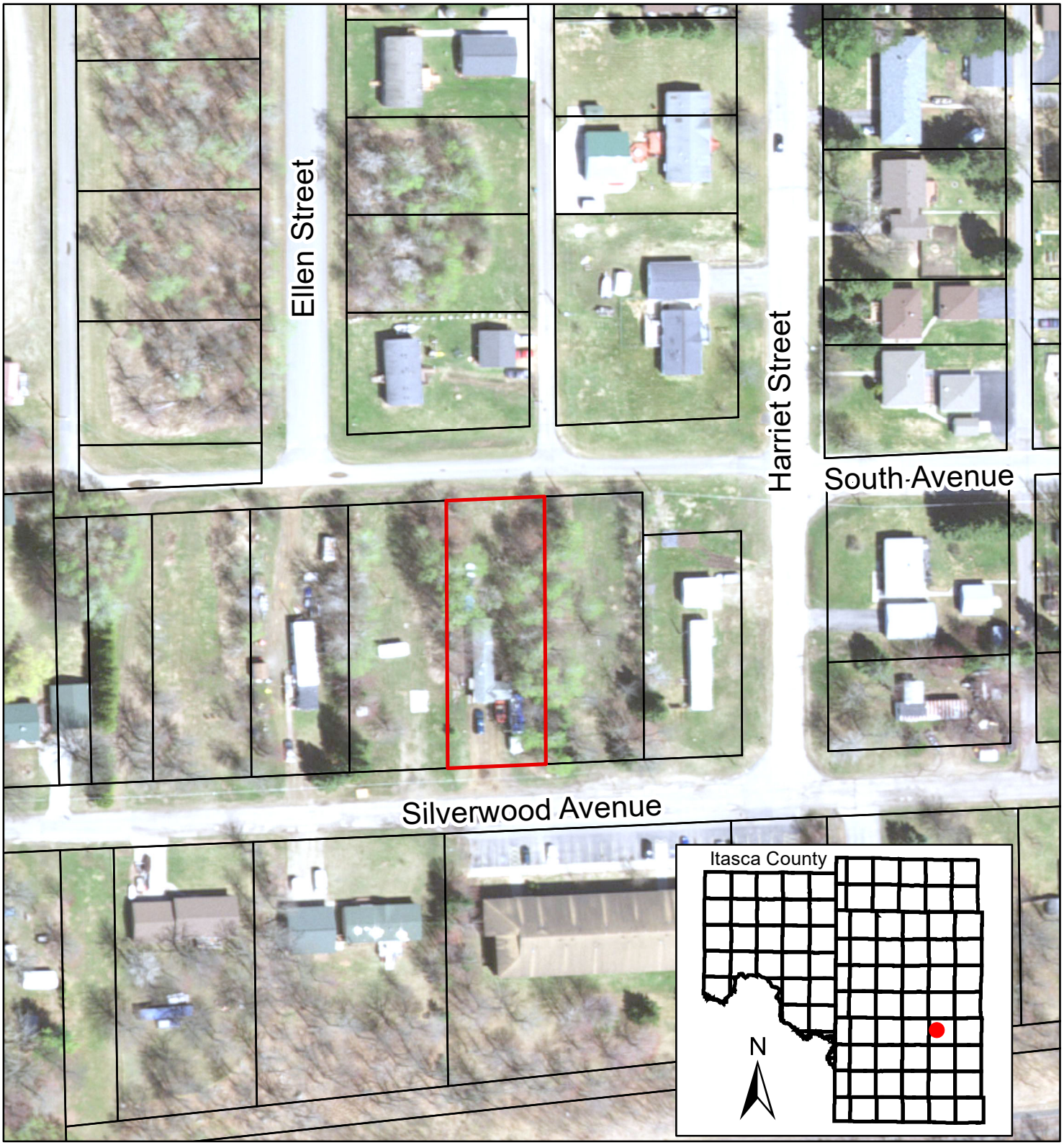
_____

Filed this _____ *day of* _____, *20*__,

_____
County Auditor

*By*_____
Deputy

Repurchase Application by Steven Keske



This information is a compilation of data from different sources with varying degrees of accuracy and requires a qualified field survey to verify.
Itasca Geographic Information System
"Decision support through automation"

0 60 120 240 Feet

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1516

DEPARTMENT: Land Department
PRESENTER: Cindy Shevich

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:
Tax-Forfeited Land Sale to Adjoining Landowners

BOARD ACTION REQUESTED:
Adopt the Resolution Re: Authorizing and Fixing the Notice and Terms of Tax-Forfeited Land Sale to Adjoining Landowners.

BACKGROUND:
The Land Department is requesting that the County Board set the values and terms of sale per the attached Notice and Terms of Tax-Forfeited Land Sale to Adjoining Landowners.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:
1. Notice and Terms 2021-5-28
2. Adjacent Land Owner List May 2021

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

ITASCA COUNTY
BOARD OF COMMISSIONERS

Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

RESOLUTION

RE: AUTHORIZING AND FIXING THE NOTICE AND TERMS OF TAX-FORFEITED LAND SALE TO ADJOINING LANDOWNERS

WHEREAS, the County Board has classified and appraised certain tax forfeited lands and list of said lands has been filed with the County Auditor, classification of said lands have been duly approved by the Town Boards and Municipalities and the appraised value of timber has been duly approved by the County Land Commissioner, and

WHEREAS, the County Board is by law designated with authority to provide for the sale of such forfeited lands on terms included in the Notice and Terms of Tax-Forfeited Land Sale to Adjoining Landowners,

NOW THEREFORE BE IT RESOLVED, that the Notice and Terms of Tax-Forfeited Land Sale to Adjoining Landowners be given by certified mail to all adjoining landowners as provided by Minnesota Statute 282.01, subdivision 7a, that the County Auditor of Itasca County shall open sealed bids for such tracts of land for sale in the order in which they appear in said Notice at 10:00 A.M. on FRIDAY, MAY 28, 2021 at the ITASCA COUNTY LAND DEPARTMENT, 1177 LAPRAIRIE AVENUE, GRAND RAPIDS, MN 55744.

NOTICE AND TERMS OF TAX-FORFEITED LAND SALE TO ADJOINING LANDOWNERS
ITASCA COUNTY LAND DEPARTMENT – FRIDAY, MAY 28, 2021, 10:00 A.M.

NOTICE IS HEREBY GIVEN, that I shall offer for sale to adjoining landowners through sealed bids, and at not less than the appraised value, the following described tracts of land forfeited to the State of Minnesota for nonpayment of taxes, which have been classified and appraised as provided by law. Said sale will be governed as to terms by resolution of the County Board authorizing the same, sealed bids shall be opened at **10:00 A.M. on FRIDAY, MAY 28, 2021**.

KORY CEASE, Itasca County Land Commissioner JEFF WALKER, Itasca Co. Auditor/Treasurer

RESOLUTION OF COUNTY BOARD AUTHORIZING AND FIXING
THE TERMS OF SALE TO ADJOINING LANDOWNERS

WHEREAS, the County Board has classified and appraised certain tax forfeited lands and list of said lands has been filed with the County Auditor, classification of said lands have been duly approved by the Town Boards and Municipalities and the appraised value of timber has been duly approved by the County Land Commissioner, and

WHEREAS, the County Board is by law designated with authority to provide for the sale of such tax-forfeited lands on terms included in the Notice of Sale,

NOW, THEREFORE, BE IT RESOLVED, that the Notice Of Tax-Forfeited Land Sale be given by certified mail to all adjoining landowners as provided by Minnesota Statute 282.01, subdivision 7a, that the County Auditor of Itasca County shall open sealed bids for such tracts of land for sale in the order in which they appear in said Notice of Sale at 10:00 A.M. on FRIDAY, MAY 28, 2021 at the ITASCA COUNTY LAND DEPARTMENT, 1177 LA PRAIRIE AVENUE, GRAND RAPIDS, MN 55744.

TERMS OF SALE

The County Board is by law designated to provide for the sale of such land on terms and such tracts shall be sold on the following terms, to wit: The appraised value of timber products listed and 15% of the appraised value of the land must be paid on the day of the land sale, except that for tracts under $501.00, the full amount of the tract is due on the day of the sale. Any remaining balance must be paid within 30 days. No timber shall be cut, removed, or damaged until the entire purchase price for the tract is paid in full.

The land and improvements are being sold AS IS and the County makes no warranties as to the condition of any buildings, wells, septic systems, soils, roads, or any other thing on the tract. The tract is being sold with the understanding that the buyer and seller agree to waive disclosures required under Minnesota Statutes Chapters 513.52 to 513.60, and 103I.235 and any associated liabilities. No representation is made as to the condition of any structure, its fixtures or contents, or the suitability for any particular use.

All tracts of land sold hereunder shall be subject to zoning ordinances, existing easements, existing railway and highway easements, power and pipeline easements and leases, if any. Sold lands that are currently zoned “public” shall be rezoned upon sale at no cost to the purchaser.

All lands whether zoned or not zoned which do not abut a legalized highway are subject to any and all existing restrictions empowered by statute relating to the expenditure of public lands.

Any lands herein offered for sale that do not adjoin or are located on a suitable legally established and maintained public highway or road, the township wherein said lands may be located, or any other municipality, shall not for a period of five years, be obligated to the establishment, construction or additional maintenance of any public roads or the expenditure of any public funds for the benefit of the owner or occupant of any lands purchased, by reason of the ownership or occupancy of any of this land; provided further that nothing herein shall be construed to create any obligation directly or indirectly on the part of any municipality of the expenditures of any money for the benefit of said tracts after the expiration of said five year period.

Any tract of land on the list is subject to withdrawal from sale by the County Board or Land Commissioner when it appears to be in the public interest to do so.

Tracts shall be sold through sealed bid. All bids must be submitted using the attached "Sealed Bid Form." The completed "Sealed Bid Form" must be submitted in a sealed envelope with the provided label affixed as the addressee and received at the ITASCA COUNTY LAND DEPARTMENT, 1177 LA PRAIRIE AVENUE, GRAND RAPIDS, MN 55744, at or before 10:00 A.M. on FRIDAY, MAY 28, 2021. Payment per these terms of sale must be enclosed in the envelope with the completed "Sealed Bid Form," in the form of a cashier's or certified check. Cash or personal checks will NOT be accepted and will result in the rejection of the bid. Payment from unsuccessful bids will be returned via certified mail. Itasca County reserves the right to reject any and all bids until the sales have closed. Successful bidders will be contacted and must sign a purchase agreement and return it to the Land Department by 4:30 p.m. on June 28, 2021. In the event of identical bids on a tract, the submitting bidders will be notified and an oral auction involving said bidders will take place at the Itasca County Land Department beginning 10:00 A.M. on June, 28, 2021 in the order of the tracts in this listing.

Any and all tracts which received zero qualifying bids at said bid opening date and time may be purchased by a qualifying bidder at not less than the appraised price on a first come, first served basis starting at 8:00 a.m. May 31, 2021 and ending at 4:30 p.m. on July 28, 2021. Any and all tracts not sold by 4:30 p.m. on July 28, 2021 will be withdrawn from sale at that time.

Pursuant to Minnesota Statute 282.12, the State of Minnesota shall reserve all tax-forfeited minerals and mineral rights, and water power rights on tax-forfeited lands.

Pursuant to Minnesota Statute 284.28, there will be added to the sale price of any tax-forfeited land, an amount equal to three percent (3%) of the total sale price, said additional amount to be deposited to the State Treasury and credited to the tax-forfeited land assurance account.

Pursuant to Minnesota Statute 282.014, a $25.00 fee will be charged to purchasers of tax-forfeited land for issuance of the state tax deed. Minnesota Statute 282.014 further requires that all State tax deeds be recorded with the County Recorder prior to issuing the deed to the purchaser. The purchaser must pay the $46.00 recording fee. In the event of Torrens Property there may be additional recording fees.

A deed tax of $1.65 for the first $3,000.00 of the purchase price. For any purchase price over $3,000, the purchaser shall pay $1.65 per every $500.00 of the purchase price payable to the County Auditor/Treasurer.

Purchaser is required to pay a fee of $50.00 for recording the well certificate where applicable, prior to the Auditor/Treasurer delivering the deed to the purchaser.

Certain tracts of tax-forfeited land located within cities forfeited with unpaid special assessments for improvements. These special assessments were cancelled at the time of forfeiture. Upon sale of this land, the municipality may establish a re-assessment schedule for payment of a portion or all the unpaid special assessments. **Itasca County recommends that individuals check for assessments with the municipality office in which the tract is located.**

Except for land in platted subdivisions and lands conveyed for correcting legal descriptions, all deeds requested after August 1, 1991, will contain the following statement: This property is not eligible for enrollment in a state funded program providing compensation for conservation of marginal land and wetlands.

ALL SALES ARE FINAL. IN CASES OF PAYMENT DEFAULT, ITASCA COUNTY WILL RETAIN THE DOWN PAYMENT (I.E. 15% OF APPRAISED LAND VALUE, ETC.) AS PENALTY AND DAMAGES, AND WILL, AT ITS SOLE DISCRETION, DECIDE WHETHER THE TRACT(S) WILL BE RE-OFFERED TO THE NEXT HIGHEST BIDDER.

Itasca County does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment and the provision of services. Prospective bidders who require special accommodations to participate in this sale should inform the Real Estate Office more than three business days before the sale. You may write to the return address shown on this notice or call telephone no. 218-327-2855 or TDD no. 218-327-2806 or 218-327-2847.

Questions regarding the sale should be directed to Itasca County Land Department, Real Estate Office, 1177 La Prairie Avenue, Grand Rapids, MN 55744 (telephone 218-327-2855).

Tax-Forfeited and Direct County Land Sale to Adjoining Landowners

By sealed bid 10:00 a.m. on

TRACT	TWP	RGE	SEC	ACRES*	LEGAL DESCRIPTION	PARCEL ID	TIMBER APPRAISED	LAND APPRAISED	TOTAL APPRAISED
A202110	55	22	24	0.15	Pt Lot 2 (See attached) 3a	14-124-4202	$ 40.00	$ 3,700.00	$ 3,740.00
A202111	55	22	24	0.17	Pt Lot 2 (See attached) 4a	14-124-4202	$ 40.00	$ 3,700.00	$ 3,740.00
A202112	55	22	24	0.15	Pt Lot 2 (See attached) 5a	14-124-4202	$ 40.00	$ 3,400.00	$ 3,440.00
A202113	56	26	2	0.14	S. 50 feet of Lot 3, Block A NORTHLAND PARK	64-480-0140	$ -	$ 500.00	$ 500.00
A202114	56	26	2	0.29	Lot 7, Block D NORTHLAND PARK	64-480-0440	$ -	$ 1,000.00	$ 1,000.00
A202115**	56	26	2	0.22	Lot 7, Block E NORTHLAND PARK	64-480-0535	$ -	$ 1,000.00	$ 1,000.00
A202116	56	26	2	0.16	S. 50 feet of Lot 12, Block F NORTHLAND PARK	64-480-0634	$ -	$ 500.00	$ 500.00
A202117	56	26	2	0.29	Lot 26, Block I NORTHLAND PARK	64-480-0966	$ -	$ 1,000.00	$ 1,000.00
A202118	56	26	2	0.14	N. 50 feet of Lot 31, Block I NORTHLAND PARK	64-480-0984	$ -	$ 500.00	$ 500.00
A202119	56	26	2	0.21	Lot 1 LESS E. 100 feet, Block J NORTHLAND PARK	64-480-1010	$ 100.00	$ 700.00	$ 800.00
A202120***	20	55	25	0.99	Block 10 LESS E. 10 feet & LESS W. 10 feet & LESS Lots 13-24 & S1/2 of vac 5th St SW lyg adj to Lot 1 WOODLAND ADD TO GRAND RAPIDS	91-725-1040	$ 600.00	$ 10,000.00	$ 10,600.00

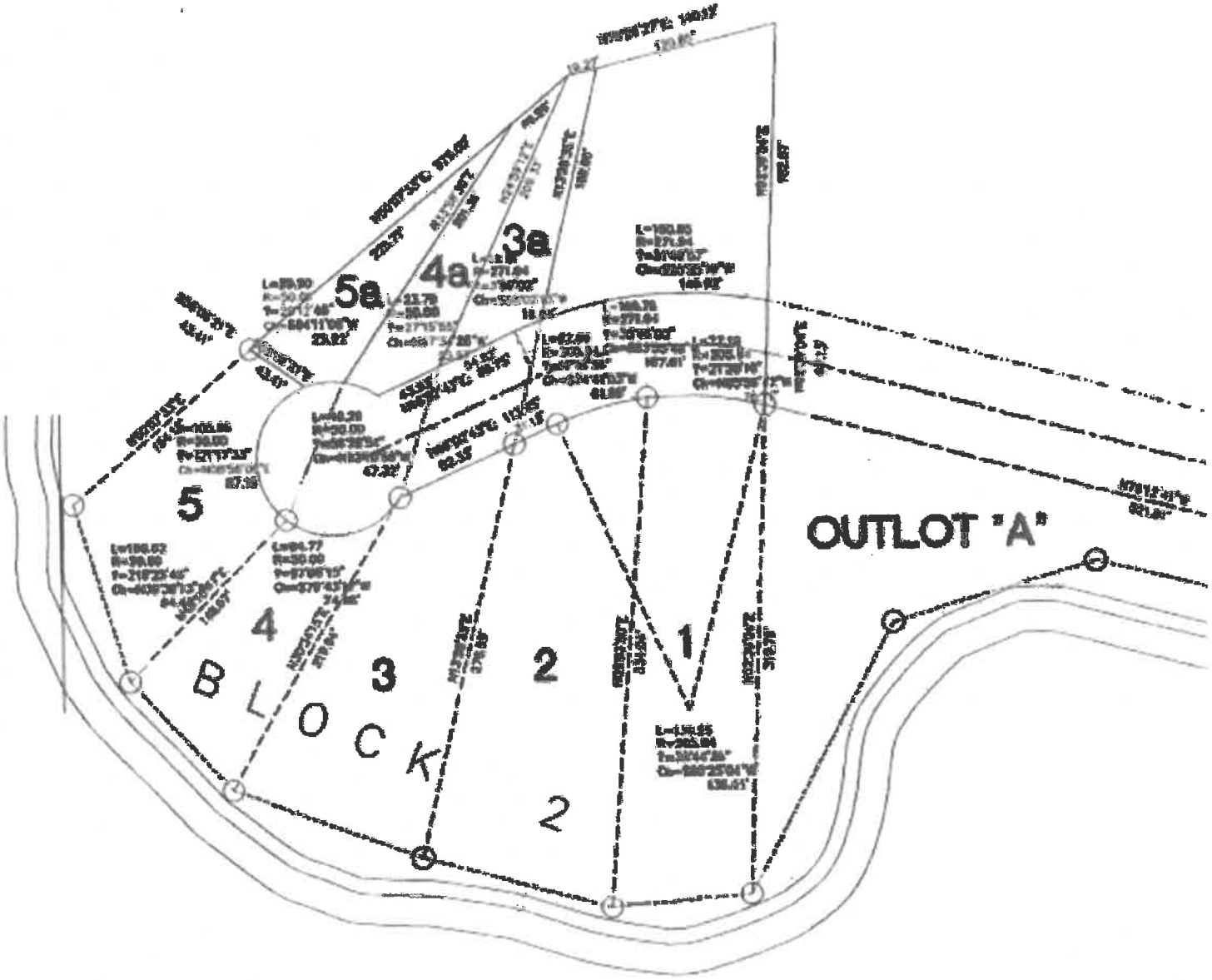
*Acres listed are not based on a survey and are an approximation only.

**Parcel is only a buildable lot if combined with 64-480-0540 and 64-480-0545

***Subject to an Easement to Northwestern Bell Telephone Co. over and across the W. 8 feet of Lots 1-12, Block 10

Parcel Acreage

3a = 0.15 ac.
4a = 0.17 ac.
5a = 0.15 ac.



Descriptions for additional Real Estate which is connected to the plat of "BEAUTY-VILLE".
H:\Departments\LandDepartment\REALESTATE\beautylake\Additional Real Estate 3aa.docx

Description for 3a.

That part of Government Lot 2 of Section Twenty-four (24), Township Fifty-five (55) North, Range Twenty-two (22) West, Itasca County, Minnesota, described as follows:

> Beginning at the northeast corner of Lot 3, Block 2, BEAUTY-VILLE, according to the plat on file and of record in the Itasca County Recorder's Office (Document No. 403341); thence North 13 degrees 28 minutes 35 seconds East, along the northerly extension of the easterly line of said Lot 3, 251.89 feet; thence South 76 degrees 26 minutes 27 seconds West 19.27 feet; thence South 24 degrees 59 minutes 12 seconds West 209.33 feet; thence South 17 degrees 39 minutes 40 seconds West 88.28 feet to the northwest corner of Lot 3, Block 2; thence North 66 degrees 02 minutes 43 seconds East along the northerly line of said Lot 3, to the point of beginning. Tract contains 0.15 acres more or less.

The State of Minnesota reserves a perpetual easement being a 66 foot strip of land for road purposes for ingress and egress over and across the existing road for access to Lots 1, 2, 3,4, and 5, Block 2; Outlot A of said plat and Government Lot 2, of Section Twenty-four (24), Township Fifty-five (55) North, Range Twenty-two (22) West, Itasca County, Minnesota.

AND

An easement for road purposes across Government Lots 1 and 2 Section Twenty-four (24), Township Fifty-five (55) North, Range Twenty-two (22) West of the Fourth Principal Meridian; said easement being 66.00 feet in width and lying 33.00 feet on both sides of the following described center line:

> Commencing at the southeast corner of said Section Twenty-four (24); thence North 00 degrees 28 minutes 58 seconds East, assigned bearing along the east line of said Section Twenty-four (24), a distance of 441.74 feet to the point of beginning of the center line to be described; thence South 89 degrees 55 minutes 11 seconds West, 354.94 feet; thence westerly along a tangential curve, concave to the north, central angle 18 degrees 19 minutes 36 seconds, radius 400.00 feet, arc length 127.94 feet; thence North 71 degrees 45 minutes 13 seconds West, 257.54 feet; thence westerly along a tangential curve, concave to the south, central angle 19 degrees 07 minutes 38 seconds, radius 1000.00 feet, arc length 333.83 feet to a point of reverse curvature; thence northwesterly along a reverse curve, central angle 59 degrees 28 minutes 21 seconds, radius 133.82 feet, arc length 138.90 feet; thence North 31 degrees 24 minutes 30 seconds West, 267.76 feet; thence northerly along a tangential curve, concave to the east, central angle 15 degrees 52 minutes 07 seconds, radius 210.14 feet, arc length 58.20 feet; thence North 15 degrees 32 minutes 23 seconds West, 505.01 feet; thence northerly along a tangential curve, concave

to the east, central angle 29 degrees 33 minutes 20 seconds, radius 267.05 feet, arc length 137.76 feet; thence North 14 degrees 00 minutes 57 seconds East 184.10 feet; thence northerly along a tangential curve, concave to the west, central angle 89 degrees 13 minutes 38 seconds, radius 160.12 feet, arc length 249.35 feet; thence North 75 degrees 12 minutes 41 seconds West, 521.81 feet; thence westerly along a tangential curve, concave to the south, central angle 38 degrees 44 minutes 36 seconds, radius 238.94 feet, arc length 161.57 feet; thence South 66 degrees 02 minutes 43 seconds West, 92.70 feet to Point "A" and there terminate said center line; the side lines of the above described easement are to terminate at the easterly circumference of the following described circle:

An easement for road purposes lying within the circumference of a circle having a radius of 50.00 feet; the center of said circle is the point which bears South 75 degrees 15 minutes 52 seconds West a distance of 50.00 feet from said Point "A".

Said easement is hereby granted for benefit of access to all of the lots in the plat of BEAUTY-VILLE.

Descriptions for additional Real Estate which is connected to the plat of "BEAUTY-VILLE".
H:\Departments\LandDepartment\REALESTATE\beautylake\Additional Real Estate 4aa.docx

Description for 4a

That part of Government Lot 2 of Section Twenty-four (24), Township Fifty-five (55) North, Range Twenty-two (22) West, Itasca County, Minnesota, described as follows:

> Beginning at the most northerly corner of Lots 4 and 5, Block 2, BEAUTY-VILLE, according to the plat on file and of record in the Itasca County Recorder's Office (Document No. 403341); thence North 23 degrees 32 minutes 36 seconds East, 96.70 feet; thence North 33 degrees 58 minutes 30 seconds East 201.36 feet; thence North 50 degrees 07 minutes 33 seconds East 49.29 feet; thence South 24 degrees 59 minutes 12 seconds West 209.33 feet; thence South 17 degrees 39 minutes 40 seconds West 88.28 feet to the northeast corner of Lot 4, Block 2; thence southwesterly along a non-tangential curve, concave to the north, central angle 97 degrees 08 minutes 15 seconds, radius 50.00 feet, arc length 84.77 feet, chord bearing South 79 degrees 43 minutes 12 seconds West along the northerly line of said Lot 4, to the point of beginning. Tract contains 0.17 acres more or less.

The State of Minnesota reserves a perpetual easement being a 66 foot strip of land for road purposes for ingress and egress over and across the existing road for access to Lots 1, 2, 3,4, and 5, Block 2; Outlot A of said plat and Government Lot 2, of Section Twenty-four (24), Township Fifty-five (55) North, Range Twenty-two (22) West, Itasca County, Minnesota.

AND

An easement for road purposes across Government Lots 1 and 2 Section Twenty-four (24), Township Fifty-five (55) North, Range Twenty-two (22) West of the Fourth Principal Meridian; said easement being 66.00 feet in width and lying 33.00 feet on both sides of the following described center line:

> Commencing at the southeast corner of said Section Twenty-four (24); thence North 00 degrees 28 minutes 58 seconds East, assigned bearing along the east line of said Section Twenty-four (24), a distance of 441.74 feet to the point of beginning of the center line to be described; thence South 89 degrees 55 minutes 11 seconds West, 354.94 feet; thence westerly along a tangential curve, concave to the north, central angle 18 degrees 19 minutes 36 seconds, radius 400.00 feet, arc length 127.94 feet; thence North 71 degrees 45 minutes 13 seconds West, 257.54 feet; thence westerly along a tangential curve, concave to the south, central angle 19 degrees 07 minutes 38 seconds, radius 1000.00 feet, arc length 333.83 feet to a point of reverse curvature; thence northwesterly along a reverse curve, central angle 59 degrees 28 minutes 21 seconds, radius 133.82 feet, arc length 138.90 feet; thence North 31 degrees 24 minutes 30 seconds West, 267.76 feet; thence northerly along a tangential curve, concave to the east, central angle 15 degrees 52

minutes 07 seconds, radius 210.14 feet, arc length 58.20 feet; thence North 15 degrees 32 minutes 23 seconds West, 505.01 feet; thence northerly along a tangential curve, concave to the east, central angle 29 degrees 33 minutes 20 seconds, radius 267.05 feet, arc length 137.76 feet; thence North 14 degrees 00 minutes 57 seconds East 184.10 feet; thence northerly along a tangential curve, concave to the west, central angle 89 degrees 13 minutes 38 seconds, radius 160.12 feet, arc length 249.35 feet; thence North 75 degrees 12 minutes 41 seconds West, 521.81 feet; thence westerly along a tangential curve, concave to the south, central angle 38 degrees 44 minutes 36 seconds, radius 238.94 feet, arc length 161.57 feet; thence South 66 degrees 02 minutes 43 seconds West, 92.70 feet to Point "A" and there terminate said center line; the side lines of the above described easement are to terminate at the easterly circumference of the following described circle:

An easement for road purposes lying within the circumference of a circle having a radius of 50.00 feet; the center of said circle is the point which bears South 75 degrees 15 minutes 52 seconds West a distance of 50.00 feet from said Point "A".

Said easement is hereby granted for benefit of access to all of the lots in the plat of BEAUTY-VILLE.

Descriptions for additional Real Estate which is connected to the plat of "BEAUTY-VILLE".
H:\Departments\LandDepartment\REALESTATE\beautylake\Additional Real Estate 5aa.docx

Description for 5a

That part of Government Lot 2 of Section Twenty-four (24), Township Fifty-five (55) North, Range Twenty-two (22) West, Itasca County, Minnesota, described as follows:

> Beginning at the most northerly corner of Lots 4 and 5, Block 2, BEAUTY-VILLE, according to the plat on file and of record in the Itasca County Recorder's Office (Document No. 403341); thence North 23 degrees 32 minutes 36 seconds East 96.70 feet; thence North 33 degrees 58 minutes 30 seconds East 201.36 feet; thence South 50 degrees 07 minutes 33 seconds West 225.71 feet to the most northerly corner of said Lot 5; thence South 55 degrees 06 minutes 21 seconds East 43.41 feet along the northerly line of said Lot 5; thence southerly along a non-tangential curve, concave to the east, central angle 121 degrees 17 minutes 33 seconds, radius 50.00 feet, arc length 105.85 feet, chord bearing South 08 degrees 56 minutes 06 seconds West, to the point of beginning. Tract contains 0.15 acres more or less.

The State of Minnesota reserves a perpetual easement being a 66 foot strip of land for road purposes for ingress and egress over and across the existing road for access to Lots 1, 2, 3,4, and 5, Block 2; Outlot A of said plat and Government Lot 2, of Section Twenty-four (24), Township Fifty-five (55) North, Range Twenty-two (22) West, Itasca County, Minnesota.

AND

An easement for road purposes across Government Lots 1 and 2 Section Twenty-four (24), Township Fifty-five (55) North, Range Twenty-two (22) West of the Fourth Principal Meridian; said easement being 66.00 feet in width and lying 33.00 feet on both sides of the following described center line:

> Commencing at the southeast corner of said Section Twenty-four (24); thence North 00 degrees 28 minutes 58 seconds East, assigned bearing along the east line of said Section Twenty-four (24), a distance of 441.74 feet to the point of beginning of the center line to be described; thence South 89 degrees 55 minutes 11 seconds West, 354.94 feet; thence westerly along a tangential curve, concave to the north, central angle 18 degrees 19 minutes 36 seconds, radius 400.00 feet, arc length 127.94 feet; thence North 71 degrees 45 minutes 13 seconds West, 257.54 feet; thence westerly along a tangential curve, concave to the south, central angle 19 degrees 07 minutes 38 seconds, radius 1000.00 feet, arc length 333.83 feet to a point of reverse curvature; thence northwesterly along a reverse curve, central angle 59 degrees 28 minutes 21 seconds, radius 133.82 feet, arc length 138.90 feet; thence North 31 degrees 24 minutes 30 seconds West, 267.76 feet; thence northerly along a tangential curve, concave to the east, central angle 15 degrees 52 minutes 07 seconds, radius 210.14 feet, arc length 58.20 feet; thence North 15 degrees 32

minutes 23 seconds West, 505.01 feet; thence northerly along a tangential curve, concave to the east, central angle 29 degrees 33 minutes 20 seconds, radius 267.05 feet, arc length 137.76 feet; thence North 14 degrees 00 minutes 57 seconds East 184.10 feet; thence northerly along a tangential curve, concave to the west, central angle 89 degrees 13 minutes 38 seconds, radius 160.12 feet, arc length 249.35 feet; thence North 75 degrees 12 minutes 41 seconds West, 521.81 feet; thence westerly along a tangential curve, concave to the south, central angle 38 degrees 44 minutes 36 seconds, radius 238.94 feet, arc length 161.57 feet; thence South 66 degrees 02 minutes 43 seconds West, 92.70 feet to Point "A" and there terminate said center line; the side lines of the above described easement are to terminate at the easterly circumference of the following described circle:

An easement for road purposes lying within the circumference of a circle having a radius of 50.00 feet; the center of said circle is the point which bears South 75 degrees 15 minutes 52 seconds West a distance of 50.00 feet from said Point "A".

Said easement is hereby granted for benefit of access to all of the lots in the plat of BEAUTY-VILLE.

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1531

DEPARTMENT: Land Department
PRESENTER: Cindy Shevich

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:
Sale of Tax-Forfeited Land to the City of Keewatin

BOARD ACTION REQUESTED:
Adopt the Resolution Re: Sale of Tax-forfeited Land to the City of Keewatin, which approves sale of Lots 1 & 2, Block 4 SPINA ADDITION TO KEEWATIN under the terms provided in Minnesota Statute 282.01, Subd. 1a para. (d) for a price of $100.00 plus all associated costs.

BACKGROUND:
The City of Keewatin has requested purchase of tax-forfeited land legally described as Lot 1 and Lot 2, Block 4, SPINA ADDITION TO KEEWATIN for the amount of $100.00. Minnesota Statute 282.01, Subd. 1a (d) allows sale of non-conservation tax-forfeited land to an incorporated governmental subdivision for less than their market value if the county board determines that

(1) a reduced price is necessary to provide an incentive to correct the blighted conditions that make the land undesirable in the open market, and

(2) the governmental subdivision has documented its specific plans for correcting the blighted conditions.

The Itasca County Board of Commissioners has classified the above described property as non-conservation land, and has determined the land to be undesirable in the open market due to blighted conditions. The City of Keewatin has documented plans to correct the blighted conditions at the expense of the City of Keewatin.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:
1. City Resolution
2. location map 92-460-0410

04/20/2021

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/27/2021 2:30 PM

ITASCA COUNTY
BOARD OF COMMISSIONERS

Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

RESOLUTION

RE: SALE OF TAX-FORFEITED LAND TO THE CITY OF KEEWATIN

WHEREAS, the City of Keewatin has requested purchase of tax-forfeited land legally described as Lot 1 and Lot 2, Block 4, SPINA ADDITION TO KEEWATIN for the amount of $100.00 and,

WHEREAS, Minnesota Statute 282.01, Subd. 1a (d) allows sale of non-conservation tax-forfeited land to an incorporated governmental subdivision for less than their market value if the county board determines that

(1) a reduced price is necessary to provide an incentive to correct the blighted conditions that make the land undesirable in the open market, and

(2) the governmental subdivision has documented its specific plans for correcting the blighted conditions, and

WHEREAS, the Itasca County Board of Commissioners has classified the above described property as non-conservation land, and has determined the land to be undesirable in the open market due to blighted conditions, and

WHEREAS, the City of Keewatin has documented plans to correct the blighted conditions at the expense of the City of Keewatin, now therefore

NOW THEREFORE BE IT RESOLVED, that the Itasca County Board of Commissioners approves sale of the above described land under the terms provided in Minnesota Statute 282.01, Subd. 1a para. (d) for a price of $100.00 plus all associated costs.

CITY OF KEEWATIN
RESOLUTION 2021 - 04

STATE OF MINNESOTA
COUNTY OF ITASCA
CITY OF KEEWATIN

A RESOLUTION REQEUSTING CONVEYANCE OF TAX-FORFEITED TRUST PARCEL FOR AN AUTHORIZED PUBLIC USE

WHEREAS, there is a LOT LOCATED AT 303 W. Elizabeth Ave. and legally described as: Lots 1 & 2 Block 4 of the SPINA ADDITION TO KEEWATIN, Itasca County, Minnesota; and

WHEREAS, Minnesota Statute 282.01 Subd. 1a€ allows for, upon written request of a governmental subdivision of the state, the County Board's approval of the conveyance of a tax forfeited trust land to the public entity for an authorized public use of the tax forfeited trust land; and

WHEREAS, the property has forfeited to the State of Minnesota, in trust for the taxing districts, and is manage by Itasca County. The property is a hazard to public safety. The City has gone to Court to declare the trailer home uninhabitable.

WHEREAS, the building is deemed to be uninhabitable and it is apparent to the City of Keewatin that the structure located at 303 W. Elizabeth Ave. constitutes a hazardous building as defined in Minnesota Statute 465.15 Subd. 3; and

THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF KEEWATIN respectfully requests that Itasca County withhold the property form sale. The City of Keewatin also requests, that the Itasca County Board consider approving conveyance of said tax-forfeited trust parcel to the City of Keewatin for $100.00, as provided for under Minnesota Statute 282.01 Subd. 1a(e) and Minnesota Statute 465.035, due to blighted conditions. The City of Keewatin would then be willing to coordinate the removal of the structures and pay for the same.

Upon vote taken, the following voted: for :
Against;

Whereupon, said Resolution Number 21-04 was declared duly passed and adopted this 14th day of APRIL, 2021.

Mayor (William King)

ATTEST:

City Clerk (Tawnya Maras)

92-460-0410 Lots 1-2, Blk 4 Keewatin

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1520

DEPARTMENT: Land Department
TIME REQUESTED: < 5 Minutes
PRESENTER: Roger Clark, Kory Cease

AGENDA ITEM:
2021 Grand Rapids Speedway Agreement

BOARD ACTION REQUESTED:
Approve the 2021 Fairgrounds Race Track Agreement between Itasca County and Grand Rapids Speedway Inc. and authorize necessary signatures.

BACKGROUND:
The lease agreement layout and language was developed with the County Attorney's Office in 2018 (Re: CRT - 4171), as well as COVID-19 considerations in 2020. Proceeds will be sent to the Itasca County Agricultural Association to be placed in the Fairgrounds Park Maintenance Fund. The Security Deposit will be held by Itasca County. An updated COVID-19 Preparedness Plan will be required for 2021.

COUNTY ATTORNEY REVIEW: Yes

SUPPORTING DOCUMENTATION:
1. 2021_Grand Rapids Speedway_Lease Agreement

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

County of Itasca, Minnesota
Lease Agreement

This Agreement is made effective this **1st day of May 2021**, by and between **Itasca County** ("Lessor"); and **Grand Rapids Speedway, Inc.**, ("Lessee"). For good and valuable consideration, the receipt and sufficiency of which the parties hereby acknowledge the parties agree as follows:

1. **Authority.** This Agreement is granted pursuant to the provisions of Minnesota Statutes Section 373.01, Subdivision(1)(a)(4) and Minnesota Statutes Section 398.32, Subdivision 3.

2. **Premises**. Lessor in consideration of the terms, conditions and contracts contained herein, and subject to such special conditions as are set forth in the Special Conditions attached hereto and made a part hereof and marked as **Exhibit A**, **Exhibit B** attached hereto and made a part hereof, and the payment of the Lease Agreement Fee to be paid by Lessee, Lessor hereby leases to the Lessee, subject at all times to sale, contract and use for other purposes, the non-exclusive rights in the described Premises as set forth below:

☐ A - Cattle barn

☐ B - Horse barn

☐ C - Beef Barn

☐ D – Poultry

☐ F - United Methodist Church

☐ H - New Moose Club

☐ I - Corn Palace

☐ J - Solid Rock

☐ K - Bingo Hall

☐ L – Eagles

☐ M - All Purpose

☐ N - Announcement Booth

☐ O - Children's barn

☐ P – Restroom

☐ Q - 4H Food Booth

☐ T - Conservation Building

☐ V - Agriculture/Horticulture Building

☐ W - 4H Exhibit

☐ X - Commercial Exhibit

☐ Y - Committee on Aging

☐ Z - Arts and Craft

☐ AA – Gazebo

☐ CC - Old Beer Garden

☐ DD - DNR Building

☒ EE - Grand Stand

☐ FF – Storage

☐ GG – Shelter

☐ HH - Trailhead Building

☐ Grounds

☒ Parking Lot

☒ Race Track

☐ Horse Arena

2.1 Personal Property/Fixtures: Personal Property or fixtures within the Premises shall not be deemed leased under this Agreement, unless otherwise authorized in writing.

3. Warranties. Lessor does not warrant its title to the premises nor undertake to defend the Lessee in the peaceable possession or use thereof. No covenant of quiet enjoyment is made. Lessee shall indemnify and hold Lessor harmless from any and all claims for damages against Lessor by third parties as a result of this Agreement.

4. Exhibits. This Lease Agreement is subject to such special conditions as are set forth in the Special Conditions Supplement attached hereto and made a part hereof and marked as **Exhibit A**. This Lease Agreement is subject to such terms as are set forth in **Exhibit B** as to insurance and indemnification.

5. Term. The term of this Agreement shall commence on the date set forth above and shall end at 12:00 a.m. on **October 1st, 2021**. The term of this Agreement is subject to termination pursuant to the default provisions in paragraph 10 herein. The Agreement may be extended or modified if provided for in the **Special Conditions** marked as **Exhibit A.**

6. Lease Agreement-Fee. Lessee shall pay to Lessor a non-refundable Lease Agreement Fee of **$600.00 per Race Event** for the non-exclusive rights to the Premises as set forth above or as set forth in the Special Conditions marked as **Exhibit A**.

7. Security Deposit. Simultaneously with the execution of this Lease, Lessee shall deposit with Lessor the sum of **Twelve Hundred Dollars ($ 1,200.00)** as a security deposit. Such security deposit shall be considered as security for the payment and performance by Lessee of all of Lessee's obligations, covenants, conditions and agreements under this Lease. Upon the expiration of the term hereof, Lessor shall, provided that Lessee is not in default under the terms hereof, return and pay back such security deposit to Lessee as set forth below. In the event of any default by Lessee hereunder, Lessor shall have the right, but shall not be obligated, to apply all or any portion of the security deposit to cure such default, in which event Lessee shall be obligated to promptly deposit with Lessor the amount necessary to restore the security deposit to its original amount.

7.1 The Security Deposit may be applied to offset any damages that may occur during the event from the Lessee or the Lessee's invitees. Review of all Premises will be conducted prior to and following the term of this Agreement. Deposits will be returnable up to two weeks after the termination of this Agreement and only if no damage has occurred. In the event of damages exceeding the amount as set forth above the Lessee will be liable for the balance of the damages.

7.2 The Security Deposit may be applied to offset any cleanup that has not been completed during or after the event. Review of all Premises will be conducted prior to and following the Term of this Agreement. Deposits will be returnable up to two weeks after the termination of this Agreement and only if no cleanup is needed. In the event of the cost of cleanup exceeds the amount as set forth above the Lessee will be liable for the balance of the cost.

8. Encumbrance. This Agreement is subject to all existing easements, rights-of-way, licenses, contracts, commingling contracts and other encumbrances upon the Premises and Lessor shall not be liable to Lessee for any damages resulting from any action taken by a holder of an interest pursuant to the rights of that holder thereunder.

9. Maintenance. Lessee shall maintain the Premises in good repair, keeping them safe and clean, removing all refuses and debris that may accumulate, to the extent consistent with sound and customary practices. Lessee shall comply with all laws affecting the Premises, including Federal, state or local statute, law, rule, regulation or ordinance, unless otherwise exempt.

10. Termination. The Lessor has the right to cancel this Agreement for nonpayment of any amount due under this Agreement or other violation of the terms and conditions of this Agreement. Termination of this Agreement does not relieve the Lessee from any liability for payment or other liability incurred under this Agreement.

10.1 This Agreement may be cancelled by the Lessor, if the Lessee has failed to secure all permits/licenses and approvals if any are necessary for the Lessee's approved activity as stated on the Special Conditions marked as Exhibit A.

10.2 Lessee shall, on the termination date, or earlier as provided for in this Agreement, peaceably and quietly surrender the Premises to the Lessor in a condition satisfactory to the Lessor. If the Lessee fails to surrender the Premises on the termination of this Agreement, the Lessor may obtain a court order as permitted by law to eject or remove the Lessee from the Premises and Lessee shall indemnify the Lessor for all expenses incurred by the Lessor.

10.3 In addition, Lessee shall remove all of Lessee's personal property at Lessee's expense, from the Premises prior to or at the termination date and time per this Agreement. Any personal property remaining shall be considered abandoned and shall be disposed of by the Lessor according to law. If this Agreement is terminated prior to its termination date, the Lessee shall not be relieved of any obligation incurred prior to termination.

10.4 Lessee acquires no additional rights by holding the Premises after termination and shall be subject to legal action for removal.

10.5 If Lessee defaults in compliance with its obligations under this Agreement, Lessor shall have the right in its exclusive discretion to permit Lessee to cure, and Lessor shall have the right upon Lessee's failure to cure such default within 10 days after receipt of written notice specifying such default, to seek such remedies or combination of remedies as may be available at law or in equity, including without limitation specific performance, damages, or termination of this Agreement. Lessor's remedies shall expressly include the right to evict Lessee and take possession of the Premises.

10.6 Lessee may terminate this Agreement for good cause, which will be at the discretion of the Lessor. In the event that this Agreement is terminated for good cause at the discretion of the Lessor, any paid lease-fees shall not be refundable, and the security deposit shall be handled in accordance with numbers 7, 7.1, and 7.2 above.

11. Right of Entry. Lessor, or its agents, contractors, or employees shall have the right to enter upon and into said Premises at any time to inspect the same. Such inspection shall not unreasonably hinder or interrupt the operations of the Lessee, except in cases where emergency entry is necessary to preserve the Premises and other property.

12. Liability. This Agreement shall not be construed as imposing any liability on the Lessor for injury or damage to the person or property of the Lessee, or to any other persons or property, arising out of any use of the Premises, or under any other easement, right-of-way, license, lease or other encumbrance now in effect.

12.1 Indemnification. Lessee agrees to defend, indemnify and hold harmless Lessor, its elected officials, officers, agents, volunteers and employees from any liability, claims, causes of action, judgments, damages, losses, costs or expenses, including reasonable attorney fees resulting directly or indirectly from any act or omission of Lessee, anyone directly or indirectly employed by them and/or anyone for whose acts and/or omissions they may be liable in the performance of the services required by this Agreement and against all loss by reason of failure of said Lessee to perform fully, in any respect, all obligations under this Agreement. See **Exhibit B**.

12.2 Insurance. Lessee agrees at all times during the term of this Agreement to have and keep in force insurance, either under a self-insurance program or separate insurance policy, as indicated and shown in attached **Exhibit B** and/or the Special Conditions marked as **Exhibit A**.

12.3 The Lessor reserves the right to terminate, suspend or rescind any Agreement not in compliance with these requirements and retains all rights thereafter to pursue any legal remedies against Lessee. All insurance policies shall be open to inspection by the Lessor, and copies of policies shall be submitted to the Lessor upon written request.

13. Banned Substances. Lessee agrees that no tobacco products, drugs, or illegal substances of any kind shall be sold or distributed on the premises under any circumstances. Alcohol may be served or sold if Lessee is properly licensed/permitted by the appropriate licensing/permitting authority and as authorized in the Special Conditions marked as **Exhibit A**. Lessee understands that any violation of this paragraph shall give the Lessor the rights to terminate this Agreement without penalty to the Lessor, and permanently bar Lessee, or any member or guest of lessee, from the Premises.

14. Lost Property. The Lessor assumes no responsibility whatsoever, for any property placed on the Premises, and the Lessor is hereby expressly released and discharged from any and all liabilities for any loss of property and discharged from any and all liabilities for any loss of property that may be sustained by the use of said Premises under this Agreement.

15. Right to Control. It is understood that the Lessor hereby reserves the right to control and manage the Premises and to enforce all necessary and proper rules for the management and operation of the Premises and for the Lessor employees or other authorized representatives to enter and exercise their authority at the Premises at any time. The Lessor also reserves the right, but not the duty, through its employees and representatives, to eject any objectionable person or persons from the Premises and Lessee hereby waives any and all claims for damages against the Lessor or any of its representatives resulting from the exercise of this authority.

16. Recovery of Expenses. If it is necessary for the Lessor to incur expenses by court action or otherwise for the ejectment of Lessee or Lessee's invitees, or the removal from the leased premises of the Lessee's or Lessee's invitee's personal property, or recovery of the amount due under this Agreement , or for any other remedy of the Lessor under this lease, and the Lessor prevails in the court action or otherwise, then the Lessee shall pay to the Lessor all expenses, including attorney's fees, thus incurred by the Lessor.

17. Severability. If any clause or provision of this Agreement is or becomes illegal, invalid or unenforceable because of present or future laws or any rule or regulation or ordinance, unless exempt, the intentions of the Lessor and Lessee here is that the remaining parts of this Agreement shall not be affected thereby.

18. Governing Law. The laws of the State of Minnesota shall govern all questions and interpretations concerning the validity and construction of this Agreement and the legal relations between the parties herein and performance under it. The appropriate venue and jurisdiction for any litigation hereunder will be those courts located within the County of Itasca, State of Minnesota. Litigation, however, in the federal courts involving the parties herein will be in the appropriate federal court within the State of Minnesota. Any claim, controversy or dispute arising out of this Agreement may upon mutual agreement of the parties be referred to non-binding or binding arbitration in accordance with the commercial rules of the American Arbitration Association. If any provisions of this Agreement are held invalid, illegal or unenforceable, the remaining provisions will not be affected.

19. Modifications/Amendment. Any alterations, variations, modifications, amendments or waivers of the provisions of this Agreement shall only be valid when they have been reduced to writing and signed by authorized representative of the Lessor and Lessee.

20. Notification. Any notice of termination given under this Agreement shall be in writing and served upon the other party either personally or by depositing such notice in the United States mail with proper address and sent by certified mail, return receipt requested. Service shall be effective on the earlier of receipt or five days after the depositing of the notice in the United States mail. The proper mailing addresses for Lessor and Lessee for the purposes of serving notice are as follows:

Lessor

Itasca County
c/o Land Commissioner
Itasca County Land Department
1177 LaPrairie Avenue
Grand Rapids, Minnesota 55744

County Auditor/ Treasurer
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, Minnesota 55744

Lessee

Grand Rapids Speedway, Inc.
P.O. Box 424
Grand Rapids, MN 55744
Bob Broking – President
218 259-4697

21. Compliance with Laws. Lessee shall abide by all Federal, State and local laws, statutes, ordinances, rules and regulations, unless exempt, now in effect or hereinafter adopted pertaining to this Agreement or to the facilities, programs and staff for which Lessee is responsible.

22. Records Audition and Retention. Lessee's books, records, documents, papers, accounting procedures and practices, and other evidences relevant to this Agreement are subject to the examination, duplication, transcription and audit by the County and either the legislative or State Auditor, pursuant to Minn. Stat. § 16C.05, subd. 5. Such evidences are also subject to review by the Comptroller General of the United States, or a duly authorized representative, if federal funds are used for any work under this Agreement. Lessee agrees to maintain such evidences for a period of six (6) years from the date services or payment were last provided or made or longer if any audit in progress required a longer retention period.

23. Waiver. Any waiver by either party of any provision of this Contract shall not imply a subsequent waiver of that or any other provision.

24. Assignment. Lessee shall not encumber or assign this Agreement or sublet the Premises or any part thereof without prior written consent of Lessor. No action of Lessor in collecting payment from any sublessee, assignee, or occupant shall constitute a waiver hereof.

25. Final Agreement. This Agreement is the final expression of the agreement of the parties and the complete and exclusive statement of the terms agreed upon, and shall supersede all prior negotiations, understandings or agreements. There are no representations, warranties, or stipulations, either oral or written, not herein contained.

25.1 If this Agreement conflicts with a Special Conditions, the Special Conditions shall control.

EXECUTION

IN WITNESS WHEREOF, the Lessor has caused this Agreement to be signed by its duly authorized officers and the Lessee has hereunto set its hand.

Dated this _____ day of _____, _____.

Lessee: **Grand Rapids Speedway, Inc.**
(Lessee's Name)

By: _____
Its _____

Lessor: **County of Itasca**

By: _____
Its_____
Chair of the Board of Commissioners

By:_____
Its_____
Clerk of the Board of Commissioners

APPROVED AS TO FORM & EXECUTION

By: _____
Itasca County Attorney

Exhibit A

Special Conditions Supplement to Lease Agreement

This document shall be considered the Special Conditions to the Lease Agreement between Itasca County, hereinafter referred to as "Lessor", and **Grand Rapids Speedway, Inc.**, hereinafter referred to as "Lessee", which was made effective on the **1st day of May 2021**.

Both Lessor and Lessee mutually agree to the following in addition to the terms contained in the Lease Agreement made effective on the **1st day of May 2021**.

COVID–19 Considerations:

In March of 2020, the World Health Organization characterized the COVID-19 outbreak as a pandemic and the Minnesota Department of Health announced the first confirmed fatality due to COVID-19 in Minnesota. On March 15, 2021, the Minnesota Governor issued an executive order 21-12 extending a peacetime emergency for this pandemic.

All recommended social distancing, best practices and requirements for opening and operating public events and gatherings from the Center for Disease Control (CDC), State of Minnesota Executive Orders, Minnesota Department of Health (MDH) and County Public Health must be followed during the course of this Agreement. Lessee must develop a 2021 COVID-19 Plan of Operation to address these public health and safety issues which must be provided to and approved by Lessor prior to starting any leased activities, events, or use of facilities.

Due to public health concerns associated with the COVD-19 pandemic and to ensure protection and general welfare of the public, Lessor reserves the right to postpone or cancel events, to prohibit specific uses/activities, or to close facilities on County property at any time during the course of this Agreement. Additionally, due to public health concerns associated with COVID-19, Lessor shall have the right in its exclusive discretion to terminate this Agreement prior to the end of the Term set forth in paragraph 5 of the Lease Agreement. When possible, notification to Lessee will be given at least 24 hours in advance but may be less in case of public health concerns or failure of Lessee to follow public health guidelines and/or COVID-19 Plan of Operation. If the Lessor postpones or cancels an event no Lease Agreement-Fee will be charged for the planned event. If the Lessor terminates this Agreement due to public health concerns associated with the COVID-19 pandemic, then the Lease Agreement-Fee for events not yet held will not be charged and the security deposit shall be handled in accordance with numbers 7, 7.1, and 7.2 of the Lease Agreement. These COVID-19 considerations will supersede when conflicting with other terms or conditions of this Agreement.

Description of allowed activities below (i.e. beer garden, vendors, food booths, activities requiring license/permit, detailed description of event, etc.):

Provide racing events for the summer of 2020. Provide 3 food booths and one beer shack – with proper permit.

Both parties of this contract mutually agree to the following in addition to the terms contained in

the Lease Agreement.

1. The Lessee is required to conduct the racing events once each week during the term of this agreement and shall only be excused from the requirements when the race is canceled due to inclement weather or other reasons beyond the control of the Lessee. The failure of Lessee to do the above shall constitute a default in the Agreement.
2. That an act of GOD may determine the fate of either party as it relates to the terms of this Agreement.
3. Both parties agree to put forth an effort to ensure that the beauty of the fairgrounds is maintained by establishing and limiting parking to established parking areas.
4. It is understood by both parties that the income and expenses for each party, as it relates to the stock car racing program, are subject to review by the other party for the sole purpose of reaching a fair and equitable rental fee.

Other Considerations

1. Lessee may conduct stock car racing once each week commencing May 1st, 2021 and terminating October 1st, 2021. Any request for an additional race in any week shall be subject to approval of Lessor.
2. Lessee is allowed to sell alcoholic beverages as long as Lessee provides a copy of a current Liquor license/permit and is in compliance with the conditions set forth in the Lease Agreement.
3. Lessee shall be responsible for the safe conduct of related stock car races and will provide necessary personnel and officials to operate said racing program. This shall include adequate security personnel for protection at all times during said racing program.
4. Lessee agrees to not knowingly allow gambling or consumption of alcoholic beverages on said premises during related stock car racing program unless proper licensing/permitting is obtained and with approval of Lessor.
5. Lessee shall obtain all necessary permits pertaining to related stock car racing and shall comply with all applicable Federal, State, and local laws, statutes, ordinance, rules and regulations, including obtaining necessary licenses/permits to operate concession stands.
6. Lessee shall have ambulance available and necessary medical facilities and personnel to insure proper safety and care for persons participating in the related racing program as well as track officials, grandstand personnel and spectators, and shall in addition thereto, supply proper firefighting equipment should a fire start as a result of the related stock car racing program.
7. Lessee shall provide the necessary equipment and shall be responsible for the proper preparation and maintenance of racetrack during described racing season.
8. Lessee shall align itself with the majority of the racing facilities in the surrounding areas by sanctioning with WISSOTA.
9. Lessee agrees to clean the pit area, grandstand, and parking area used by spectators after each weekly racing program, **preferably the night of or the following morning after racing has occurred.**

10. Lessee shall not have a stock car racing program during the weekend of the Northern Minnesota Swap Meet & Car Show unless this restriction is waived by the sponsors of the Northern Minnesota Swap Meet & Car Show.

11. Lessee shall have exclusive rights to the advertising sign space available on the back of the grandstand, the center of the racetrack, on the pit wall at the end of the track and the fence adjacent to the parking lot. Sign holders have been guaranteed a year of advertising and have exclusive rights to their advertising spaces at the Itasca County Fairgrounds for a fee paid to West Range Racing Incorporated (WRRI), to include the events at Itasca County Fairgrounds, regardless of who is sponsoring the event. No further funding will be required of them for their advertising billboards to be displayed. This excludes potential signs.

12. Due to high cost of maintenance WRRI, requests that they be consulted in regard to any usage of the Grand Rapids Speedway before any events are scheduled or allowed to run on the track surface during the course of the year.

And in consideration of all other terms and conditions herein set forth, the Lessor agrees to the following:

1. Lessor agrees to pay the cost of electrical and water needs for the racing events.

2. Lessor grants Lessee exclusive rights to all concession and concession related products during all related stock car racing programs, with the following exception: Other concession stands will be allowed to be open outside of the grandstand during the fair.

Mobile Food booths will be limited to ____3____ mobile food booths

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1527

DEPARTMENT: Probation
TIME REQUESTED: < 5 Minutes
PRESENTER: Jason Anderson

AGENDA ITEM:
Joint Powers Agreement Between Itasca County and the Minnesota State Bureau of Criminal Apprehension (BCA)

BOARD ACTION REQUESTED:
Adopt the Resolution Re: Approving State of Minnesota Joint Powers Agreements with the County of Itasca on Behalf of its Probation Department and authorize Itasca County Board Chair Burl Ives, Itasca County Administrator Brett Skyles, and Itasca County Probation Director Jason Anderson to sign the State of Minnesota Joint Powers Agreement and Court Data Services Subscriber Amendment to CJDN Subscriber Agreement between the Itasca County and the State of Minnesota.

BACKGROUND:
This joint powers agreement is a five-year agreement which is up for renewal. It provides the Itasca County Probation Department with access to the CJDN systems and tools needed to effectuate the investigation and prosecution of crimes. The agreement was last renewed in 2016, and moving forward, will now require a monthly fee of $50 for each agency, which will be paid out of the budget of the Itasca County Probation Department.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:
1. Itasca Co Probation Master JPA
2. Itasca Co Probation Court Amendment

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

ITASCA COUNTY
BOARD OF COMMISSIONERS

Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

RESOLUTION

RE: APPROVING STATE OF MINNESOTA JOINT POWERS AGREEMENT WITH THE COUNTY OF ITASCA ON BEHALF OF ITS PROBATION DEPARTMENT

WHEREAS, the County of Itasca on behalf of its Probation Department desires to enter into Joint Powers Agreements with the State of Minnesota, Department of Public Safety, Bureau of Criminal Apprehension to use systems and tools available over the State's criminal justice data communications network for which the County is eligible. The Joint Powers Agreements further provide the County with the ability to add, modify and delete connectivity, systems and tools over the five year life of the agreement and obligates the County to pay the costs for the network connection.

NOW, THEREFORE, BE IT RESOLVED by the County Board of Itasca County, Minnesota as follows:

1. That the State of Minnesota Joint Powers Agreements by and between the State of Minnesota acting through its Department of Public Safety, Bureau of Criminal Apprehension and the County of Itasca on behalf of its Probation Department are hereby approved.

2. That the Probation Director, Jason Anderson, or his or her successor, is designated the Authorized Representative for the Probation Department. The Authorized Representative is also authorized to sign any subsequent amendment or agreement that may be required by the State of Minnesota to maintain the County's connection to the systems and tools offered by the State.

3.That Burl Ives, the Chair of the County of Itasca Board of Commissioners, and Brett Skyles, the Itasca County Administrator, are authorized to sign the State of Minnesota Joint Powers Agreements.

State of Minnesota
Joint Powers Agreement

This Agreement is between the State of Minnesota, acting through its Department of Public Safety on behalf of the Bureau of Criminal Apprehension ("BCA"), and the County of Itasca on behalf of its Probation Office ("Governmental Unit"). The BCA and the Governmental Unit may be referred to jointly as "Parties."

Recitals

Under Minn. Stat. § 471.59, the BCA and the Governmental Unit are empowered to engage in agreements that are necessary to exercise their powers. Under Minn. Stat. § 299C.46, the BCA must provide a criminal justice data communications network to benefit political subdivisions as defined under Minn. Stat. § 299C.46, subd. 2 and subd. 2(a). The Governmental Unit is authorized by law to utilize the criminal justice data communications network pursuant to the terms set out in this Agreement. In addition, BCA either maintains repositories of data or has access to repositories of data that benefit authorized political subdivisions in performing their duties. The Governmental Unit wants to access data in support of its official duties.

The purpose of this Agreement is to create a method by which the Governmental Unit has access to those systems and tools for which it has eligibility, and to memorialize the requirements to obtain access and the limitations on the access.

Agreement

1 Term of Agreement

1.1 Effective Date. This Agreement is effective on the date the BCA obtains all required signatures under Minn. Stat. § 16C.05, subdivision 2.

1.2 Expiration Date. This Agreement expires five years from the date it is effective.

2 Agreement Between the Parties

2.1 General Access. BCA agrees to provide Governmental Unit with access to the Minnesota Criminal Justice Data Communications Network (CJDN) and those systems and tools which the Governmental Unit is authorized by law to access via the CJDN for the purposes outlined in Minn. Stat. § 299C.46.

2.2 Methods of Access.

The BCA offers three (3) methods of access to its systems and tools. The methods of access are:

A. **Direct access** occurs when individual users at the Governmental Unit use the Governmental Unit's equipment to access the BCA's systems and tools. This is generally accomplished by an individual user entering a query into one of BCA's systems or tools.

B. **Indirect Access** occurs when individual users at the Governmental Unit go to another Governmental Unit to obtain data and information from BCA's systems and tools. This method of access generally results in the Governmental Unit with indirect access obtaining the needed data and information in a physical format like a paper report.

C. **Computer-to-Computer System Interface** occurs when the Governmental Unit's computer exchanges data and information with BCA's computer systems and tools using an interface. Without limitation, interface types include: state message switch, web services, enterprise service bus and message queuing.

For purposes of this Agreement, Governmental Unit employees or contractors may use any of these methods to use BCA's systems and tools as described in this Agreement. Governmental Unit will select a

method of access and can change the methodology following the process in Clause 2.10.

2.3 Federal Systems Access. In addition, pursuant to 28 CFR §20.30-38 and Minn. Stat. §299C.58, BCA may provide Governmental Unit with access to the Federal Bureau of Investigation (FBI) National Crime Information Center.

2.4 Governmental Unit Policies. Both the BCA and the FBI's Criminal Justice Information Systems (FBI-CJIS) have policies, regulations and laws on access, use, audit, dissemination, hit confirmation, logging, quality assurance, screening (pre-employment), security, timeliness, training, use of the system**,** and validation. Governmental Unit has created its own policies to ensure that Governmental Unit's employees and contractors comply with all applicable requirements. Governmental Unit ensures this compliance through appropriate enforcement. These BCA and FBI-CJIS policies and regulations, as amended and updated from time to time, are incorporated into this Agreement by reference. The policies are available at https://bcanextest.x.state.mn.us/launchpad/.

2.5 Governmental Unit Resources. To assist Governmental Unit in complying with the federal and state requirements on access to and use of the various systems and tools, information is available at https://sps.x.state.mn.us/sites/bcaservicecatalog/default.aspx. Additional information on appropriate use is found in the Minnesota Bureau of Criminal Apprehension Policy on Appropriate Use of Systems and Data available at https://bcanextest.x.state.mn.us/launchpad/cjisdocs/docs.cgi?cmd=FS&ID=795&TYPE=DOCS.

2.6 Access Granted.

A. Governmental Unit is granted permission to use all current and future BCA systems and tools for which Governmental Unit is eligible. Eligibility is dependent on Governmental Unit (i) satisfying all applicable federal or state statutory requirements; (ii) complying with the terms of this Agreement; and (iii) acceptance by BCA of Governmental Unit's written request for use of a specific system or tool.

B. To facilitate changes in systems and tools, Governmental Unit grants its Authorized Representative authority to make written requests for those systems and tools provided by BCA that the Governmental Unit needs to meet its criminal justice obligations and for which Governmental Unit is eligible.

2.7 Future Access. On written request from the Governmental Unit, BCA also may provide Governmental Unit with access to those systems or tools which may become available after the signing of this Agreement, to the extent that the access is authorized by applicable state and federal law. Governmental Unit agrees to be bound by the terms and conditions contained in this Agreement that when utilizing new systems or tools provided under this Agreement.

2.8 Limitations on Access. BCA agrees that it will comply with applicable state and federal laws when making information accessible. Governmental Unit agrees that it will comply with applicable state and federal laws when accessing, entering, using, disseminating, and storing data. Each party is responsible for its own compliance with the most current applicable state and federal laws.

2.9 Supersedes Prior Agreements. This Agreement supersedes any and all prior agreements between the BCA and the Governmental Unit regarding access to and use of systems and tools provided by BCA.

2.10 Requirement to Update Information. The parties agree that if there is a change to any of the information whether required by law or this Agreement, the party will send the new information to the other party in writing within 30 days of the change. This clause does not apply to changes in systems or tools provided under this Agreement.

This requirement to give notice additionally applies to changes in the individual or organization serving the Governmental Unit as its prosecutor. Any change in performance of the prosecutorial function must be provided to the BCA in writing by giving notice to the Service Desk, BCA.ServiceDesk@state.mn.us.

2.11 Transaction Record. The BCA creates and maintains a transaction record for each exchange of data utilizing its systems and tools. In order to meet FBI-CJIS requirements and to perform the audits described in Clause 7, there must be a method of identifying which individual users at the Governmental Unit conducted a

particular transaction.

If Governmental Unit uses either direct access as described in Clause 2.2A or indirect access as described in Clause 2.2B, BCA's transaction record meets FBI-CJIS requirements.

When Governmental Unit's method of access is a computer-to-computer interface as described in Clause 2.2C, the Governmental Unit must keep a transaction record sufficient to satisfy FBI-CJIS requirements and permit the audits described in Clause 7 to occur.

If a Governmental Unit accesses data from the Driver and Vehicle Services Division in the Minnesota Department of Public Safety and keeps a copy of the data, Governmental Unit must have a transaction record of all subsequent access to the data that are kept by the Governmental Unit. The transaction record must include the individual user who requested access, and the date, time and content of the request. The transaction record must also include the date, time and content of the response along with the destination to which the data were sent. The transaction record must be maintained for a minimum of six (6) years from the date the transaction occurred and must be made available to the BCA within one (1) business day of the BCA's request.

2.12 Court Information Access. Certain BCA systems and tools that include access to and/or submission of Court Records may only be utilized by the Governmental Unit if the Governmental Unit completes the Court Data Services Subscriber Amendment, which upon execution will be incorporated into this Agreement by reference. These BCA systems and tools are identified in the written request made by the Governmental Unit under Clause 2.6 above. The Court Data Services Subscriber Amendment provides important additional terms, including but not limited to privacy (see Clause 8.2, below), fees (see Clause 3 below), and transaction records or logs, that govern Governmental Unit's access to and/or submission of the Court Records delivered through the BCA systems and tools.

2.13 Vendor Personnel Screening. The BCA will conduct all vendor personnel screening on behalf of Governmental Unit as is required by the FBI CJIS Security Policy. The BCA will maintain records of the federal, fingerprint-based background check on each vendor employee as well as records of the completion of the security awareness training that may be relied on by the Governmental Unit.

3 Payment

The Governmental Unit currently accesses the criminal justice data communications network described in Minn. Stat. §299C.46. The bills are sent quarterly for the amount of One Hundred Fifty Dollars ($150.00) or a total annual cost of Six Hundred Dollars ($600.00).

The Governmental Unit will identify its contact person for billing purposes, and will provide updated information to BCA's Authorized Representative within ten business days when this information changes.

If Governmental Unit chooses to execute the Court Data Services Subscriber Amendment referred to in Clause 2.12 in order to access and/or submit Court Records via BCA's systems, additional fees, if any, are addressed in that amendment.

4 Authorized Representatives

The BCA's Authorized Representative is the person below, or her successor:

Name: Dana Gotz, Deputy Superintendent
Address: Minnesota Department of Public Safety; Bureau of Criminal Apprehension
1430 Maryland Avenue
Saint Paul, MN 55106

Telephone: 651.793.2007
Email Address: Dana.Gotz@state.mn.us

The Governmental Unit's Authorized Representative is the person below, or his/her successor:

Name: Director Jason Anderson
Address: 115 NE 5th St
Grand Rapids, MN 55744
Telephone: 218.327.2869
Email Address: jason.anderson@co.itasca.mn.us

5 Assignment, Amendments, Waiver, and Agreement Complete

5.1 Assignment. Neither party may assign nor transfer any rights or obligations under this Agreement.

5.2 Amendments. Any amendment to this Agreement, except those described in Clauses 2.6 and 2.7 above must be in writing and will not be effective until it has been signed and approved by the same parties who signed and approved the original agreement, their successors in office, or another individual duly authorized.

5.3 Waiver. If either party fails to enforce any provision of this Agreement, that failure does not waive the provision or the right to enforce it.

5.4 Agreement Complete. This Agreement contains all negotiations and agreements between the BCA and the Governmental Unit. No other understanding regarding this Agreement, whether written or oral, may be used to bind either party.

6 Liability

Each party will be responsible for its own acts and behavior and the results thereof and shall not be responsible or liable for the other party's actions and consequences of those actions. The Minnesota Torts Claims Act, Minn. Stat. § 3.736 and other applicable laws govern the BCA's liability. The Minnesota Municipal Tort Claims Act, Minn. Stat. Ch. 466 and other applicable laws, governs the Governmental Unit's liability.

7 Audits

7.1 Under Minn. Stat. § 16C.05, subd. 5, the Governmental Unit's books, records, documents, internal policies and accounting procedures and practices relevant to this Agreement are subject to examination by the BCA, the State Auditor or Legislative Auditor, as appropriate, for a minimum of six years from the end of this Agreement.

Under Minn. Stat. § 6.551, the State Auditor may examine the books, records, documents, and accounting procedures and practices of BCA. The examination shall be limited to the books, records, documents, and accounting procedures and practices that are relevant to this Agreement.

7.2 Under applicable state and federal law, the Governmental Unit's records are subject to examination by the BCA to ensure compliance with laws, regulations and policies about access, use, and dissemination of data.

7.3 If the Governmental Unit accesses federal databases, the Governmental Unit's records are subject to examination by the FBI and BCA; the Governmental Unit will cooperate with FBI and BCA auditors and make any requested data available for review and audit.

7.4 If the Governmental Unit accesses state databases, the Governmental Unit's records are subject to examination by the BCA: the Governmental Unit will cooperate with the BCA auditors and make any requested data available for review and audit.

7.5 To facilitate the audits required by state and federal law, Governmental Unit is required to have an inventory of the equipment used to access the data covered by this Agreement and the physical location of each.

8 Government Data Practices

8.1 BCA and Governmental Unit. The Governmental Unit and BCA must comply with the Minnesota Government Data Practices Act, Minn. Stat. Ch. 13, as it applies to all data accessible under this Agreement, and as it applies to all data created, collected, received, stored, used, maintained, or disseminated by the Governmental Unit under this Agreement. The remedies of Minn. Stat. §§ 13.08 and 13.09 apply to the release of the data referred to in this clause by either the Governmental Unit or the BCA.

8.2 Court Records. If Governmental Unit chooses to execute the Court Data Services Subscriber Amendment referred to in Clause 2.12 in order to access and/or submit Court Records via BCA's systems, the following provisions regarding data practices also apply. The Court is not subject to Minn. Stat. Ch. 13 but is subject to the *Rules of Public Access to Records of the Judicial Branch* promulgated by the Minnesota Supreme Court. All parties acknowledge and agree that Minn. Stat. § 13.03, subdivision 4(e) requires that the BCA and the Governmental Unit comply with the *Rules of Public Access* for those data received from Court under the Court Data Services Subscriber Amendment. All parties also acknowledge and agree that the use of, access to or submission of Court Records, as that term is defined in the Court Data Services Subscriber Amendment, may be restricted by rules promulgated by the Minnesota Supreme Court, applicable state statute or federal law. All parties acknowledge and agree that these applicable restrictions must be followed in the appropriate circumstances.

9 Investigation of Alleged Violations; Sanctions

For purposes of this clause, "Individual User" means an employee or contractor of Governmental Unit.

9.1 Investigation. The Governmental Unit and BCA agree to cooperate in the investigation and possible prosecution of suspected violations of federal and state law referenced in this Agreement. Governmental Unit and BCA agree to cooperate in the investigation of suspected violations of the policies and procedures referenced in this Agreement. When BCA becomes aware that a violation may have occurred, BCA will inform Governmental Unit of the suspected violation, subject to any restrictions in applicable law. When Governmental Unit becomes aware that a violation has occurred, Governmental Unit will inform BCA subject to any restrictions in applicable law.

9.2 Sanctions Involving Only BCA Systems and Tools.

The following provisions apply to BCA systems and tools not covered by the Court Data Services Subscriber Amendment. None of these provisions alter the Governmental Unit internal discipline processes, including those governed by a collective bargaining agreement.

9.2.1 For BCA systems and tools that are not covered by the Court Data Services Subscriber Amendment, Governmental Unit must determine if and when an involved Individual User's access to systems or tools is to be temporarily or permanently eliminated. The decision to suspend or terminate access may be made as soon as alleged violation is discovered, after notice of an alleged violation is received, or after an investigation has occurred. Governmental Unit must report the status of the Individual User's access to BCA without delay. BCA reserves the right to make a different determination concerning an Individual User's access to systems or tools than that made by Governmental Unit and BCA's determination controls.

9.2.2 If BCA determines that Governmental Unit has jeopardized the integrity of the systems or tools covered in this Clause 9.2, BCA may temporarily stop providing some or all the systems or tools under this Agreement until the failure is remedied to the BCA's satisfaction. If Governmental Unit's failure is continuing or repeated, Clause 11.1 does not apply and BCA may terminate this Agreement immediately.

9.3 Sanctions Involving Only Court Data Services

The following provisions apply to those systems and tools covered by the Court Data Services Subscriber Amendment, if it has been signed by Governmental Unit. As part of the agreement between the Court and

the BCA for the delivery of the systems and tools that are covered by the Court Data Services Subscriber Amendment, BCA is required to suspend or terminate access to or use of the systems and tools either on its own initiative or when directed by the Court. The decision to suspend or terminate access may be made as soon as an alleged violation is discovered, after notice of an alleged violation is received, or after an investigation has occurred. The decision to suspend or terminate may also be made based on a request from the Authorized Representative of Governmental Unit. The agreement further provides that only the Court has the authority to reinstate access and use.

9.3.1 Governmental Unit understands that if it has signed the Court Data Services Subscriber Amendment and if Governmental Unit's Individual Users violate the provisions of that Amendment, access and use will be suspended by BCA or Court. Governmental Unit also understands that reinstatement is only at the direction of the Court.

9.3.2 Governmental Unit further agrees that if Governmental Unit believes that one or more of its Individual Users have violated the terms of the Amendment, it will notify BCA and Court so that an investigation as described in Clause 9.1 may occur.

10 Venue

Venue for all legal proceedings involving this Agreement, or its breach, must be in the appropriate state or federal court with competent jurisdiction in Ramsey County, Minnesota.

11 Termination

11.1 Termination. The BCA or the Governmental Unit may terminate this Agreement at any time, with or without cause, upon 30 days' written notice to the other party's Authorized Representative.

11.2 Termination for Insufficient Funding. Either party may immediately terminate this Agreement if it does not obtain funding from the Minnesota Legislature, or other funding source; or if funding cannot be continued at a level sufficient to allow for the payment of the services covered here. Termination must be by written notice to the other party's authorized representative. The Governmental Unit is not obligated to pay for any services that are provided after notice and effective date of termination. However, the BCA will be entitled to payment, determined on a pro rata basis, for services satisfactorily performed to the extent that funds are available. Neither party will be assessed any penalty if the agreement is terminated because of the decision of the Minnesota Legislature, or other funding source, not to appropriate funds. Notice of the lack of funding must be provided within a reasonable time of the affected party receiving that notice.

12 Continuing Obligations

The following clauses survive the expiration or cancellation of this Agreement: Liability; Audits; Government Data Practices; 9. Investigation of Alleged Violations; Sanctions; and Venue.

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The Parties indicate their agreement and authority to execute this Agreement by signing below.

1. GOVERNMENTAL UNIT

Name: _____
(PRINTED)

Signed: _____

Title: _____
(with delegated authority)

Date: _____

Name: _____
(PRINTED)

Signed: _____

Title: _____
(with delegated authority)

Date: _____

2. DEPARTMENT OF PUBLIC SAFETY, BUREAU OF CRIMINAL APPREHENSION

Name: _____
(PRINTED)

Signed: _____

Title: _____
(with delegated authority)

Date: _____

3. COMMISSIONER OF ADMINISTRATION
As delegated to the Office of State Procurement

By: _____

Date: _____

COURT DATA SERVICES SUBSCRIBER AMENDMENT TO CJDN SUBSCRIBER AGREEMENT

This Court Data Services Subscriber Amendment ("Subscriber Amendment") is entered into by the State of Minnesota, acting through its Department of Public Safety, Bureau of Criminal Apprehension, ("BCA") and the County of Itasca on behalf of its Probation Officer ("Agency"), and by and for the benefit of the State of Minnesota acting through its State Court Administrator's Office ("Court") who shall be entitled to enforce any provisions hereof through any legal action against any party.

Recitals

This Subscriber Amendment modifies and supplements the Agreement between the BCA and Agency, SWIFT Contract number 190450, of even or prior date, for Agency use of BCA systems and tools (referred to herein as "the CJDN Subscriber Agreement"). Certain BCA systems and tools that include access to and/or submission of Court Records may only be utilized by the Agency if the Agency completes this Subscriber Amendment. The Agency desires to use one or more BCA systems and tools to access and/or submit Court Records to assist the Agency in the efficient performance of its duties as required or authorized by law or court rule. Court desires to permit such access and/or submission. This Subscriber Amendment is intended to add Court as a party to the CJDN Subscriber Agreement and to create obligations by the Agency to the Court that can be enforced by the Court. It is also understood that, pursuant to the Master Joint Powers Agreement for Delivery of Court Data Services to CJDN Subscribers ("Master Authorization Agreement") between the Court and the BCA, the BCA is authorized to sign this Subscriber Amendment on behalf of Court. Upon execution the Subscriber Amendment will be incorporated into the CJDN Subscriber Agreement by reference. The BCA, the Agency and the Court desire to amend the CJDN Subscriber Agreement as stated below.

The CJDN Subscriber Agreement is amended by the addition of the following provisions:

1. **TERM; TERMINATION; ONGOING OBLIGATIONS.** This Subscriber Amendment shall be effective on the date finally executed by all parties and shall remain in effect until expiration or termination of the CJDN Subscriber Agreement unless terminated earlier as provided in this Subscriber Amendment. Any party may terminate this Subscriber Amendment with or without cause by giving written notice to all other parties. The effective date of the termination shall be thirty days after the other party's receipt of the notice of termination, unless a later date is specified in the notice. The provisions of sections 5 through 9, 12.b., 12.c., and 15 through 24 shall survive any termination of this Subscriber Amendment as shall any other provisions which by their nature are intended or expected to survive such termination. Upon termination, the Subscriber shall perform the responsibilities set forth in paragraph 7(f) hereof.

2. **Definitions**. Unless otherwise specifically defined, each term used herein shall have the meaning assigned to such term in the CJDN Subscriber Agreement.

a. **"Authorized Court Data Services"** means Court Data Services that have been authorized for delivery to CJDN Subscribers via BCA systems and tools pursuant to an Authorization Amendment to the Joint Powers Agreement for Delivery of Court Data Services to CJDN Subscribers ("Master Authorization Agreement") between the Court and the BCA.

b. **"Court Data Services"** means one or more of the services set forth on the Justice Agency Resource webpage of the Minnesota Judicial Branch website (for which the current address is www.courts.state.mn.us) or other location designated by the Court, as the same may be amended from time to time by the Court.

c. "**Court Records**" means all information in any form made available by the Court to Subscriber through the BCA for the purposes of carrying out this Subscriber Amendment, including:

i. "**Court Case Information**" means any information in the Court Records that conveys information about a particular case or controversy, including without limitation Court Confidential Case Information, as defined herein.

ii. "**Court Confidential Case Information**" means any information in the Court Records that is inaccessible to the public pursuant to the Rules of Public Access and that conveys information about a particular case or controversy.

iii. "**Court Confidential Security and Activation Information"** means any information in the Court Records that is inaccessible to the public pursuant to the Rules of Public Access and that explains how to use or gain access to Court Data Services, including but not limited to login account names, passwords, TCP/IP addresses, Court Data Services user manuals, Court Data Services Programs, Court Data Services Databases, and other technical information.

iv. "**Court Confidential Information**" means any information in the Court Records that is inaccessible to the public pursuant to the Rules of Public Access, including without limitation both i) Court Confidential Case Information; and ii) Court Confidential Security and Activation Information.

d. "**DCA**" shall mean the district courts of the state of Minnesota and their respective staff.

e. "**Policies & Notices**" means the policies and notices published by the Court in connection with each of its Court Data Services, on a website or other location designated by the Court, as the same may be amended from time to time by the Court. Policies & Notices for each Authorized Court Data Service identified in an approved request form under section 3, below, are hereby made part of this Subscriber Amendment by this reference and provide additional terms and conditions that govern Subscriber's use of Court Records accessed through such services, including but not limited to provisions on access and use limitations.

f. "**Rules of Public Access**" means the Rules of Public Access to Records of the Judicial Branch promulgated by the Minnesota Supreme Court, as the same may be amended from time to time, including without limitation lists or tables published from time to time by the Court entitled *Limits on Public Access to Case Records or Limits on Public Access to Administrative Records*, all of which by this reference are made a part of this Subscriber Amendment. It is the obligation of Subscriber to check from time to time for updated rules, lists, and tables and be familiar with the contents thereof. It is contemplated that such rules, lists, and tables will be posted on the Minnesota Judicial Branch website, for which the current address is www.courts.state.mn.us.

g. "**Court**" shall mean the State of Minnesota, State Court Administrator's Office.

h. **"Subscriber"** shall mean the Agency.

i. "**Subscriber Records**" means any information in any form made available by the Subscriber to the Court for the purposes of carrying out this Subscriber Amendment.

3. REQUESTS FOR AUTHORIZED COURT DATA SERVICES. Following execution of this Subscriber Amendment by all parties, Subscriber may submit to the BCA one or more separate requests for Authorized Court Data Services. The BCA is authorized in the Master Authorization Agreement to process, credential and approve such requests on behalf of Court and all such requests approved by the BCA are adopted and incorporated herein by this reference the same as if set forth verbatim herein.

a. **Activation**. Activation of the requested Authorized Court Data Service(s) shall occur promptly following approval.

b. **Rejection**. Requests may be rejected for any reason, at the discretion of the BCA and/or the Court.

c. **Requests for Termination of One or More Authorized Court Data Services**. The Subscriber may request the termination of an Authorized Court Data Services previously requested by submitting a notice to Court with a copy to the BCA. Promptly upon receipt of a request for termination of an Authorized Court Data Service, the BCA will deactivate the service requested. The termination of one or more Authorized Court Data Services does not terminate this Subscriber Amendment. Provisions for termination of this Subscriber Amendment are set forth in section 1. Upon termination of Authorized Court Data Services, the Subscriber shall perform the responsibilities set forth in paragraph 7(f) hereof.

4. SCOPE OF ACCESS TO COURT RECORDS LIMITED. Subscriber's access to and/or submission of the Court Records shall be limited to Authorized Court Data Services identified in an approved request form under section 3, above, and other Court Records necessary for Subscriber to use Authorized Court Data Services. Authorized Court Data Services shall only be used according to the instructions provided in corresponding Policies & Notices or other materials and only as necessary to assist Subscriber in the efficient performance of Subscriber's duties

required or authorized by law or court rule in connection with any civil, criminal, administrative, or arbitral proceeding in any Federal, State, or local court or agency or before any self-regulatory body. Subscriber's access to the Court Records for personal or non-official use is prohibited. Subscriber will not use or attempt to use Authorized Court Data Services in any manner not set forth in this Subscriber Amendment, Policies & Notices, or other Authorized Court Data Services documentation, and upon any such unauthorized use or attempted use the Court may immediately terminate this Subscriber Amendment without prior notice to Subscriber.

5. GUARANTEES OF CONFIDENTIALITY. Subscriber agrees:

a. To not disclose Court Confidential Information to any third party except where necessary to carry out the Subscriber's duties as required or authorized by law or court rule in connection with any civil, criminal, administrative, or arbitral proceeding in any Federal, State, or local court or agency or before any self-regulatory body.

b. To take all appropriate action, whether by instruction, agreement, or otherwise, to insure the protection, confidentiality and security of Court Confidential Information and to satisfy Subscriber's obligations under this Subscriber Amendment.

c. To limit the use of and access to Court Confidential Information to Subscriber's bona fide personnel whose use or access is necessary to effect the purposes of this Subscriber Amendment, and to advise each individual who is permitted use of and/or access to any Court Confidential Information of the restrictions upon disclosure and use contained in this Subscriber Amendment, requiring each individual who is permitted use of and/or access to Court Confidential Information to acknowledge in writing that the individual has read and understands such restrictions. Subscriber shall keep such acknowledgements on file for one year following termination of the Subscriber Amendment and/or CJDN Subscriber Agreement, whichever is longer, and shall provide the Court with access to, and copies of, such acknowledgements upon request. For purposes of this Subscriber Amendment, Subscriber's bona fide personnel shall mean individuals who are employees of Subscriber or provide services to Subscriber either on a voluntary basis or as independent contractors with Subscriber.

d. That, without limiting section 1 of this Subscriber Amendment, the obligations of Subscriber and its bona fide personnel with respect to the confidentiality and security of Court Confidential Information shall survive the termination of this Subscriber Amendment and the CJDN Subscriber Agreement and the termination of their relationship with Subscriber.

e. That, notwithstanding any federal or state law applicable to the nondisclosure obligations of Subscriber and Subscriber's bona fide personnel under this Subscriber Amendment, such obligations of Subscriber and Subscriber's bona fide personnel are founded independently on the provisions of this Subscriber Amendment.

6. APPLICABILITY TO PREVIOUSLY DISCLOSED COURT RECORDS. Subscriber acknowledges and agrees that all Authorized Court Data Services and related Court Records disclosed to Subscriber prior to the effective date of this Subscriber Amendment shall be subject to the provisions of this Subscriber Amendment.

7. LICENSE AND PROTECTION OF PROPRIETARY RIGHTS. During the term of this Subscriber Amendment, subject to the terms and conditions hereof, the Court hereby grants to Subscriber a nonexclusive, nontransferable, limited license to use Court Data Services Programs and Court Data Services Databases to access or receive the Authorized Court Data Services identified in an approved request form under section 3, above, and related Court Records. Court reserves the right to make modifications to the Authorized Court Data Services, Court Data Services Programs, and Court Data Services Databases, and related materials without notice to Subscriber. These modifications shall be treated in all respects as their previous counterparts.

a. Court Data Services Programs. Court is the copyright owner and licensor of the Court Data Services Programs. The combination of ideas, procedures, processes, systems, logic, coherence and methods of operation embodied within the Court Data Services Programs, and all information contained in documentation pertaining to the Court Data Services Programs, including but not limited to manuals, user documentation, and passwords, are trade secret information of Court and its licensors.

b. Court Data Services Databases. Court is the copyright owner and licensor of the Court Data Services Databases and of all copyrightable aspects and components thereof. All specifications and information pertaining to the Court Data Services Databases and their structure, sequence and organization, including without limitation data schemas such as the Court XML Schema, are trade secret information of Court and its licensors.

c. Marks. Subscriber shall neither have nor claim any right, title, or interest in or use of any trademark used in connection with Authorized Court Data Services, including but not limited to the marks “MNCIS” and “Odyssey.”

d. Restrictions on Duplication, Disclosure, and Use. Trade secret information of Court and its licensors will be treated by Subscriber in the same manner as Court Confidential Information. In addition, Subscriber will not copy any part of the Court Data Services Programs or Court Data Services Databases, or reverse engineer or otherwise attempt to discern the source code of the Court Data Services Programs or Court Data Services Databases, or use any trademark of Court or its licensors, in any way or for any purpose not specifically and expressly authorized by this Subscriber Amendment. As used herein, "trade secret information of Court and its licensors" means any information possessed by Court which derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use. "Trade secret information of Court and its licensors" does not, however, include information which was known to Subscriber prior to Subscriber’s receipt thereof, either directly or indirectly, from Court or its licensors, information which is independently developed by Subscriber without reference to or use of information received from Court or its licensors, or information which would not qualify as a trade secret under Minnesota law. It will not be a violation of this section 7, sub-section d, for Subscriber to make up to one copy of training materials and configuration documentation, if any, for each individual authorized to access, use, or configure Authorized Court Data Services, solely for its own use in connection with this Subscriber Amendment. Subscriber will take all steps reasonably necessary to protect the copyright, trade secret, and trademark rights of Court and its licensors and Subscriber will advise its bona fide personnel who are permitted access to any of the Court Data Services Programs and Court Data Services Databases, and trade secret information of Court and its licensors, of the restrictions upon duplication, disclosure and use contained in this Subscriber Amendment.

e. Proprietary Notices. Subscriber will not remove any copyright or proprietary notices included in and/or on the Court Data Services Programs or Court Data Services Databases, related documentation, or trade secret information of Court and its licensors, or any part thereof, made available by Court directly or through the BCA, if any, and Subscriber will include in and/or on any copy of the Court Data Services Programs or Court Data Services Databases, or trade secret information of Court and its licensors and any documents pertaining thereto, the same copyright and other proprietary notices as appear on the copies made available to Subscriber by Court directly or through the BCA, except that copyright notices shall be updated and other proprietary notices added as may be appropriate.

f. Title; Return. The Court Data Services Programs and Court Data Services Databases, and related documentation, including but not limited to training and configuration material, if any, and logon account information and passwords, if any, made available by the Court to Subscriber directly or through the BCA and all copies, including partial copies, thereof are and remain the property of the respective licensor. Except as expressly provided in section 12.b., within ten days of the effective date of termination of this Subscriber Amendment or the CJDN Subscriber Agreement or within ten days of a request for termination of Authorized Court Data Service as described in section 4, Subscriber shall either: (i) uninstall and return any and all copies of the applicable Court Data Services Programs and Court Data Services Databases, and related documentation, including but not limited to training and configuration materials, if any, and logon account information, if any; or (2) destroy the same and certify in writing to the Court that the same have been destroyed.

8. INJUNCTIVE RELIEF. Subscriber acknowledges that the Court, Court's licensors, and DCA will be irreparably harmed if Subscriber's obligations under this Subscriber Amendment are not specifically enforced and that the Court, Court's licensors, and DCA would not have an adequate remedy at law in the event of an actual or threatened violation by Subscriber of its obligations. Therefore, Subscriber agrees that the Court, Court's licensors, and DCA shall be entitled to an injunction or any appropriate decree of specific performance for any actual or threatened violations or breaches by Subscriber or its bona fide personnel without the necessity of the Court, Court's licensors, or DCA showing actual damages or that monetary damages would not afford an adequate remedy. Unless Subscriber is an office, officer, agency, department, division, or bureau of the state of Minnesota, Subscriber shall be liable to the Court, Court's licensors, and DCA for reasonable attorneys fees incurred by the Court, Court's licensors, and DCA in obtaining any relief pursuant to this Subscriber Amendment.

9. LIABILITY. Subscriber and the Court agree that, except as otherwise expressly provided herein, each party will be responsible for its own acts and the results thereof to the extent authorized by law and shall not be responsible for the acts of any others and the results thereof. Liability shall be governed by applicable law. Without limiting the foregoing, liability of the Court and any Subscriber that is an office, officer, agency, department, division, or bureau of the state of Minnesota shall be governed by the provisions of the Minnesota Tort Claims Act, Minnesota Statutes, section 3.376, and other applicable law. Without limiting the foregoing, if Subscriber is a political subdivision of the state of Minnesota, liability of the Subscriber shall be governed by the provisions of Minn. Stat. Ch. 466 (Tort Liability, Political Subdivisions) or other applicable law. Subscriber and Court further acknowledge that the liability, if any, of the BCA is governed by a separate agreement between the Court and the BCA dated December 13, 2010 with DPS-M -0958.

10. AVAILABILITY. Specific terms of availability shall be established by the Court and communicated to Subscriber by the Court and/or the BCA. The Court reserves the right to terminate this Subscriber Amendment immediately and/or temporarily suspend Subscriber's Authorized Court Data Services in the event the capacity of any host computer system or legislative appropriation of funds is determined solely by the Court to be insufficient to meet the computer needs of the courts served by the host computer system.

11. [reserved]

12. ADDITIONAL USER OBLIGATIONS. The obligations of the Subscriber set forth in this section are in addition to the other obligations of the Subscriber set forth elsewhere in this Subscriber Amendment.

a. Judicial Policy Statement. Subscriber agrees to comply with all policies identified in Policies & Notices applicable to Court Records accessed by Subscriber using Authorized Court Data Services. Upon failure of the Subscriber to comply with such policies, the Court shall have the option of immediately suspending the Subscriber's Authorized Court Data Services on a temporary basis and/or immediately terminating this Subscriber Amendment.

b. Access and Use; Log. Subscriber shall be responsible for all access to and use of Authorized Court Data Services and Court Records by Subscriber's bona fide personnel or by means of Subscriber's equipment or passwords, whether or not Subscriber has knowledge of or authorizes such access and use. Subscriber shall also maintain a log identifying all persons to whom Subscriber has disclosed its Court Confidential Security and Activation Information, such as user ID(s) and password(s), including the date of such disclosure. Subscriber shall maintain such logs for a minimum period of six years from the date of disclosure, and shall provide the Court with access to, and copies of, such logs upon request. The Court may conduct audits of Subscriber's logs and use of Authorized Court Data Services and Court Records from time to time. Upon Subscriber's failure to maintain such logs, to maintain accurate logs, or to promptly provide access by the Court to such logs, the Court may terminate this Subscriber Amendment without prior notice to Subscriber.

c. Personnel. Subscriber agrees to investigate, at the request of the Court and/or the BCA, allegations of misconduct pertaining to Subscriber's bona fide personnel having access to or use of Authorized Court Data Services, Court Confidential Information, or trade secret information of the Court and its licensors where such persons are alleged to have violated the provisions of this Subscriber Amendment, Policies & Notices, Judicial Branch policies, or other security requirements or laws regulating access to the Court Records.

d. Minnesota Data Practices Act Applicability. If Subscriber is a Minnesota Government entity that is subject to the Minnesota Government Data Practices Act, Minn. Stat. Ch. 13, Subscriber acknowledges and agrees that: (1) the Court is not subject to Minn. Stat. Ch. 13 (see section 13.90) but is subject to the Rules of Public Access and other rules promulgated by the Minnesota Supreme Court; (2) Minn. Stat. section 13.03, subdivision 4(e) requires that Subscriber comply with the Rules of Public Access and other rules promulgated by the Minnesota Supreme Court for access to Court Records provided via the

BCA systems and tools under this Subscriber Amendment; (3) the use of and access to Court Records may be restricted by rules promulgated by the Minnesota Supreme Court, applicable state statute or federal law; and (4) these applicable restrictions must be followed in the appropriate circumstances.

13. FEES; INVOICES. Unless the Subscriber is an office, officer, department, division, agency, or bureau of the state of Minnesota, Subscriber shall pay the fees, if any, set forth in applicable Policies & Notices, together with applicable sales, use or other taxes. Applicable monthly fees commence ten (10) days after notice of approval of the request pursuant to section 3 of this Subscriber Amendment or upon the initial Subscriber transaction as defined in the Policies & Notices, whichever occurs earlier. When fees apply, the Court shall invoice Subscriber on a monthly basis for charges incurred in the preceding month and applicable taxes, if any, and payment of all amounts shall be due upon receipt of invoice. If all amounts are not paid within 30 days of the date of the invoice, the Court may immediately cancel this Subscriber Amendment without notice to Subscriber and pursue all available legal remedies. Subscriber certifies that funds have been appropriated for the payment of charges under this Subscriber Amendment for the current fiscal year, if applicable.

14. MODIFICATION OF FEES. Court may modify the fees by amending the Policies & Notices as provided herein, and the modified fees shall be effective on the date specified in the Policies & Notices, which shall not be less than thirty days from the publication of the Policies & Notices. Subscriber shall have the option of accepting such changes or terminating this Subscriber Amendment as provided in section 1 hereof.

15. WARRANTY DISCLAIMERS.

a. WARRANTY EXCLUSIONS. EXCEPT AS SPECIFICALLY AND EXPRESSLY PROVIDED HEREIN, COURT, COURT'S LICENSORS, AND DCA MAKE NO REPRESENTATIONS OR WARRANTIES OF ANY KIND, INCLUDING BUT NOT LIMITED TO THE WARRANTIES OF FITNESS FOR A PARTICULAR PURPOSE OR MERCHANTABILITY, NOR ARE ANY WARRANTIES TO BE IMPLIED, WITH RESPECT TO THE INFORMATION, SERVICES OR COMPUTER PROGRAMS MADE AVAILABLE UNDER THIS AGREEMENT.

b. ACCURACY AND COMPLETENESS OF INFORMATION. WITHOUT LIMITING THE GENERALITY OF THE PRECEDING PARAGRAPH, COURT, COURT'S LICENSORS, AND DCA MAKE NO WARRANTIES AS TO THE ACCURACY OR COMPLETENESS OF THE INFORMATION CONTAINED IN THE COURT RECORDS.

16. RELATIONSHIP OF THE PARTIES. Subscriber is an independent contractor and shall not be deemed for any purpose to be an employee, partner, agent or franchisee of the Court, Court's licensors, or DCA. Neither Subscriber nor the Court, Court's licensors, or DCA shall have the right nor the authority to assume, create or incur any liability or obligation of any kind, express or implied, against or in the name of or on behalf of the other.

17. NOTICE. Except as provided in section 2 regarding notices of or modifications to Authorized Court Data Services and Policies & Notices, any notice to Court or Subscriber

hereunder shall be deemed to have been received when personally delivered in writing or seventy-two (72) hours after it has been deposited in the United States mail, first class, proper postage prepaid, addressed to the party to whom it is intended at the address set forth on page one of this Agreement or at such other address of which notice has been given in accordance herewith.

18. NON-WAIVER. The failure by any party at any time to enforce any of the provisions of this Subscriber Amendment or any right or remedy available hereunder or at law or in equity, or to exercise any option herein provided, shall not constitute a waiver of such provision, remedy or option or in any way affect the validity of this Subscriber Amendment. The waiver of any default by either Party shall not be deemed a continuing waiver, but shall apply solely to the instance to which such waiver is directed.

19. FORCE MAJEURE. Neither Subscriber nor Court shall be responsible for failure or delay in the performance of their respective obligations hereunder caused by acts beyond their reasonable control.

20. SEVERABILITY. Every provision of this Subscriber Amendment shall be construed, to the extent possible, so as to be valid and enforceable. If any provision of this Subscriber Amendment so construed is held by a court of competent jurisdiction to be invalid, illegal or otherwise unenforceable, such provision shall be deemed severed from this Subscriber Amendment, and all other provisions shall remain in full force and effect.

21. ASSIGNMENT AND BINDING EFFECT. Except as otherwise expressly permitted herein, neither Subscriber nor Court may assign, delegate and/or otherwise transfer this Subscriber Amendment or any of its rights or obligations hereunder without the prior written consent of the other. This Subscriber Amendment shall be binding upon and inure to the benefit of the Parties hereto and their respective successors and assigns, including any other legal entity into, by or with which Subscriber may be merged, acquired or consolidated.

22. GOVERNING LAW. This Subscriber Amendment shall in all respects be governed by and interpreted, construed and enforced in accordance with the laws of the United States and of the State of Minnesota.

23. VENUE AND JURISDICTION. Any action arising out of or relating to this Subscriber Amendment, its performance, enforcement or breach will be venued in a state or federal court situated within the State of Minnesota. Subscriber hereby irrevocably consents and submits itself to the personal jurisdiction of said courts for that purpose.

24. INTEGRATION. This Subscriber Amendment contains all negotiations and agreements between the parties. No other understanding regarding this Subscriber Amendment, whether written or oral, may be used to bind either party, provided that all terms and conditions of the CJDN Subscriber Agreement and all previous amendments remain in full force and effect except as supplemented or modified by this Subscriber Amendment.

IN WITNESS WHEREOF, the Parties have, by their duly authorized officers, executed this Subscriber Amendment in duplicate, intending to be bound thereby.

1. SUBSCRIBER (AGENCY)

Subscriber must attach written verification of authority to sign on behalf of and bind the entity, such as an opinion of counsel or resolution.

Name: _____
(PRINTED)

Signed: _____

Title: _____
(with delegated authority)

Date: _____

Name: _____
(PRINTED)

Signed: _____

Title: _____
(with delegated authority)

Date: _____

2. DEPARTMENT OF PUBLIC SAFETY, BUREAU OF CRIMINAL APPREHENSION

Name: _____
(PRINTED)

Signed: _____

Title: _____
(with delegated authority)

Date: _____

3. COMMISSIONER OF ADMINISTRATION

delegated to Materials Management Division

By: _____

Date: _____

4. COURTS

Authority granted to Bureau of Criminal Apprehension

Name: _____
(PRINTED)

Signed: _____

Title: _____
(with authorized authority)

Date: _____

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1384

DEPARTMENT: Administrative Services
TIME REQUESTED: 10 Minutes
PRESENTER: Chair

AGENDA ITEM:
Citizen Input

BOARD ACTION REQUESTED:
Receive Citizen Input

BACKGROUND:
The Itasca County Board of Commissioners encourages citizen input. Each citizen will be allowed to address the County Board one time for up to three (3) minutes in length. Comments should be directed to the Board as a body. When addressing the Board, please state your name and address for the record. The Board will take all information under advisement. As part of County Board protocol, it is unacceptable for any speaker to slander or engage in character assassination at a County Board meeting. In addition, no political grandstanding, candidate endorsement, or other attempts to influence the outcome of an election shall be permitted. Any violation of the above statement shall result in the loss of your remaining time.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

RESULT:	**INFORMATIONAL - NO ACTION TAKEN**

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1521

DEPARTMENT: Administrative Services
TIME REQUESTED: 5 Minutes
PRESENTER: Terry Snyder

AGENDA ITEM:
Resolution to Oppose the Parole of James Shane Swanson

BOARD ACTION REQUESTED:
Adopt the Resolution Re: Opposition for the Parole of James Shane Swanson.

BACKGROUND:

COUNTY ATTORNEY REVIEW: Yes and/or Pending

SUPPORTING DOCUMENTATION:
1. Swanson parole letter county - Medure

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Terry Snyder
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

ITASCA COUNTY
BOARD OF COMMISSIONERS

Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

RESOLUTION 2021-25

RE: OPPOSITION FOR THE PAROLE OF JAMES SHANE SWANSON

WHEREAS, on June 15, 1991 at 2:45 a.m., Carin Streufert, a resident of Itasca County, left a downtown Grand Rapids restaurant never to be seen again; and

WHEREAS, after an intense investigation by the Itasca County Sheriff's Department and the Grand Rapids Police Department, James Shane Swanson and his co-defendant were arrested and admitted to the killing of Carin Streufert; and

WHEREAS, James Shane Swanson was convicted on December 14, 1991 of Count 1 - First Degree Murder-Premeditated (Life Sentence), Count 2 - First Degree Murder in the Commission of Another Crime (Life Sentence), Count 3 - First Degree Murder Aid and Abet (Life Sentence), Count 4 - First Degree Murder with First Degree Criminal Sexual Conduct (Life Sentence), and Count 5 - Kidnapping (91 Years); and

WHEREAS, the Itasca County Board of Commissioners feels that the release of James Shane Swanson would create an extreme safety risk.

NOW THEREFORE BE IT RESOLVED, on this date of April 20, 2021, that the Itasca County Board of Commissioners does hereby oppose the parole of James Shane Swanson and does recommend his continued incarceration.

RESULT:	**APPROVED (5 TO 0)**
MOVER:	Commissioner Terry Snyder
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

STATE OF MINNESOTA
Office of County Administrator
ss. County of Itasca

I, BRETT SKYLES, Administrator of the County of Itasca, do hereby certify that I have compared the foregoing with the original resolution filed in my office on the 20th day of April A.D. 2021 and that the same is a true and correct copy of the whole thereof.

WITNESS MY HAND AND SEAL OF OFFICE at Grand Rapids, Minnesota, this 20th day of April A.D. 2021.

Administrator

ADDITIONAL INFORMATION
APRIL 20, 2021
ITEM #6.2

April 20, 2021

Itasca County Board of Commissioners
123 NE 4th Street
Grand Rapids, MN 55744

REF: Parole of James Shane Swanson

Dear Commissioners:

I'm writing to you to express my support for the resolution on your board agenda requesting the Department of Corrections to deny parole for James Shane Swanson.

I was one of the lead investigators in this case. In my 34 years of law enforcement, I have never seen a person so cold and calculated in committing such a heinous crime.

Swanson was convicted of four counts of varying first degree murder and one count of kidnapping. He was sentenced to life in our state correctional facility. This crime had a very profound impact on our community and it still lingers today.

I support your resolution requesting DOC to deny parole for James Swanson.

Thank you for supporting this resolution.

Respectfully,

Pat Medure
Lead Investigator
Former Itasca County Sheriff

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1517

DEPARTMENT: Health & Human Services **TIME REQUESTED:** 10 Minutes
PRESENTER: Sarah Anderson

AGENDA ITEM:
Review and Approval of IMCare QI/UM documents

BOARD ACTION REQUESTED:
Review and approval of the IMCare 2021 Quality Program Description, 2021 UM Program Description, 2021 QI UM Program Evaluation and the 2021 QI/UM Workplan.

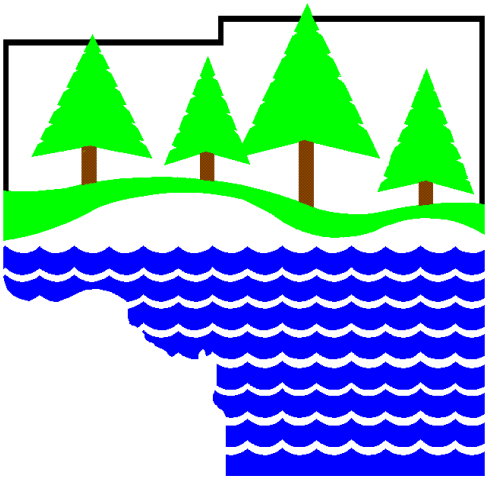
BACKGROUND:

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:
1. 2020 QI UM Program Evaluation
2. 2021 UM Program Description
3. 2021 Quality Program Description
4. 2021 QIUM Work Plan

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**



2020 ITASCA MEDICAL CARE PROGRAM EVALUATION

Approved by:

IMCare External QI/UM Committee: 03/17/2021
Itasca County Board of Commissioners: 4/27/2021

Mission Statement...

- The IMCare mission is to ensure access to high-quality, patient-centered, cost-effective health care for Itasca County residents through coordination and collaboration with local community partners and providers.

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Executive Summary

Itasca Medical Care (IMCare) is committed to identifying opportunities to improve the care and services enrollees receive from IMCare and its network of providers. To attain quality improvement, IMCare utilizes an incorporated Quality Improvement (QI) and Utilization Management (UM) Program and dynamic QI/UM Work Plan to direct QI/UM program activities that enhance enrollee health and well-being. The following is an evaluation and summary of 2020 QI/UM activities.

In 2020, IMCare made many strides towards quality improvement, with a strong focus on staff development, provider and enrollee education. IMCare provided enrollee education through the IMCare website and biannual newsletters. IMCare staff also provided enrollees with a wealth of information through activities of care. Education ranged from ongoing IMCare quality programs to navigating the IMCare network during the COVID-19 pandemic. IMCare made efforts to ensure enrollees had access to any needed COVID-19 services, as well as ongoing health maintenance care.

Providers were kept informed of ongoing quality programs, as well as the many COVID-19 service changes through the biannual provider newsletters, provider updates and COVID-19 Provider Manual Chapter located on the IMCare website.

In addition to quality improvements, IMCare developed measures to create a more uniform and robust UM program in 2020. Throughout 2020, IMCare provided periodic group education for UM staff at the internal UM Operations workgroup, as well as daily one-on-one instruction as needed from lead staff. Additionally, through the work of the IMCare Utilization Review Workgroup, IMCare modified or reduced authorization requirements during 2020, to improve enrollee access to appropriate care. IMCare continued ongoing improvement of grievance and appeal processes, and all staff and Itasca County Elderly Waiver Case Manager delegates completed training in early 2020. This initiative began in 2018, but efforts have been ongoing since then.

Program Overview

The IMCare program is administered by Itasca County Health and Human Services (ICHHS). IMCare enrollees are those who are eligible for benefits under Minnesota Health Care Programs. IMCare was established in 1982, with General Assistance Medical Care (GAMC). The Prepaid Medical Assistance Program (PMAP) was implemented on July 1, 1985, as a demonstration project, and expanded to include MinnesotaCare (MNCare) in 1996. In 2001, IMCare become a County Based Purchasing (CBP) organization. Minnesota Senior Care Plus (MSC+) was added in July of 2005, and a Medicare Advantage product, Minnesota Senior Health Options (MSHO), was added in January 2006. Accountability for the management and improvement of the quality of clinical care and services provided to enrollees rests on the ICHHS Board of Commissioners (BOC). The BOC consists of five county commissioners, and is responsible for ensuring the implementation of all aspects of the QI and UM programs. The BOC delegates day-to-day operational responsibilities for the program to the IMCare Director. The IMCare Director, Medical Director, Pharmacy Director, QI/UM Director/s and Compliance Officer report quality

program activities and outcomes to the Provider Advisory Subcommittee (PAC), the External QI/UM Committee, and the BOC quarterly. Annually, the BOC reviews and approves IMCare QI and UM program descriptions, the QI/UM Work Plan, and the QI/UM Program Evaluation.

The purpose of the QI and UM programs is to support the mission, vision and values of Itasca County and IMCare, through ongoing improvement, evaluation and monitoring of patient safety and delivery of services to our enrollees, including medical and behavioral health services. IMCare partners with providers, public and private community organizations, and delegated entities to support the QI and UM programs.

QI and UM goals and objectives are based upon information gathered through a variety of sources, such as survey results, utilization and claims data, Healthcare Effectiveness Data and Information Set (HEDIS) data, Minnesota Department of Health (MDH) Quality Assurance Examinations, and Minnesota Department of Human Services (DHS) Triennial Compliance Audits (TCA). The dynamic QI/UM Work Plan is developed to identify the goals and objectives that IMCare recognized during the evaluation of monitoring and tracking of QI/UM activities and progress throughout the year. The 2020 QI/UM Work Plan activities and outcome measurements collected throughout the year are outlined below.

2020 Quality Program Activities

Healthcare Effectiveness Data and Information Set (HEDIS)

IMCare collects HEDIS data, to comply with contract requirements for both DHS and the Centers for Medicare & Medicaid Services (CMS). The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of healthcare performance measures in the United States. HEDIS is a nationally-recognized and comprehensive set of clinical indicators used to assess and compare the performance of health plans, physician groups and employers. Claims data is used to generate administrative results (Admin) and for selected measurements, a chart audit methodology (Hybrid) is used. In measures with more than 411 eligible enrollees, a random sample of 411 is used to represent the measure. Sampling is not used for measures with fewer than 411 eligible enrollees. Rates are calculated using NCQA HEDIS specifications and results are verified by an external audit vendor and submitted to MDH, DHS and CMS.

2020 HEDIS – Medicaid

IMCare performed well in several 2020 HEDIS measures. Breast cancer screening, while below goal for both populations, showed a modest increase in the PMAP population, coming in just under goal (Figure 1). Cervical cancer screening met goal for both populations (Figure 2). Network facilities continue to offer preventive health reminders on the home page of the patient's access to their electronic health record, with the ability to schedule an appointment from the reminder.

Figure 1. 2018-2020 HEDIS Breast Cancer Screening - PMAP/MNCare

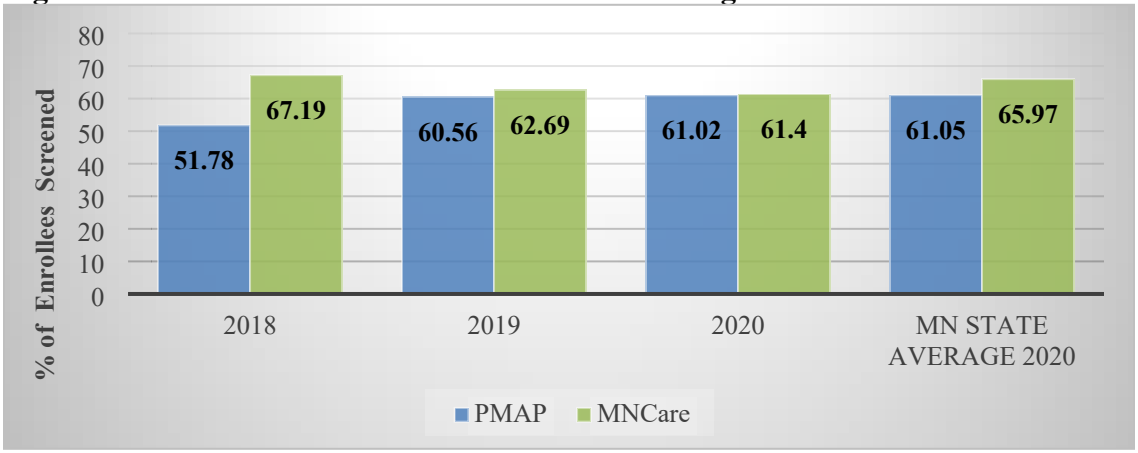
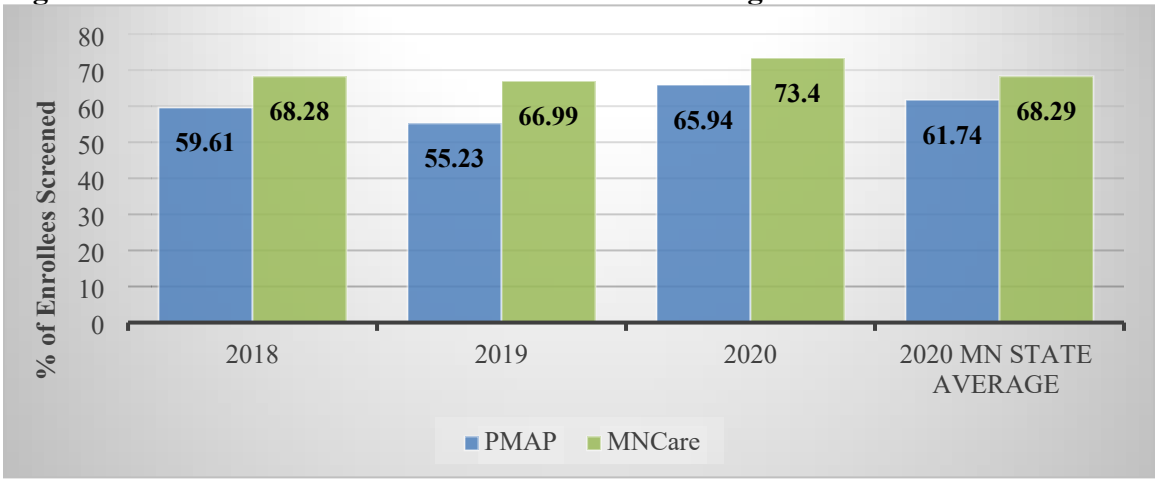


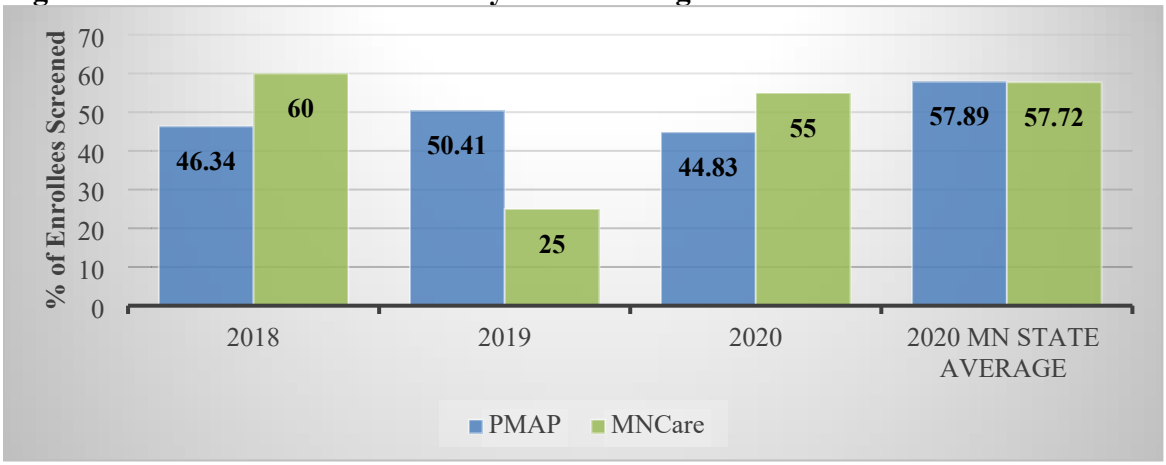
Figure 2. 2018-2020 HEDIS Cervical Cancer Screening - PMAP/MNCare



Chlamydia Screening

Chlamydia screening remained below goal for both populations in 2020, but the MNCare population showed a significant increase from 2019 data (Figure 3).

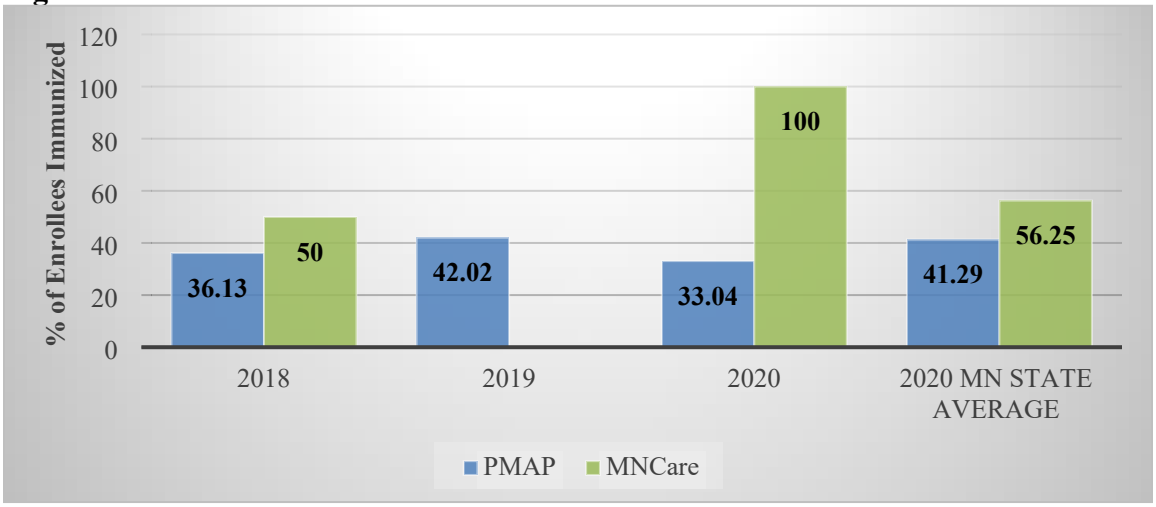
Figure 3. 2018-2020 HEDIS Chlamydia Screening - PMAP/MNCare



Childhood Immunizations (CIS)

The PMAP childhood immunization combo 10 rate did not meet goal in 2020, showing a slight decline from 2019 (Figure 4). This measure was met in the MNCare population, but with an extremely small representation of the population.

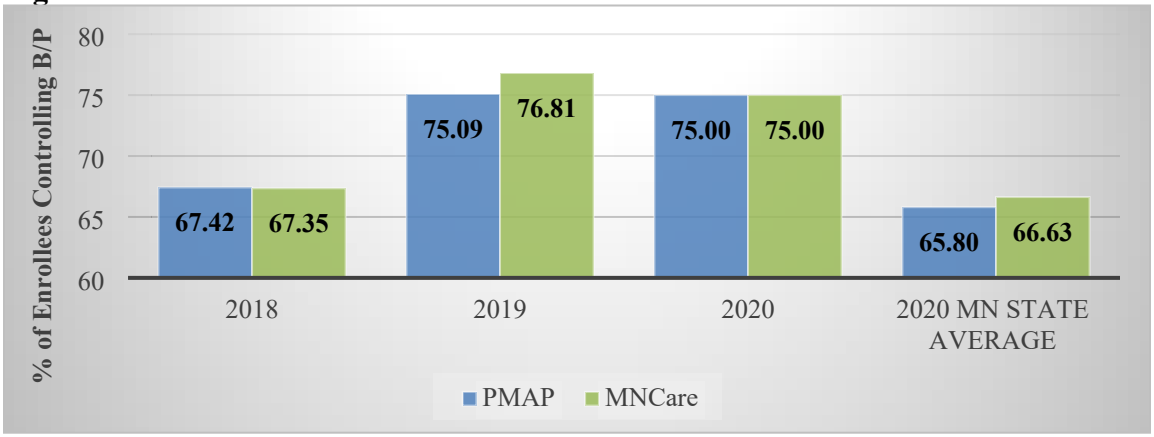
Figure 4. 2018-2020 HEDIS Childhood Immunizations - PMAP/MNCare



Controlling Blood Pressure (CBP)

In 2020, IMCare exceeded goals for blood pressure control for enrollees with and without diabetes (Figure 5).

Figure 5. 2018-2020 HEDIS Blood Pressure Control - PMAP/MNCare



Prenatal and Postpartum Care (PPC)

IMCare continues to perform well in perinatal measures, largely in part to *A Health Pregnancy* program and working collaboratively with Itasca County Public Health (Figures 6 and 7).

Figure 6. 2018-2020 HEDIS Prenatal Care - PMAP/MNCare

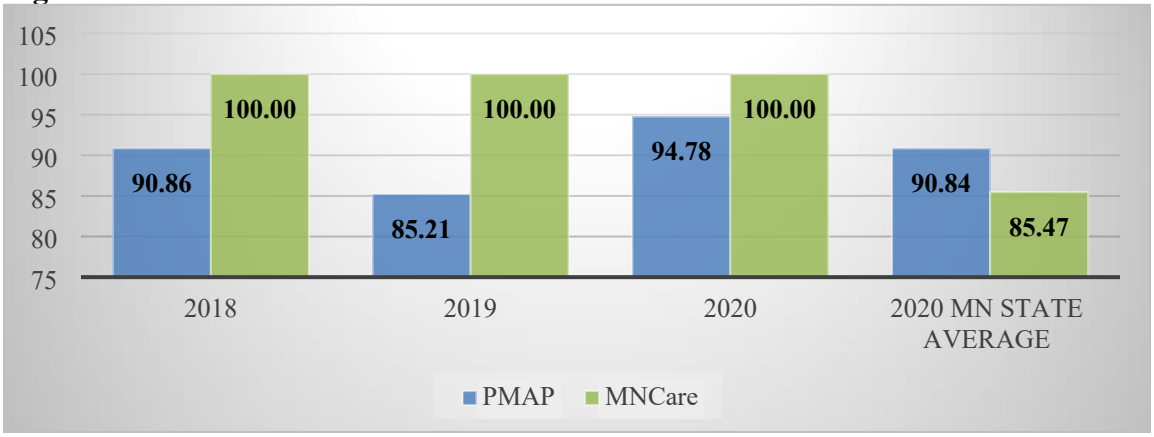
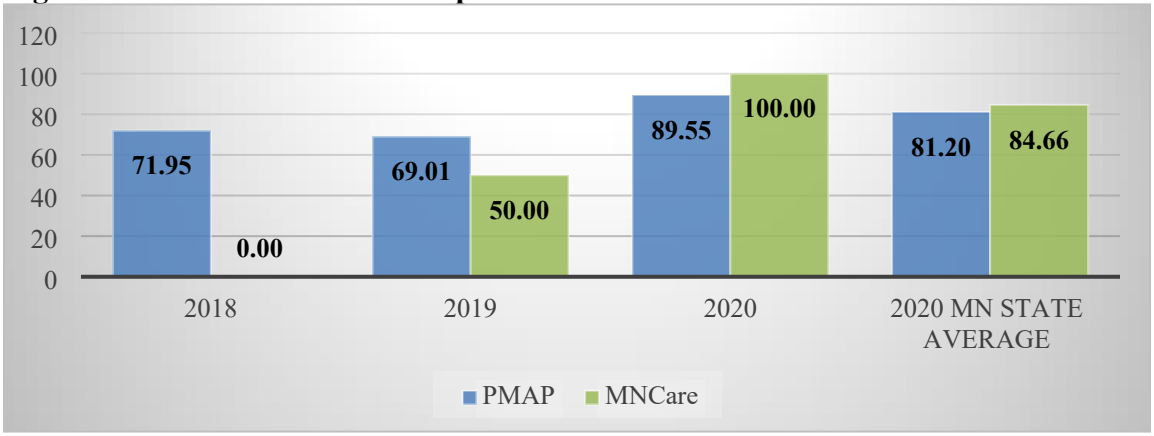


Figure 7. 2018-2020 HEDIS Postpartum Care - PMAP/MNCare



2020 HEDIS - MSHO

Overall, goals were met in several measures in 2020. Good diabetes control, as evidenced by HbA1c less than 8%, and blood pressure control in enrollees with diabetes improved considerably from 2019 (Figures 8 and 9). These findings may be correlated with increased provider education via provider newsletter articles focused on practice guidelines for medical care in adults with diabetes. Diabetic eye exams and nephropathy testing/treatment fell below goal in 2020. Secondary chart review for enrollee eye exams yielded no additional data. Practice guidelines disseminated to providers by IMCare in 2020 included current evidence-based recommendations regarding care of patients with diabetes, including regular eye exams and screening for nephropathy.

Figure 8. 2018-2020 HEDIS Blood Pressure Control - MSHO

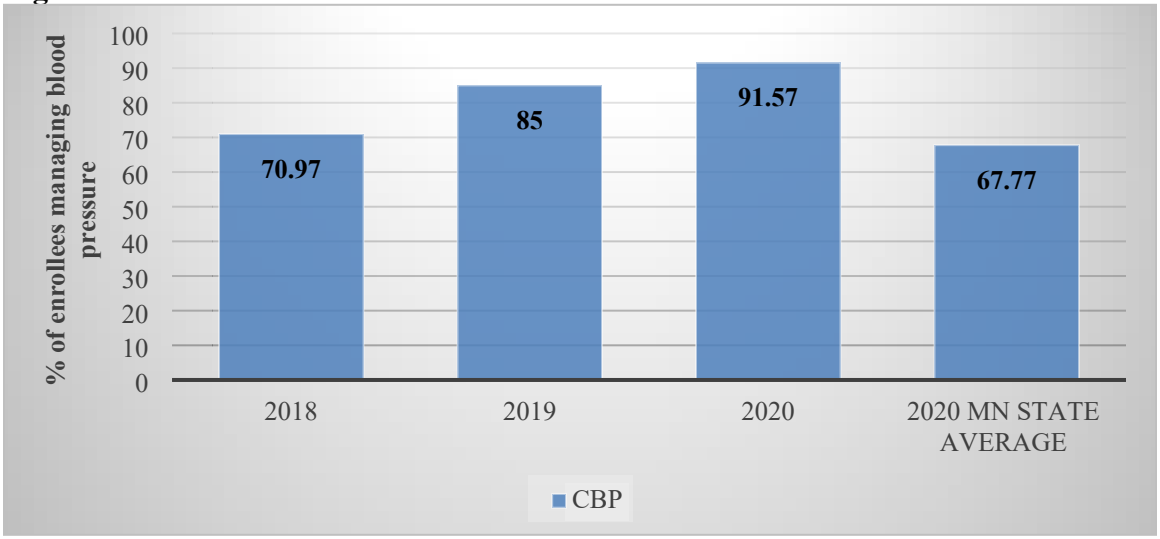
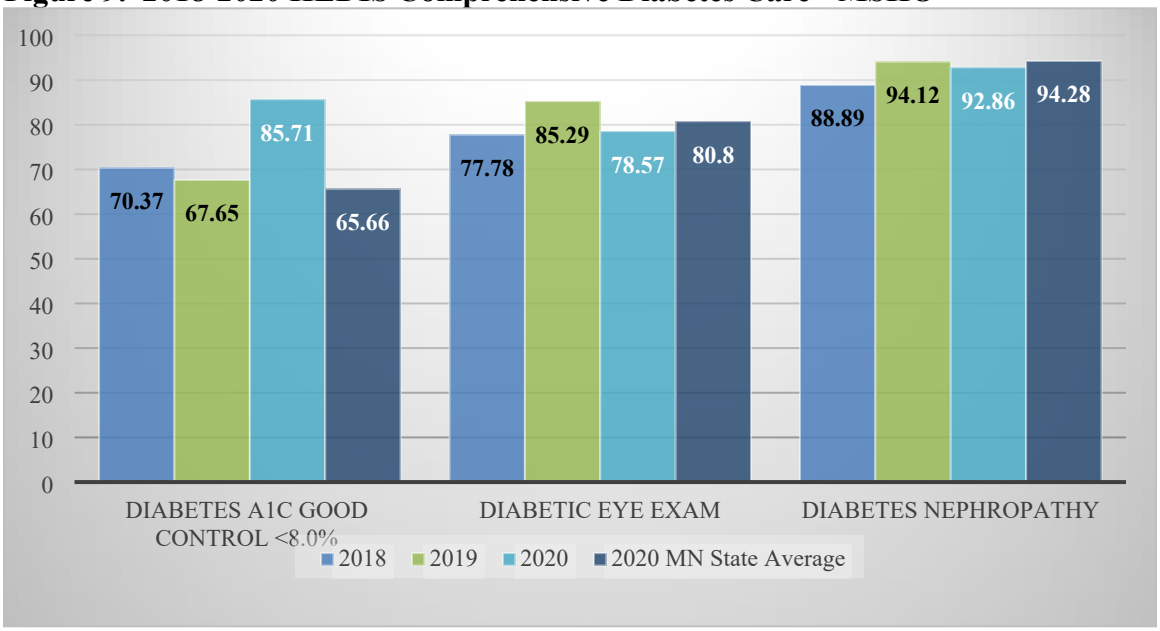


Figure 9. 2018-2020 HEDIS Comprehensive Diabetes Care - MSHO



The increase in the potentially harmful drug-disease interactions rate from 2019 to 2020 was due to an increase in the number of enrollees with dementia on the target drugs (Figure 10). The high-risk medication rate also increased from 2019 to 2020 and did not meet goal. While medication review and medication reconciliation post discharges measures exceeded goal, pain screening and functional status assessment measures fell just below goal in 2020 (Figures 11 and 12). Pain screening is also measured in the annual care plan audit, at which time IMCare regularly reminds care coordinators to address all components of the assessment.

Figure 10. 2018-2020 HEDIS Potentially Harmful Drug-Disease Interactions - MSHO

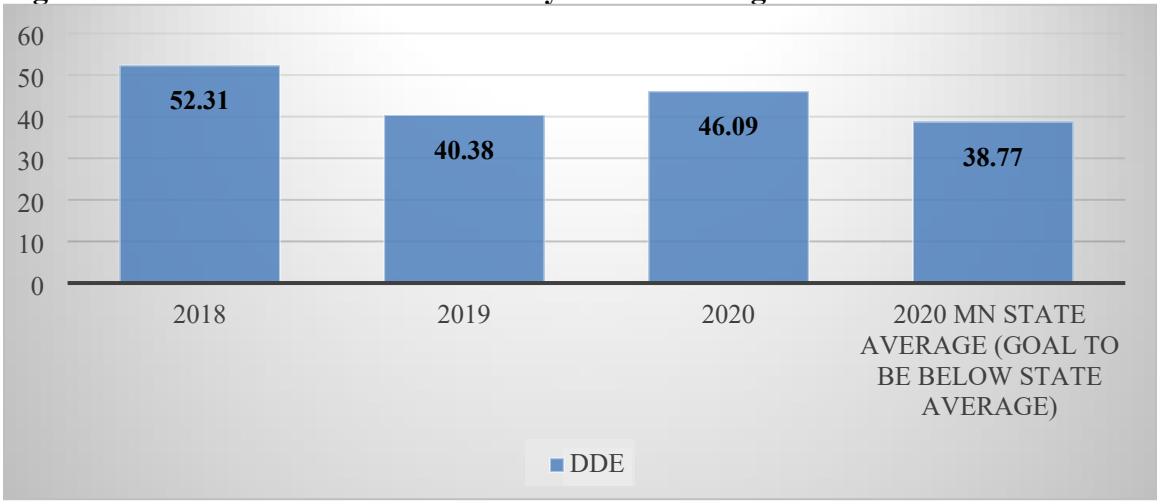


Figure 11. 2018-2020 HEDIS Care for Older Adults - MSHO

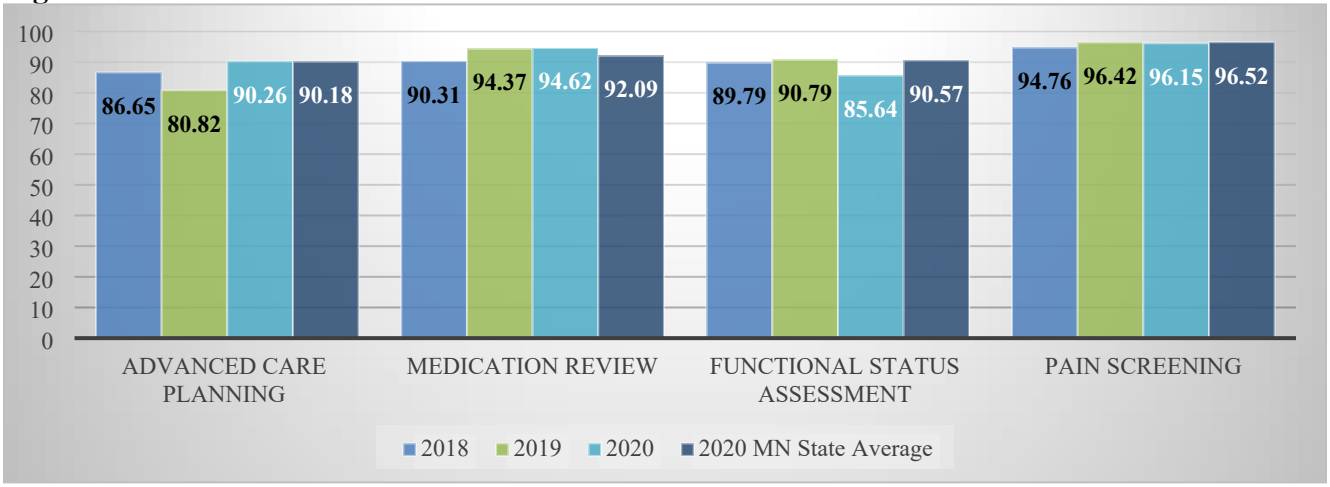
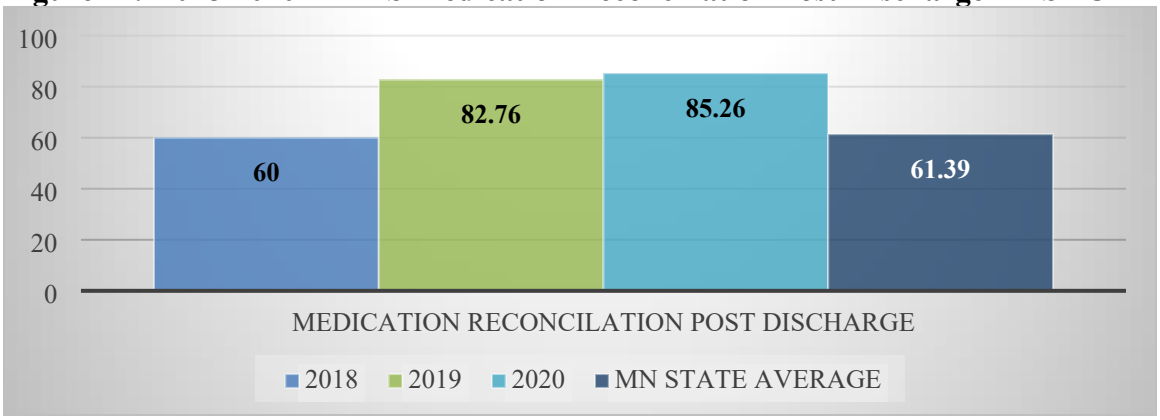


Figure 12. 2018-2020 HEDIS Medication Reconciliation Post-Discharge - MSHO



Performance Improvement Projects

2018-2020 Opioid Prescribing Improvement Project (OPIP)

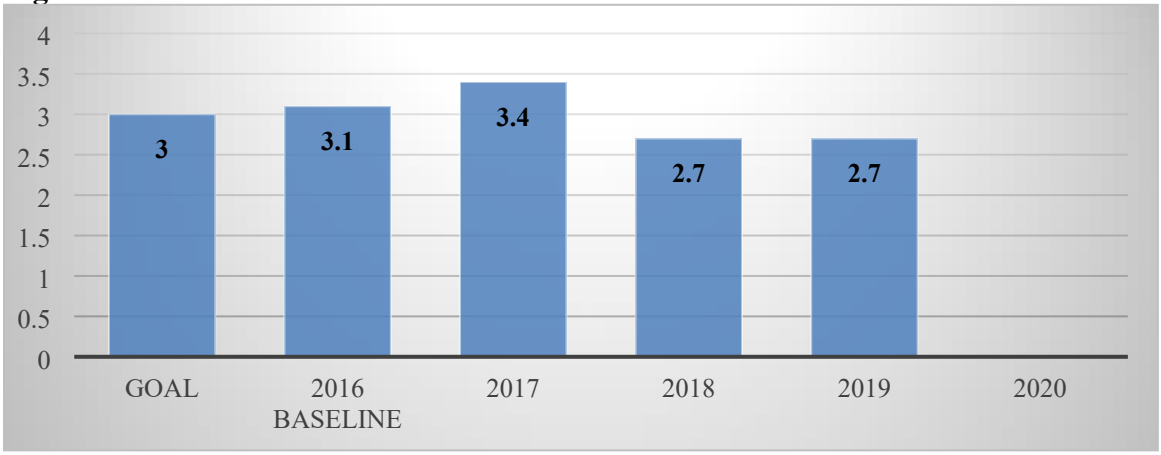
The Opioid Prescribing Improvement Project (OPIP) was designed to decrease the number of New Chronic Users (NCUsers) of opioid pain medications in the study population by the end of CY2019, and sustain the improvement through CY2020. The OPIP is required by and defined in the 2020 DHS Families & Children Contract with Itasca Medical Care, Section 7.2.1, "In 2018, the STATE selected the Preventing Chronic Opioid Use topic for the PIP to be conducted over a three-year period (calendar years 2018, 2019, and 2020). The PIP must be consistent with CMS' published protocol entitled *"Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects,"* STATE requirements, and include steps one through seven of the CMS protocol."

In 2020, IMCare carried out numerous interventions aimed at reducing the number of new chronic opioid users. The most impactful were in the IMCare pharmacy claims system, including continued programming of hard rejects, which required prior authorization to bypass the following items: initial opioid fills limited to a 7-day supply for enrollees who were opioid naïve for 90 days prior; opioid quantity limits exceeding 90 morphine milligram equivalents (MME)/day for all cumulative opioids within designated categories; and step therapy for extended release opioids, requiring fill of immediate release opioids within the last 90 days.

Global provider education via newsletter included the Centers for Disease Control and Prevention (CDC) *Checklist For Prescribing Opioids for Chronic Pain*, and 2018-2020 IMCare opioid project updates. Global enrollee education via newsletter included information about alternative therapies for the treatment of chronic pain, over the counter and prescription drug disposal, chronic pain self-management workshops in the area, and IMCare 2018-2020 IMCare opioid projects. Lastly, the IMCare Pharmacy Director, in collaboration with University of Minnesota School of Pharmacy, provided education regarding Medication Assisted Therapy (MAT) to Itasca County employees on 08/31/2020 and 09/04/2020.

The goal of the OPIP is to decrease the IMCare NCUsers rate (as defined by DHS) to 3.0. The baseline rate (2016 NCUsers Rate) was 3.1. The 2017 rate for the Medicaid population was 3.4, with a lower rate of 2.7 in 2018 and 2019 (Figure 13). The 2020 NCUsers rate has not been provided by DHS to date, but has an anticipated release date of May 2021. The delay in data and lack of enrollee-specific data makes it difficult to determine effectiveness of current interventions and modify accordingly. The point of sale opioid rejects seemed to be the most impactful intervention for IMCare throughout the OPIP. Due to the high number of opioid-related rejects at the pharmacy point-of-sale, and low-level opioid-related drug authorization requests, it appears that the pharmacy is contacting providers at the time of reject messaging and the provider is modifying prescribing to comply with best practice guidelines. This pattern of change may also be correlated with the strong focus of network facilities to reduce opioid misuse and abuse.

Figure 13. PMAP & MNCare NCUsers Rates



2018-2020 Opioid Prescribing Quality Improvement Project (OPQIP)

As per the 2020 *Contract For Minnesota Senior Health Options and Minnesota Senior Care Plus Services with Itasca Medical Care*, Section 7.2.1.1, "The STATE and MCOs selected the topic for the PIP to be conducted over a three-year period (calendar years 2018, 2019, and 2020). Topics should address the full spectrum of clinical and nonclinical areas associated with the MCO and not consistently eliminate any particular subset of Enrollees or topics when viewed over multiple years. The PIP must be consistent with CMS' published protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects*," STATE requirements, and include steps one through seven of the CMS protocol." DHS selected the 2018-2020 Quality Improvement Project topic, hereafter referred to as the Opioid Prescribing Quality Improvement Project (OPQIP). IMCare implemented the OPQIP for its Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus Services (MSC+) populations on January 1, 2018. The OPQIP is designed to decrease the number of New Chronic Users (NCUsers) of opioid pain medications in the study population by the end of CY2019, and sustain this improvement through CY2020.

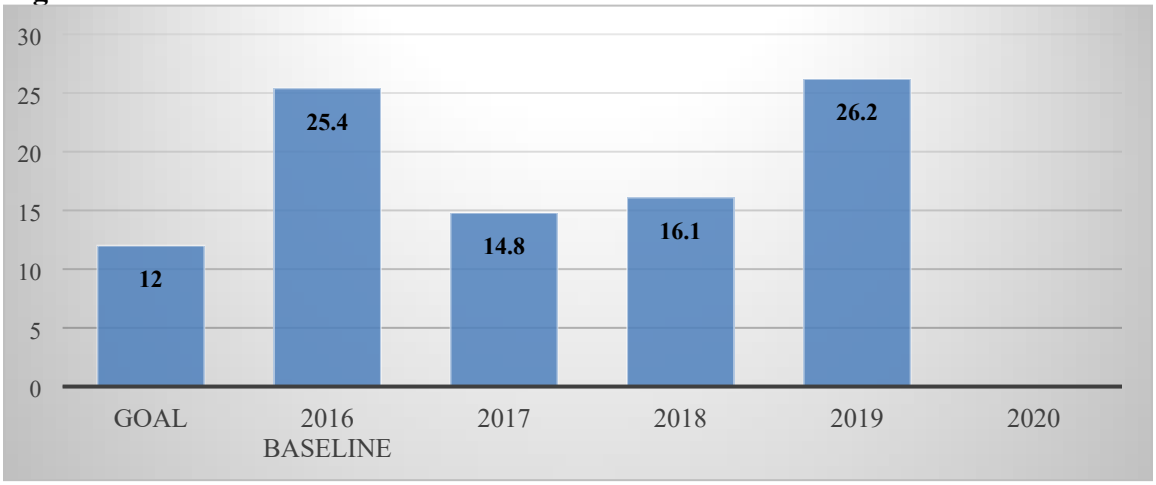
In 2020, IMCare carried out numerous interventions aimed at reducing the number of new chronic opioid users in the senior population. The IMCare pharmacy claims system continued programming of soft rejects, requiring pharmacist intervention to bypass the following items: cumulative opioid quantity limits exceeding 90 morphine milligram equivalents (MME)/day for all cumulative opioids; four or more opioid prescribers in 30 days; or four or more pharmacies used to obtain opioids in 30 days. Global provider education via newsletter included the CDC *Checklist For Prescribing Opioids for Chronic Pain*, and 2018-2020 IMCare opioid project updates. Global enrollee education via newsletter included information about alternative therapies for the treatment of chronic pain, over the counter and prescription drug disposal, chronic pain self-management workshops in the area, and IMCare 2018-2020 IMCare opioid projects.

The IMCare Pharmacy Director, in collaboration with University of Minnesota School of Pharmacy, provided education regarding MAT to Itasca County employees on 08/31/2020 and 09/04/2020. In addition, senior care coordinators and elderly waiver case managers were provided an update regarding the OPQIP at the Stakeholders Advisory Committee meeting on

04/01/2020. Lastly, IMCare partnered with our Pharmacy Benefit Manager (PBM), CVS Caremark, to administer the Medicare Point of Sale Drug Utilization Review (POS DUR) program, to help ensure clinically-appropriate use of opioids in seniors.

The goal of this OPQIP is to decrease the IMCare NCUsers rate (as defined by DHS) to 12 or less. The baseline rate (2016 NCUsers Rate) was 25.4. The 2019 rate for the MSHO/MSC+ population was 26.2, not meeting goal (Figure 14). Because DHS does not provide IMCare with enrollee-level data, it is difficult to determine the reason that seven additional enrollees met NCUser specifications in 2019. The 2020 NCUsers rate has not been provided by DHS to date, but has an anticipated release date of May 2021. While it is difficult to fully evaluate the effectiveness of the current opioid interventions without the 2020 NCUsers rate, it is apparent that this project has limited ability to impact change, due to the small number of individuals included in the study population and the inability to reproduce the data as generated by DHS. In review of CMS Opioid Patient Safety Analysis reports, IMCare has little to no inappropriate utilization of opioids among the senior population and met all goals. The POS DUR reports support this conclusion as well.

Figure 14. Senior NCUsers Rates



Focus Studies

Emergency Department (ED) Utilization Focus Study (FS)

IMCare identified enrollees with high ED utilization, in order to provide timely and appropriate enrollee education and case management (CM), as well as to identify and intervene in cases of potential fraud, waste and/or abuse. Monthly ED FS reports included enrollees with four or more cumulative ED visits since the beginning of the calendar year (excluding visits for cancer, neoplasm/blood disorders, pregnancy, perinatal, and/or congenital anomalies).

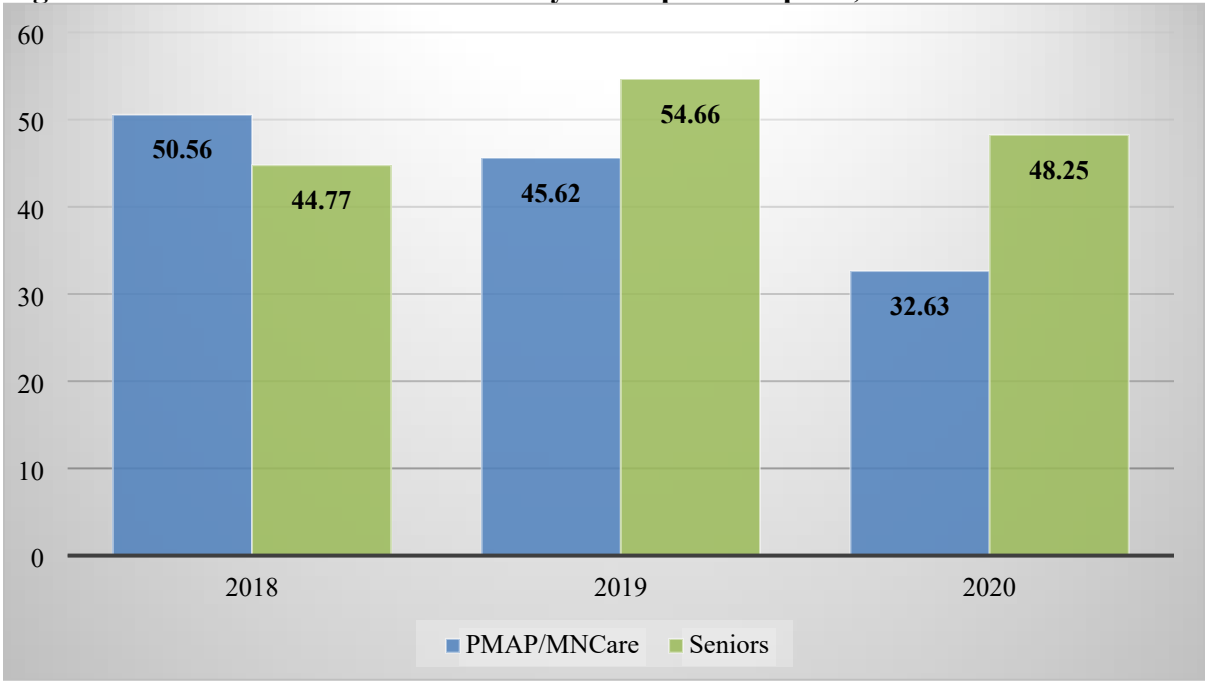
In 2020, IMCare provided global enrollee education regarding appropriate use of the ED and network urgent care options in both the Spring/Summer and Fall/Winter enrollee newsletters. Individual enrollee/caregiver education and CM regarding appropriate use of the ED and network clinic/urgent care options were administered by an IMCare Managed Care Nurse (MCN) or senior care coordinator. When appropriate, enrollee Restricted Recipient Program (RRP) warning or placement occurred. Provider newsletters included the 2019 ED FS results and a request for intervention suggestions; the process for reporting suspected fraud, waste and

abuse to IMCare; and education regarding IMCare CM services and the process for referral. Additionally, the IMCare Compliance staff attended DHS Universal Restricted Recipient Program (URRP) meetings throughout 2020.

Of the 129 Medicaid enrollees identified through the ED FS in 2020, fifteen received individualized written education regarding their ED use; three received RRP warning letters; and one was enrolled in the RRP. Of the 38 senior enrollees identified through the ED FS in 2020, 100% received case management.

Medicaid ED utilization relative to enrollment decreased 28.47% from 2019 to 2020, meeting goal (Figure 15). Senior ED utilization relative to enrollment decreased 11.73% from 2019 to 2020, also meeting goal. The global pandemic may have contributed to decreased ED utilization, with fewer people seeking care overall during the pandemic. IMCare first saw an increase in COVID-related ED utilization in the last quarter of 2020.

Figure 15. Total Number of ED Visits by the Population per 1,000 Enrollee Months



Controlled Substance (CS) Focus Study (FS)

IMCare identified enrollees with a high number of controlled substance prescription fills and use of multiple providers/pharmacies to obtain controlled substance prescriptions, in order to provide timely and appropriate enrollee education/CM and intervene in cases of potential fraud, waste and/or abuse.

IMCare completed a number of interventions to reduce inappropriate controlled substance use in 2020. Global provider education via newsletter included the 2019 CS FS results and a request for CS FS intervention suggestions; the CDC *Checklist For Prescribing Opioids for Chronic Pain*; a recommendation to use the MN Prescription Monitoring Program (PMP); information about IMCare opioid pharmacy edits and prescribing guidelines/recommendations; the process

for reporting suspected fraud waste and abuse; and 2018-2020 IMCare Opioid Project updates. IMCare Compliance staff attended DHS URRP meetings and the IMCare Pharmacy Director attended DHS Universal Pharmacy Policy Workgroup (UPPW) meetings. IMCare continued to list buprenorphine products, used to treat opioid dependence, on the Medicaid Formulary with no prior authorization requirement. In addition, IMCare continued to allow enrollees to receive out-of-network methadone treatment with no prior authorization requirement.

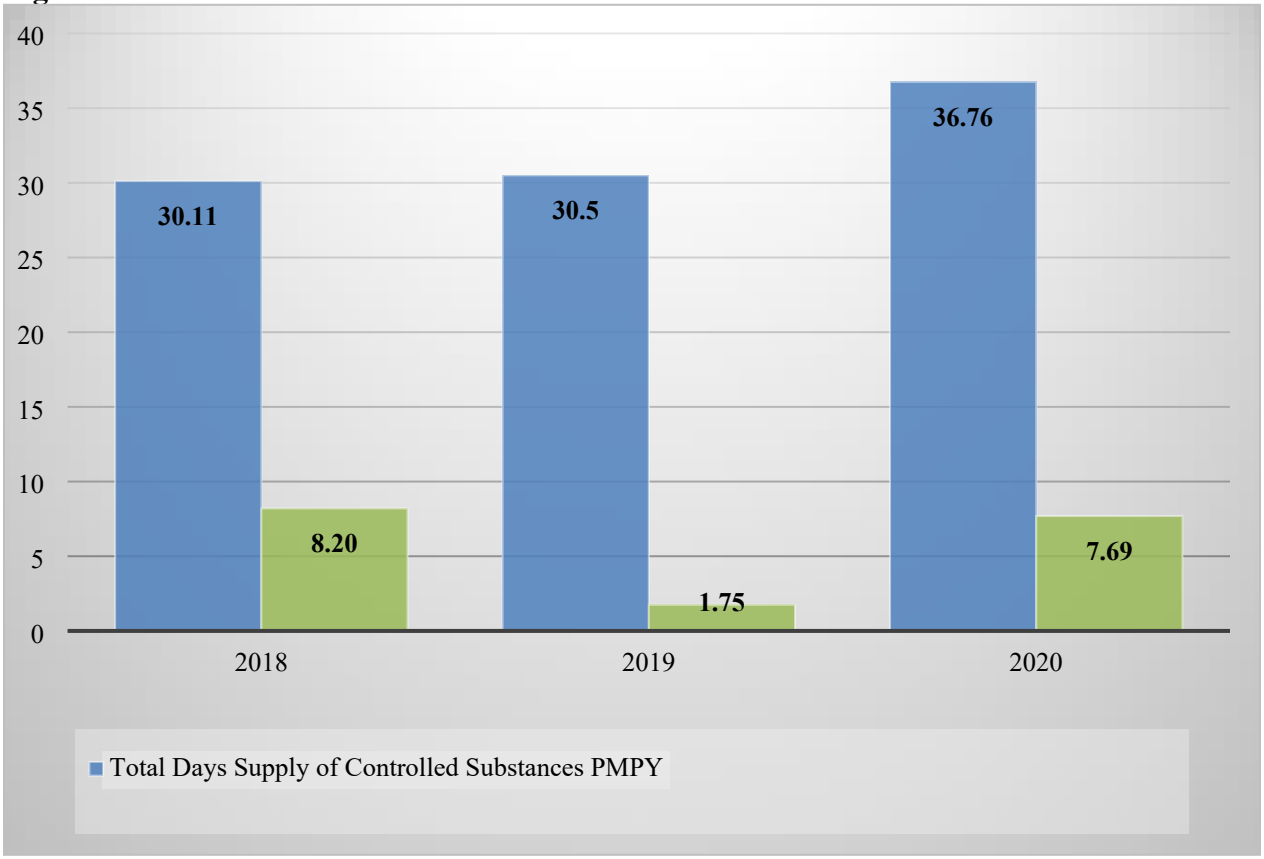
Global enrollee education via newsletter included information about alternative therapies for the treatment of chronic pain; over the counter and prescription drug disposal; chronic pain self-management workshops in the area; and opioid use in seniors. The CVS/Caremark Safety and Monitoring Solutions (SMS) and Enhanced Safety and Monitoring Solution (ESMS) programs were administered by CVS/Caremark for IMCare throughout 2020. Additionally, individual enrollee education/CM regarding CS use and the potential dangers of using multiple providers/pharmacies for CS prescriptions was administered by an IMCare MCN throughout 2020. When appropriate, enrollee Restricted Recipient Program (RRP) warning or placement occurred.

CVS/Caremark SMS program interventions were less robust in 2020 than in 2019, but still resulted in decreased use of controlled substances (four enrollees), duplicate therapy (one enrollee) and multiple pharmacies/prescribers to obtain controlled substances (16 enrollees). In 2020, IMCare identified 217 enrollees through the CS FS, increased from 176 enrollees in 2019. Eleven enrollees received individualized education regarding their CS fills, one received an RRP warning letter, and one was enrolled in the RRP.

Although the number of enrollees receiving methadone treatment for opioid use disorder showed minimal change from 2018 to 2020, the number of enrollees utilizing buprenorphine drugs significantly increased each year, from 39 enrollees in 2018 to 86 enrollees in 2020. While IMCare does not have an in-network methadone MAT provider, network providers began offering buprenorphine MAT in 2017, which likely accounts for the increase in this treatment option over the past three years.

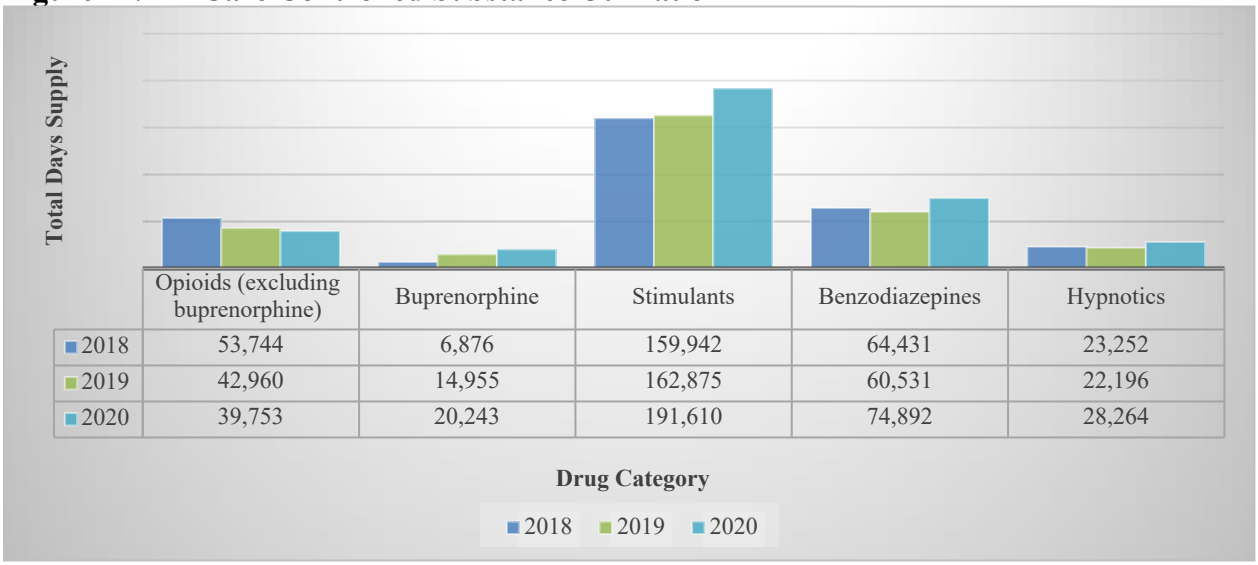
The total days-supply (TDS) of controlled substances (DEA schedules II-V, excluding buprenorphine MAT) dispensed per Medicaid enrollee increased 20.52% from 2019 to 2020, not meeting goal (Figure 16). In addition, IMCare did not meet the 2020 PMAP High Dosage Opioids (HDO) goal (MN state average rate of 5.92%), but did meet the MNCare goal for the measure.

Figure 16. IMCare CS FS Outcome Measures



The TDS of opioids (excluding buprenorphine drugs) dispensed decreased each year; however, the dispensed TDS of stimulants, benzodiazepines and hypnotics all increased from 2019 to 2020 (Figure 17).

Figure 17. IMCare Controlled Substance Utilization



	Opioids (excluding buprenorphine)	Buprenorphine	Stimulants	Benzodiazepines	Hypnotics
2018	53,744	6,876	159,942	64,431	23,252
2019	42,960	14,955	162,875	60,531	22,196
2020	39,753	20,243	191,610	74,892	28,264

A Healthy Pregnancy Prenatal Initiative Focus Study

A prenatal focus study, referred to as *A Healthy Pregnancy* program, was developed in 2007, in collaboration with the Itasca County Public Health Maternal Child Health (MCH) Division. This program is for at-risk IMCare pregnant enrollees. The *Minnesota Health Care Program (MHCP) Provider Manual* states, "At-risk is used to describe a pregnant woman who requires additional prenatal care services because of factors that increase the probability of a preterm delivery, a low birth weight infant, or a poor birth outcome." The program includes prenatal education and support and is free to pregnant enrollees.

IMCare sends a pregnancy congratulatory letter to each pregnant enrollee. The letter encourages her to seek early prenatal care and informs her about the program and who she can contact for additional information. After enrollment in the program, each pregnant enrollee is matched to an MCH nurse in the *Prenatal and Healthy Beginnings* program. The education provided through the program follows the *MHCP Provider Manual* guidelines for enhanced services. Topics include information about normal body changes in pregnancy, fetal development, self-care, pregnancy danger warning signs, preventing preterm labor, review of signs and symptoms of preterm labor, lifestyle and parenting support, breastfeeding, and labor and delivery education. Postpartum education is also included in *A Healthy Pregnancy* program, providing education and support to new mothers. It is the intent of IMCare and the Itasca County Public Health MCH division, through *A Healthy Pregnancy* program, to facilitate positive behaviors conducive to a favorable pregnancy outcome, by providing education that may preclude an enrollee's risk for preterm labor and delivery.

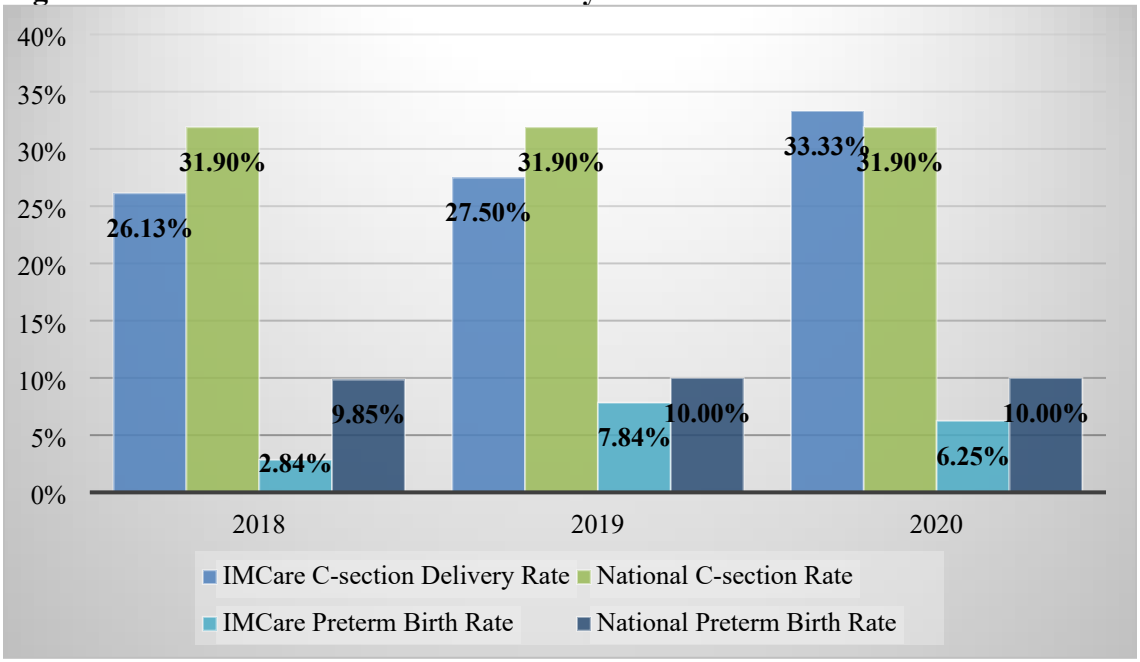
Pregnant IMCare enrollees who have not previously participated in *A Healthy Pregnancy* program are eligible for gift cards for their participation. During the prenatal period, those who accept prenatal visits with MCH receive a $40.00 Target gift card for the first visit, and a $30.00 Target gift card for the second visit. During the postpartum period, enrollees are eligible to receive a $30.00 Target gift card, if they accept a visit from the MCH and have a postpartum visit with their doctor within the prescribed 7-84 days postpartum timeframe.

The number of congratulatory letters sent in 2020 increased slightly from 2019, but 16 enrollees received two letters during 2020. This was in part due to eligibility rules during the COVID-19 pandemic, when the Itasca County Eligibility Specialist was unable to change eligibility for any individual who would be negatively impacted by the change; therefore, many people remained on the pregnancy benefit beyond the standard postpartum period. IMCare updated methodology for determining *A Healthy Pregnancy* program participation rates by using claims data to capture all pregnant enrollees receiving MCH nursing services, rather than just capturing those who were eligible and received gift cards for their participation. This change may result in an increase of identified participants over time. There are some limitations to this method, if the visits are not billed timely to IMCare after fourth quarter.

The IMCare C-section delivery rate increased by just over 5% from 2019 to 2020, and was above the most recent national average (recorded in 2018) in 2020 (Figure 18). The increase was due to only six additional c-sections in 2020, so it is difficult to determine if this is a trend, or just correlated with increased enrollment. In addition, there may have been an increase in planned inductions at network facilities to allow for COVID-19 testing prior to admission, and if the

inductions were unsuccessful, this may have contributed to the increased C-section rate. In contrast, the rate of preterm births decreased from 2019 to 2020. This finding may correlate with COVID-19 shelter-at-home orders, allowing pregnant enrollees more time to rest and access pregnancy resources both in-person and virtually.

Figure 18. 2018-2020 Prenatal Focus Study Outcomes



Special Health Care Needs

Medicaid Special Health Care Needs

IMCare identified enrollees with special health care needs through regular analysis of claims, hospital admissions and utilization management information. Enrollees were referred to case management for screening. In 2020, IMCare PMAP and MNCare enrollees ages 18-64 years old with an identified special health care need included enrollees with:

- at least one inpatient stay with the primary diagnosis of asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypertension, bacterial pneumonia or urinary tract infection (UTI);
- four or more Emergency Department visits during the measurement year;
- at least one hospital readmission within five days for same or similar diagnosis;
- referred to complex case management program for screening or have care coordination contact log present;
- use of home care services; and/or
- total claims exceeding $100,000.

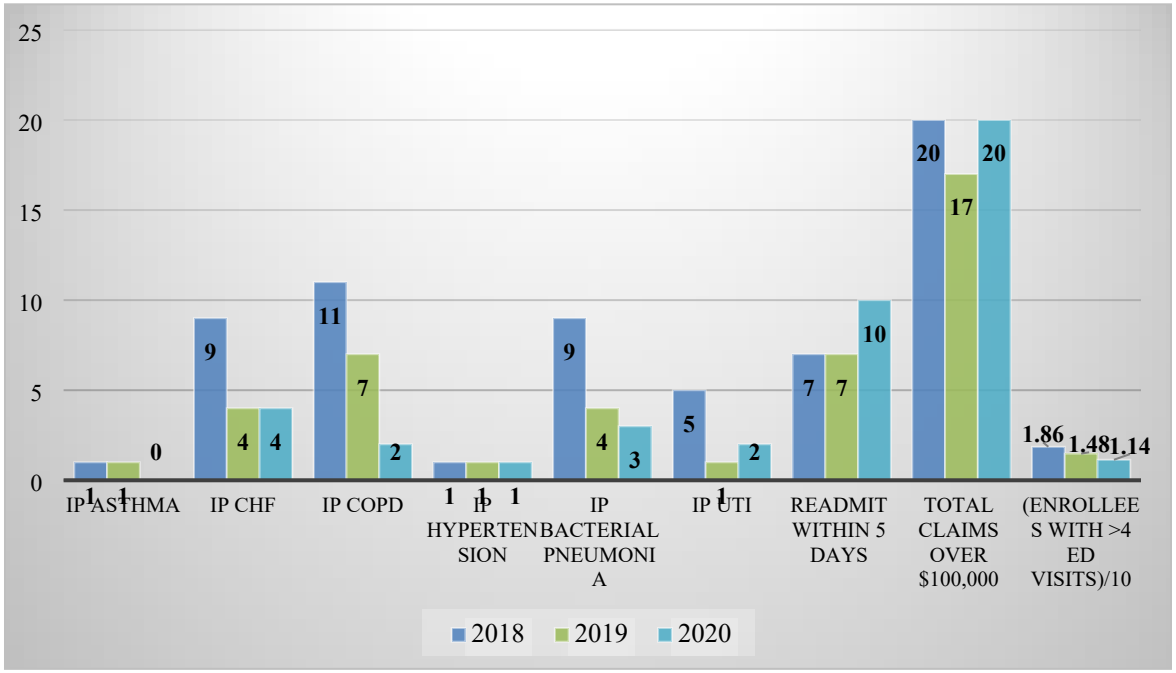
In 2020, all but three of the measures identifying enrollees with special health care needs showed year-to-year decrease (Figure 19). This decrease correlated with the COVID-19 pandemic, which resulted in lower utilization of services. Hospital stays that may have previously been attributed to areas identified in the above measures may have had a primary diagnosis of COVID-19 and; therefore, would not be included in this data. Readmissions within 5 days for

same or similar diagnoses increased from 2019 to 2020. Per review of enrollee-level data, in 2020, there were seven unique enrollees with readmissions, three of which had more than one readmission. In 2019, there were seven unique enrollees who each only had one readmission. The number of enrollees impacted from year-to-year was the same, but the acuity of the conditions appears to have increased. This may be attributed to the shutdown of preventative services for several months due to the COVID-19 pandemic, which resulted in lower utilization of preventative or outpatient services. Those who were hospitalized presented in a more severe or acute stage of their condition and required longer or additional hospitalizations.

ED utilization has consistently declined over the last three years, largely in part to ED FS interventions. Additionally, the facility that serves the highest volume of IMCare enrollees added ED care coordinators, one social worker and one registered nurse. They are available during business hours to help with coordination of care and/or follow up for enrollees who frequent the ED. The social worker assists enrollees who present with mental health, substance use disorder diagnosis or other social factors. The registered nurse assists enrollees who present with complex medical problems as needed. The addition of this service may explain reduced ED rates overall.

There was a significant decrease in the number of enrollees identified for Complex Case Management (CCM) from 2019 to 2020. Previously, enrollees enrolled in the Disease Management (DM) program were included in this measure; however, the DM program was discontinued in 2019 and replaced by the Population Health Management program, which has primarily a preventative health approach and would not be reflected in CCM data. Total claims exceeding $100,000 increased by three enrollees in 2020. This was primarily due to additional enrollees receiving specialty medication for the treatment of psoriasis.

Figure 19. 2018-2020 Number of Medicaid Enrollees with the Specified Special Health Care Needs



Seniors (MSHO and MSC+) Special Health Care Needs

IMCare assesses the quality and timeliness of case management/care coordination provided to seniors through the annual audit of case management/care coordination record documentation. A Social Worker (SW) or a Public Health Certified Registered Nurse (PHN) conducts all activities of care coordination and case management for IMCare seniors. From the time of an initial request, the MNChoices Assessment (MNChoices) or Long-Term Care Consultation Services Assessment (LTCC) is completed within 20 calendar days for the Elderly Waiver (EW) population. Within 30 days of enrollment, a Health Risk Assessment (HRA) or LTCC must be completed for Community-Well (CW) enrollees, and a nursing facility assessment is completed for skilled nursing facility (SNF) enrollees. Annually, IMCare audits records for timeliness of screenings and reassessments.

Public Health (PH) provides care coordination/case management for IMCare MSHO and MSC+ enrollees who, through their assessment, have been determined to meet Nursing Facility Level of Care criteria, and so qualify for Home and Community-Based Services (HCBS) under the EW. In addition, IMCare care coordinators manage care for the CW and SNF populations. The assessment process for all enrollees includes information to improve health care delivery and promote positive health outcomes.

IMCare has an active program to reach out to all CW and SNF enrollees aged 65 years and older. A nursing facility assessment is completed within 30 days of enrollment for all SNF enrollees. If CW enrollees agree to a face-to-face visit, IMCare care coordinators/case managers complete a comprehensive health assessment within 30 days of enrollment. Reassessments are offered annually, within 364 days of the previous assessment, or more frequently if indicated by the enrollee's comprehensive care plan or a change in condition. The HRA or LTCC assessment tool is used to complete the comprehensive health assessment for CW enrollees. These tools assess enrollee health status, including condition-specific issues; supports and services needed based on strengths, choices and preferences in life domain areas; documentation of clinical health history and medications; activities of daily living (ADL) and instrumental activities of daily living (IADL); mental health status and cognitive functioning; life planning activities; evaluation of visual and hearing needs, preferences and limitations; evaluation of caregiver resources and involvement; evaluation of cultural and linguistic needs, preferences or limitations; and evaluation of available benefits and community resources.

IMCare also works with senior enrollee during a transition. The transition process utilizes the Eric A. Coleman "Four Pillars" conceptual model, thereby improving quality of care and preventing readmissions. During the transition process, when CW and EW enrollees discharge to their usual care setting, the enrollee's Care Coordinator/Case Manager contacts them to determine if they have a follow-up appointment scheduled; if they have transportation to their appointment; if they know the signs/symptoms to report to the provider; if they have knowledge of their medications and how to take them; and if they have and/or utilize a personal health record. If the enrollee needs help in any of these areas, the Care Coordinator/Case Manager assists them.

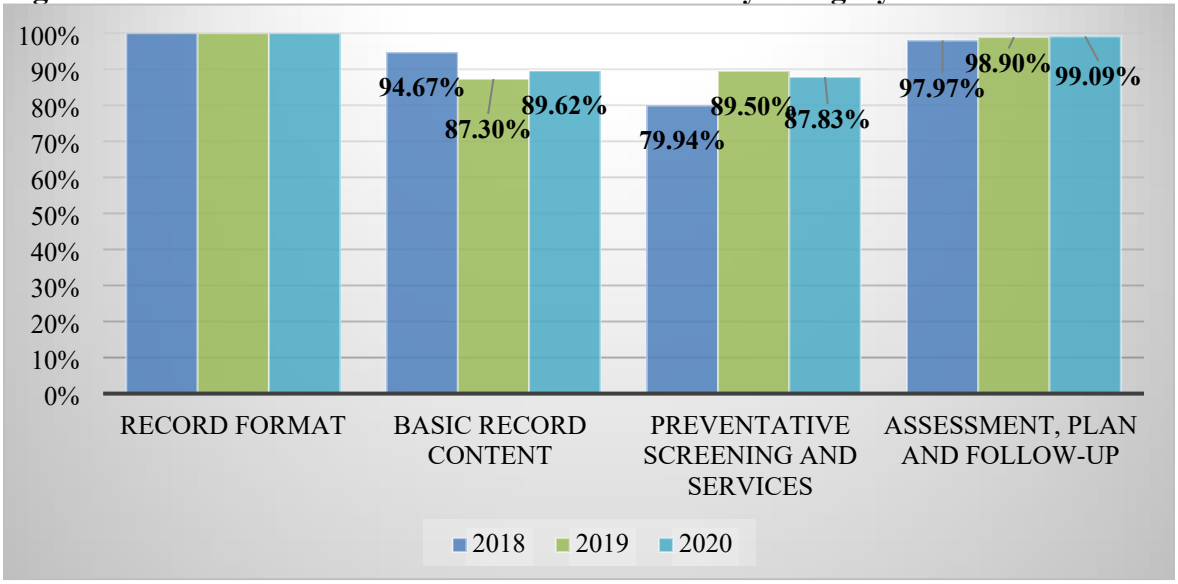
Record Audits

Medical Record Audit

IMCare annually audits enrollee medical records to determine provider compliance with regulatory requirements and National Committee for Quality Assurance (NCQA) standards. Additionally, IMCare ensures that medical records are maintained with timely, legible and accurate documentation of patient information, per IMCare medical record documentation standards.

In 2020, IMCare audited a total of 221 medical records, with the following breakdown: Fairview Nashwauk was audited on 11 charts; Hibbing Family Medical Center was audited on 30 charts; Scenic Rivers Bigfork was audited on 30 charts; Grand Itasca Clinic and Hospital was audited on 30 charts; Fairview Hibbing was audited on 30 charts; Essentia Health Grand Rapids was audited on 30 charts; Essentia Health Deer River was audited on 30 charts; and Essentia Health Hibbing was audited on 30 charts. Overall, 94.14% of measures were met for the medical record audit, which is above the goal of 80%.

Figure 20. 2018-2020 Medical Record Audit Results by Category



This year, there were several occurrences of auditor omissions identified and inconsistency with audit format, leading to some deviation among denominators. In addition, this year's audit was completed with the 8/30 audit methodology (as supported by NCQA), versus the 30/30 audit methodology, as used in previous audits. Most measures met goal in 2020. Measures below goal included tobacco cessation information offered to those who identified that they were smokers, and health care directives for individuals over 18 years of age. These measures have been below goal for three consecutive audit cycles. Future auditor training will focus on better understanding individual measurement supporting data, such as data stating refusal or declining of an advance directive meets the applicable measure.

The 2020 (2019 data) post audit review of audit tools and data spreadsheets identified the need to contact facilities to request either additional EMR access or submission of print screens of data that was not available to auditors during the review. Two of the facilities confirmed that auditors

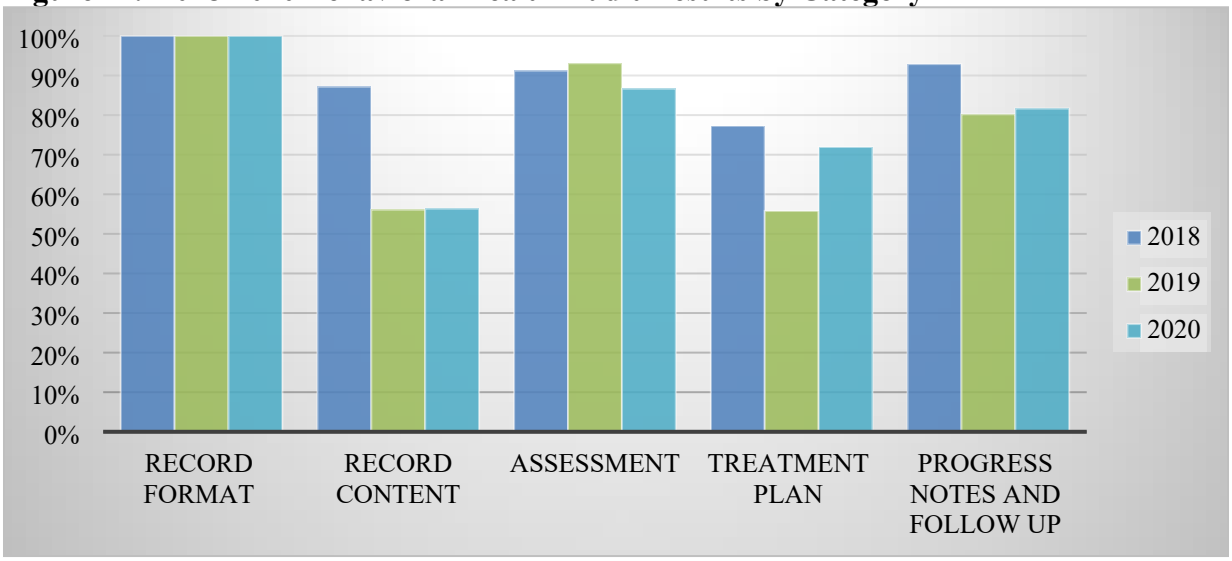
did not have access to the tabs necessary to validate the data required in some of the measurements, specifically measurement that addresses necessary enrollee demographic data. Auditors have been instructed to reach out to the identified contact at the facility or bring concerns to the QI/UM Director if there is difficulty accessing data.

Behavioral Health Treatment Record Audit

IMCare conducts annual behavioral health (BH) treatment record audits to determine if providers are documenting important elements of behavioral health treatment, according to regulatory requirements and National Committee for Quality Assurance (NCQA) standards, in the assessment and treatment plan, progress notes, and follow-up of IMCare enrollees. Additionally, IMCare assures that behavioral health treatment records are maintained with timely, legible and accurate documentation of patient information, per IMCare behavioral health treatment record documentation standards.

In 2020, IMCare audited a total of 157 BH records at 14 BH clinics, with an overall average of 80.86%, above the 80% goal. For each clinic, five initial records were reviewed. For any unmet measures, all remaining records were then reviewed for the unmet measures. The methodology explains the varying denominators among the measures. Measures that were consistently met in the first five charts have lower denominators than those that were initially unmet. It is also important to note that enrollee records randomly selected from 2019 may not reflect measures facilities put into place as a result of feedback from the 2019 BH audit.

Figure 21. 2018-2020 Behavioral Health Audit Results by Category



Record content deficiencies were noted in demographic data collection, with one missing component resulting in an unmet measure, meaning all five components must be present to meet this measure. Auditor instruction included the necessity of all components being present. If they were unable to find data, they were instructed to contact the facility lead identified on the 2020 Facility Contact List, and/or reach out to the QI/UM Director. Assessment content deficiencies were related to the specific type of Diagnostic Assessment (DA) being completed and the measurement data necessary for each DA type. Treatment plan deficiencies were present in 2018 (2017 data), 2019 (2018 data) and 2020 (2019 data), with the treatment plan being

reviewed and signed every 90 days and informed consent for individual treatment plan not meeting measurement goal. Progress notes and follow-up deficiencies were also present in 2018 (2017 data), 2019 (2018 data) and 2020 (2019 data), regarding follow-up of any unresolved problems being addressed at the follow up visit.

Three measures that did not meet goal in 2019, but met goal in the 2020 audit, included:

- Enrollee authorization to release private information and enrollee information obtained from outside sources must be documented.
- Assessment methods are documented for standard and extended diagnostic assessments.
- Evidence of coordination of care with other relevant mental health providers and/or medical professionals must be documented.

Credentialing

Individual Practitioner Credentialing

DHS requires that IMCare, "adopt a uniform credentialing and recredentialing process and comply with that process consistent with State regulations and current NCQA *Standards and Guidelines for the Accreditation of Health Plans*." IMCare credentials individual practitioners who:

- are licensed, certified or registered by Minnesota to practice independently;
- have an independent relationship with IMCare; and
- provide medical, dental or behavioral healthcare services to IMCare enrollees.

Credentialed practitioners may work in a variety of settings, including individual practices, group practices, facilities and/or telemedicine. IMCare requires initial credentialing for practitioners new to IMCare, as well as practitioners with any break in network participation. Practitioners must complete the IMCare credentialing process prior to providing care to IMCare enrollees. IMCare makes the final decision whether to approve or deny a practitioner's initial credentialing application within 180 calendar days of the practitioner's signed attestation date on the application.

IMCare recredentials individual practitioners at least every 36 months. This timeframe is only extended when a practitioner cannot be recredentialed due to active military assignment, medical leave or sabbatical. In these instances, practitioners are recredentialed within 60 calendar days of his/her return to practice. IMCare also performs ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles, and takes appropriate action against practitioners when quality issues are identified.

IMCare ensures that all network office sites meet defined standards by performing/reviewing site visit audits in order to assess the quality, safety and accessibility of office sites where care is delivered. IMCare audits the office sites of individual practitioners:

- Prior to the completion of the initial credentialing process.
- When a practitioner relocates or opens an additional office.
- When a complaint is received about an office site.
- When office site issues are identified during other quality improvement activities.
- Otherwise, as deemed necessary by IMCare staff/leadership.

IMCare requires that credentialing/recredentialing processes are conducted in a nondiscriminatory manner (Policy and Procedure 1.08.05). In addition, IMCare has credentialing system controls in place to ensure the integrity, accuracy, confidentiality and security of credentialing/recredentialing processes and all related information (Policy and Procedure 1.08.14).

IMCare completes an annual audit of individual practitioner initial credentialing and recredentialing files to ensure that all required elements were present at the time of the credentialing/recredentialing decision, applicable timeframes were met, and there is no evidence of discrimination during the credentialing/recredentialing process.
In 2020, IMCare individual practitioner credentialing interventions included:

- All 2019 annual credentialing reports were reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC), which serves as the IMCare Credentialing Committee, on 02/12/2020.
- Quarterly credentialing and timeliness of credentialing/recredentialing reports were reviewed/approved by the PAC.
- Individual practitioner credentialing/recredentialing files and ongoing monitoring concerns were presented to the PAC, who recommended a course of action.
- IMCare credentialing policies and procedures were updated to meet the 2020 NCQA *Standards and Guidelines for the Accreditation of Health Plans*, and reviewed/approved by the PAC on 08/12/2020.
- Initial appointment and reappointment credentialing/recredentialing checklists were updated throughout the year as needed.
- IMCare credentialing staff maintained the *Individual Practitioner Credentialing Roster, Site Visit Log,* and IMCare provider directories throughout the year.

In 2020, IMCare credentialed/recredentialed a total of 135 individual practitioners, increased from 109 practitioners in 2019. All credentialing/recredentialing applications were processed within the required timeframes for completion. All 16 of the practitioner terminations in 2020 were not for cause (e.g., practitioner moved out of the area, retired, etc.). The IMCare network continues to grow, from a total of 278 credentialed practitioners in 2018, to 314 practitioners in 2020. All audited individual practitioner office site visit audits exceeded the 80% goal in 2020. In addition, all credentialing/recredentialing file audit measures met the 100% goal in 2020.

Organizational Provider Credentialing
DHS requires, "For organizational Providers, including nursing facilities, hospitals, and Medicare certified home health care agencies; the MCO shall adopt a uniform credentialing and recredentialing process and comply with that process consistent with State regulations." IMCare follows the NCQA *Standards and Guidelines for the Accreditation of Health Plans* to ensure a consistent, thorough credentialing process that meets community standards and current contractual and legal requirements. Organizational providers credentialed by IMCare include network:

- Hospitals
- Medicare Certified Home Health Agencies (HHA)
- Skilled Nursing Facilities (SNF)
- Free-Standing Surgical Centers

- Behavioral Healthcare Facilities (that are licensed by the State of Minnesota to provide mental health (MH) and/or substance abuse (CD) services in inpatient, residential, and/or ambulatory settings)

Organizational providers are credentialed at the time of initial contracting and recredentialed at least every 36 months thereafter, to ensure that the provider is in good standing with federal/state regulatory bodies and has been reviewed/approved by an appropriate accrediting body (Policy and Procedure 1.08.11). An onsite quality assessment is not required if the provider is accredited by an applicable accrediting body or is in a rural area, as defined by the U.S. Census Bureau. Onsite quality assessments of non-accredited organizational providers are completed:

- Prior to the completion of the initial credentialing process and at least every three years thereafter.
- When a provider relocates or opens an additional site.
- When a complaint is received about a provider site.
- When provider site issues are identified during other quality improvement activities.
- Otherwise, as deemed necessary by IMCare staff/leadership.

For non-accredited providers, IMCare may use a state or federal quality review in lieu of a site visit, if the review is no more than three years old, and IMCare obtains the survey report/letter stating that the provider was reviewed and passed inspection. IMCare makes the final decision whether to approve or deny an organizational provider's initial credentialing application within 180 calendar days of the signed attestation date on the *Organizational Provider Credentialing/Recredentialing Application*. IMCare recredentials organizational providers at least every 36 months.

In 2020, IMCare organizational provider credentialing interventions included:

- The *2019 Organizational Provider Credentialing Report* and the *2019 Site Visit Audit Report* were reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/12/2020.
- Quarterly credentialing reports, including organizational provider credentialing/ recredentialing information, were reviewed/approved by the PAC throughout 2020.
- IMCare credentialing policies and procedures were updated to meet the 2020 NCQA *Standards and Guidelines for the Accreditation of Health Plans* and reviewed/approved by the PAC on 08/12/2020.
- The *Organizational Provider Credentialing/Recredentialing Checklist* was updated throughout the year as needed.
- IMCare credentialing staff maintained the *Organizational Provider Recredentialing Log, Site Visit Log,* and IMCare provider directories throughout the year.

No organizational provider initial credentialing applications were submitted to IMCare in 2020, and no organizational providers were due for recredentialing in 2020. In addition, no IMCare onsite quality assessments of organizational providers were required during 2020.

Provider Service Contracting

Provider Participation Agreements/Contracted Partners

IMCare contracts with individual practitioners and providers, including those making UM decisions. IMCare providers must cooperate with QI/UM program activities, maintain confidentiality of enrollee information and records, and allow IMCare to use provider performance data. IMCare provider participation agreements also include compliance with applicable federal and state regulations, statutes, rules and laws, including reporting requirements. In 2017, IMCare prepared and distributed an addendum for current signed agreements, addressing the requirement of providers to report to IMCare, within five days, any information regarding individuals or entities who have been excluded from participation in Medicaid.

In addition to the Medical Director, IMCare contracts with an Internal Medicine physician, pharmacist, dentist, and behavioral health associate, to provide administrative support to IMCare. These individuals attend all applicable committee meetings, and provide valuable input regarding IMCare QI and UM programs.

Affirmative Statement

The affirmative statement declares that IMCare does not use incentives or encourage barriers to care and/or service. Additionally, it states IMCare does not specifically reward or incentivize providers and/or IMCare staff for denial of service determinations.

The IMCare Affirmative Statement is reviewed at least annually and disseminated to all providers and enrollees. In 2020, it was included in the Enrollee Handbook, enrollee newsletters, updated provider contracts, and the IMCare Provider Manual. It is also reviewed annually by IMCare staff.

IMCare includes Affirmative Statement requirements in provider participation agreements. IMCare updates the Affirmative Statement Policy and Procedure to meet federal and state requirements and includes it in the Provider Manual. The affirmative statement is reviewed and distributed to all providers, annually.

Health Care Directives

IMCare distributes health care directive information at least annually to enrollees and providers and it is reviewed annually by IMCare staff. Health care directive information is included in provider contracts. The policy and procedure for health care directives is included in the IMCare Provider Manual.

The Health Care Directive Information notice is included in the Enrollee Handbook. Health care directive information was included in the Spring/Summer 2020 and Fall/Winter 2020 enrollee newsletters. Additionally, CaseTrakker includes health care directives so they can be documented by care coordinators.

Historically, IMCare has not met goal on documentation of health care records in the medical and behavioral health record audits. The most recent audits showed a compliance rate of 37.91%, which is a decrease of 22.09% over the previous year's record reviews. The measure is

applicable to enrollees 18 years old and older. While low rates in the 18-64 year olds could be expected, the rate for all IMCare populations (18+) is well below the goal of 80%.

Documentation of health care directives in medical records is the desired method of measuring compliance with health care directive requirements. Consequently, all practitioners and facilities do not employ the same electronic medical record (EHR) system. This makes it a challenge for IMCare chart abstractors to identify documentation. In addition, encouraging the younger, healthier population to consider a health care directive is challenging.

Accessibility of Services

In 2020, IMCare ensured enrollee access to Primary Care Providers (PCP), Specialty Care Providers (SCP), Behavioral Health Care Providers and certain Ancillary Providers by identifying gaps in network adequacy through data analysis, as required by DHS and NCQA standards.

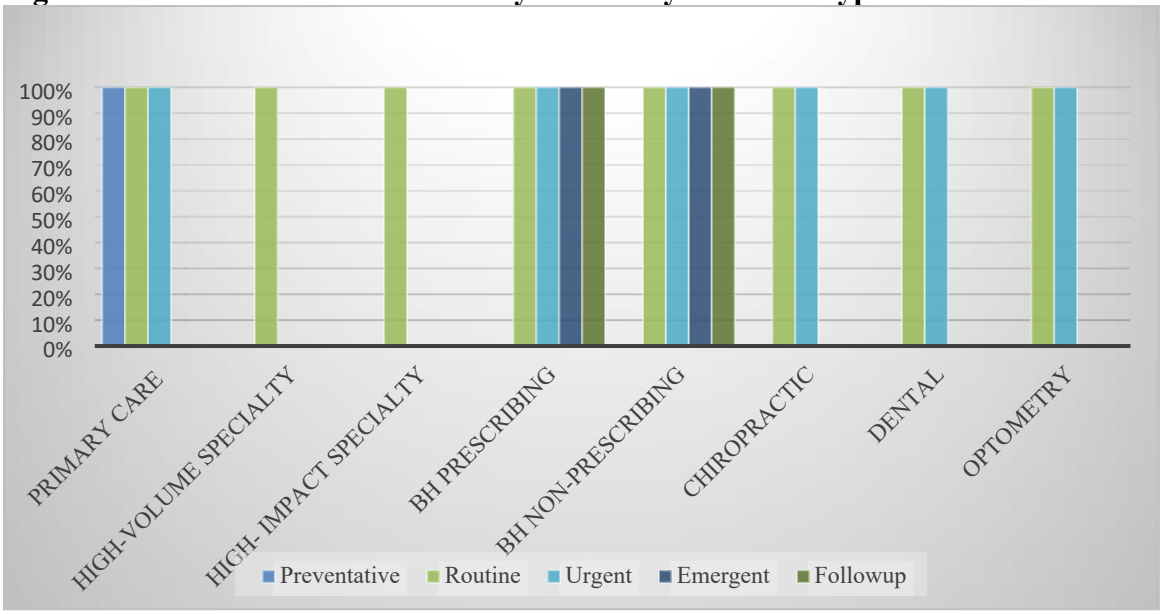
2019-2020 Interventions:

- IMCare ensured access to providers for minority and special needs populations by conducting cultural, ethnic, racial and linguistic needs assessments of all enrollees at enrollment (and additionally as needed) through Health Screening Surveys and Long-Term Care Consultations (LTCC). IMCare also received and reviewed a monthly list of enrollees identified as having potential cultural, ethnic, racial and linguistic needs from DHS. The IMCare Provider Directory included the languages spoken at each of the primary care clinics. American Indians were able to utilize tribal and Indian Health Services clinics, in addition to network providers, without prior authorization by IMCare.
- IMCare complied with the Mental Health Parity and Addiction Equity Act (MHPAEA, Pub.L. 110-343) making it easier for enrollees with mental health and substance use disorders to get the care they need by prohibiting certain discriminatory practices that limit coverage for behavioral health treatment and services.
- A reminder system was utilized to facilitate timely reporting of clinic grievances by providers. Each provider was emailed/faxed/mailed a copy of the report and a reminder one to two weeks prior to the deadline dates. A follow-up reminder was emailed/faxed/ phoned if IMCare still had not received the form after the due date.
- The 2019 Accessibility of Services Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/13/2019 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 12/18/2019.
- The 2019 Practitioner/ Facility Grievance Report was reviewed/approved by the PAC on 02/12/2020 and the External QI/UM Committee on 03/18/2020.
- The 2019 Credentialing File Audit Report was reviewed/approved by the PAC on 02/12/2020 and the External QI/UM Committee on 03/18/2020.
- The 2019 Site Visit Audit Report was reviewed/approved by the PAC on 02/12/2020 and the External QI/UM Committee on 03/18/2020.
- An article regarding IMCare Accessibility Standards was included in the Fall 2019 Provider Newsletter.
- IMCare conducted individual outreach to behavioral health providers who did not meet IMCare Access Standards during the 2018-2019 reporting period to determine how providers would work to meet standards during the next reporting period.

- Provider surveys were modified to clarify questions that providers indicated they initially misunderstood through individual outreach.

During the study period, IMCare met goal for all accessibility measurements and provider types (Figure 22). Overall, IMCare maintained an adequate care network as it relates to provider accessibility. In addition to the provider accessibility measurements included in the report, multiple other avenues to care also are available to IMCare enrollees. IMCare adheres to the Mental Health Parity and Addiction Equity Act (MHPAEA, Pub.L. 110-343), making it easier for enrollees with mental health and substance use disorders to get the care they need by prohibiting certain discriminatory practices that limit coverage for behavioral health treatment and services. Coverage for mental health and substance use disorders is less restrictive than the coverage that generally is available for medical/surgical conditions. IMCare entertains all individual behavioral health practitioner requests for credentialing and all providers who can meet NCQA credentialing standards are added to the IMCare network. Furthermore, the Itasca County Crisis Response Team provides around-the-clock urgent/emergent behavioral health care to Itasca County residents. Network urgent care facilities and emergency departments also ensure accessibility of urgent/emergent care. Analysis of enrollee grievances revealed no grievances related to cultural/ethnic/racial/linguistic enrollee needs or accessibility of IMCare providers during the study period.

Figure 22. 2020 Provider Accessibility Results by Provider Type



Practitioner Availability and Network Adequacy

In 2020, IMCare ensured the availability of providers and services by identifying gaps in network adequacy through data analysis, as required by NCQA and IMCare contracts with the DHS. IMCare maintains and monitors a network of providers, supported by written agreements, and provides adequate availability to covered services to meet the needs of the population served in accordance with Minnesota Statutes §62D.124, §62K.10, Minnesota Rules, part 4685.1010, 42 C.F.R. § 438.68, DHS Contract section 11.6.1, and CMS contracts.

2019-2020 Interventions:

- IMCare ensured provider availability for minority and special needs populations by conducting cultural, ethnic, racial and linguistic needs assessments of all enrollees at enrollment (and additionally as needed) through Initial Enrollee Screening and Long-Term Care Consultations (LTCC). IMCare also received and reviewed a monthly list of enrollees identified as having potential cultural, ethnic, racial and linguistic needs from DHS. The IMCare Provider Directory included the languages spoken at each of the primary care clinics. American Indians were able to utilize tribal and Indian Health Services clinics, in addition to network providers, without prior authorization by IMCare.
- The 2019 Provider Availability and Network Adequacy Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/13/2019 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 12/18/2019.
- The 2019 Practitioner/Facility Grievance Report was reviewed/approved by the PAC on 02/12/2020 and the External QI/UM Committee on 03/18/2020.
- An article regarding IMCare Accessibility Standards was included in the Fall 2019 Provider Newsletter.

During the study period, IMCare met goal for primary care providers and all specialty care availability measures. There were nine households that were not within 30 miles of a primary care provider with admitting privileges specifically, however the primary care providers in network generally work collaboratively to meet enrollee needs, so this is not seen as a barrier for enrollees. Provider to enrollee ratios for obstetrics/gynecology, orthopedics, cardiology and oncology all met goal. In order to ensure specialty care availability, IMCare allows enrollees to see all network and outreach specialty providers in the IMCare service area. In addition, IMCare allows enrollees to see specialty care providers at the nearest out-of-network tertiary care center without a referral or prior authorization.

IMCare met goal for nearly all behavioral health provider to enrollee ratios, but not geographic availability measures. All psychiatrists in the IMCare service area are IMCare network providers; however, there is a long-standing national and rural shortage of this provider type. IMCare allows enrollees to see psychiatrists at the nearest out-of-network tertiary care center without a referral or prior authorization and has participated in local recruitment efforts. During the study period, eight households in northwest Itasca County did not have access to a mental health provider within 30 miles. A recent increase in telemedicine mental health services has improved enrollee access to these services, which would not be reflected on the current GeoAccess map. IMCare network facilities provide medical stabilization for enrollees requiring mental health and chemical dependency assessment/admission, when necessary. In addition, the Itasca County Crisis Response Team provides around-the-clock urgent/emergent behavioral health care to Itasca County residents.

Nearly all ancillary service provider, pharmacy and hospital measures met goal for the study period. Eleven households in northwest Itasca County did not have access to a hospital within 30 minutes. The noted enrollee households must travel approximately 40 minutes to the nearest hospital. This group of enrollees account for less than one percent of the total IMCare enrollment. IMCare contracts with all hospitals within Itasca County and through analysis,

IMCare identified that no hospitals in the surrounding counties would be closer to access for these households, due to the very rural area.

In July 2018, IMCare implemented a tracking system for authorizations to allow for retroactive review of in and out-of-network requests by provider specialty. Per review of this data for the 2019-2020 measurement period, enrollee's utilization of specialty care services out-of-network do not appear to be correlated with unmet access standards. Overall, the ratio of enrollees seeking care out-of-network remains quite low in comparison to total enrollment.

IMCare completed a quantitative and qualitative analysis, by product line, of enrollee DTRs, grievances and appeals data related to network adequacy and experience. During the study period, there were only six denials based on the out-of-network status of the provider, when a network option was available. None were appealed. In addition, there were no enrollee grievances related to issues with provider availability or network adequacy.

Enrollee Experience

Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

An external vendor, as delegated by DHS and CMS, conducted the survey and compiled a report for all public Managed Care Organizations (MCOs). The standardized survey instrument used was the CAHPS. Samples for each IMCare population were generated as outlined below.

- PMAP: A random sample of 1,350 eligible IMCare enrollees, ages 18-64 years, was used.
- MNCare: IMCare data was combined with PrimeWest Health, Hennepin Health and South Country Health Alliance, for a total sample size of 1,350 enrollees.
- MSC+: IMCare data was combined with PrimeWest Health and South Country Health Alliance, for a total sample size of 1,200 enrollees.

Table 1. 2020 CAHPS Survey Completion Rate

	Eligible Sample Size	# of Enrollees who Completed the Survey	Survey Completion Rate
PMAP	1,350	326	24.33%
MNCare	1,350*	467*	35.30%
MSC+	1,224*	664*	56.10%

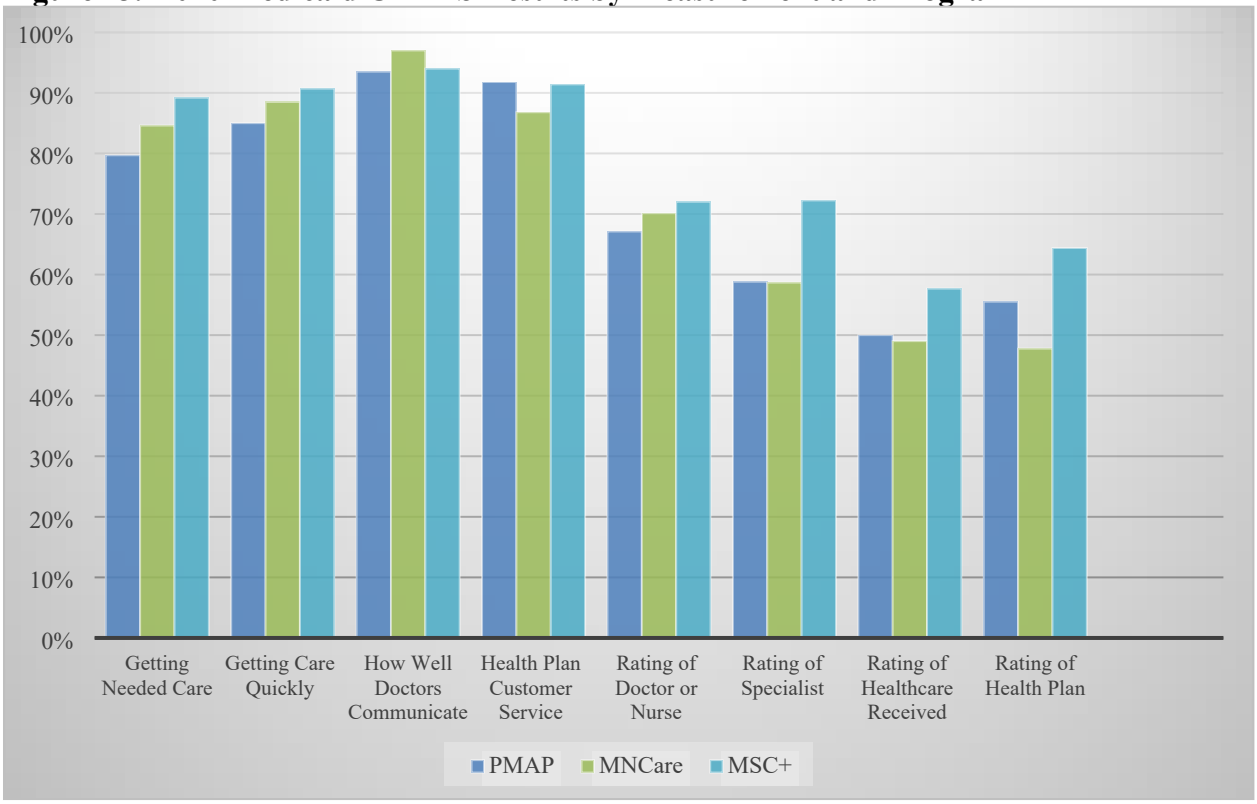
* Combined Sample

The Medicare CAHPS Survey, extracted by a separate vendor than the Medicaid populations, was cancelled in 2020 due to the COVID-19 pandemic; therefore, data is not available for analysis. DHS used the Health Survey Advisory Group (HSAG) vendor again in 2020 and as a result there was a combined enrollee sample for the MNCare and MSC+ population due to inclusion criteria. Of those who responded in the combined samples, IMCare enrollees accounted for 10.5% of responses for MNCare and 10.8% of responses for MSC+.

In 2020, less than 50% of measures across populations were above the MN state average goal. However, all measures below the MN state average were within 5% of goal. One measure, Getting Care Quickly, had year-to-year increases across all populations. This may be attributed to hiring of new providers at many IMCare network facilities, allowing for more appointment availability. Health Plan Customer Services had large year-to-year increases for both PMAP and

MNCare populations; MSC+ rates did not show year-to-year increase, but remained consistently above 90% and met goal. IMCare has increased success in retention of customer service staff, creating a better, more efficient experience for IMCare enrollees. Rating of Health Plan had significant year-to-year drop for MNCare population; however, IMCare only made up a small fraction of the overall responses, so it is difficult to determine the reason for decrease. The MSC+ responses were overall more satisfied across all measures, which is consistent with previous years. Each senior enrollee has a designated care coordinator, who assists with navigating the IMCare network and acts as a point of contact. This may improve overall healthcare experience for these enrollees.

Figure 23. 2020 Medicaid CAHPS Results by Measurement and Program



CAHPS survey results are self-limiting, in that they do not identify specific enrollees who responded with dissatisfaction, to allow for further exploration by IMCare to identify and resolve any specific patterns or problems. Additionally, results for the survey are not available until well into the following year, which make real-time interventions unrealistic.

Senior Enrollee Satisfaction with Care Coordination Survey

IMCare surveys enrollees to assess their level of satisfaction with care coordination services. This includes coordinating services for enrollees across settings of care, including but not limited to needs assessment, service authorization, care communication, and risk assessment. An important element to the care coordination process is evaluating enrollee satisfaction with his or her care coordinator. This evaluation is a DHS contract and NCQA requirement.

In August 2020, IMCare mailed the Care Coordinator Satisfaction Survey to 669 MSHO and MSC+ enrollees. Two hundred fifty-nine responses were received. Ninety-two were from EW enrollees, 140 were from CW enrollees, and 27 were from SNF enrollees. The overall response rate was 38.71%, which is an increase of 8.97% over the response rate of 29.74% in 2019.

As a CBP plan, IMCare capitalizes upon the arrangement with our delegate, Itasca County Public Health, to deliver localized care coordination services. All care coordinators are either IMCare staff or public health staff. The survey data displays that the care coordinators exceed the 80% goal in all aspects of EW and CW care coordination (Figure 24). This is indicative of IMCare's commitment to a strong focus on person-centered planning, as well as the wealth of experience our care coordinators bring to our enrollees. Care coordinators are also very knowledgeable about resources and services available within their immediate and surrounding communities. This commitment, experience and knowledge helps IMCare ensure compliance with its mission of empowering and engaging enrollees in their health care goals. It also ensures the care coordination model is effective and efficient in its service delivery.

In past years, CW and SNF facility enrollee responses were included in one chart. These two populations have very different needs, and some aspects of their care coordination are very different. For these reasons, their responses to this year's survey have been separated, and the 80% goal was not met for SNF enrollees in three questions – M2, M6, and M7. This reflects the fact that SNF enrollees are most often not contacted by phone, and they are not offered services above and beyond what they receive in their facility. Also, in 2019, it was decided to make changes to the survey to tailor it to the three different populations; however, it became apparent that CTD does not allow for separate surveys to be created and mailed to each population. Because of this, the questions were revised, and the same survey was again mailed to all enrollees. It is evident that several questions remain not applicable to many enrollees. Finally, IMCare decided to include some examples of enrollee comments in this year's report. Most of these comments were positive. When they were not, most of them were either neutral or were related to not knowing who the care coordinator is and/or not having met them yet.

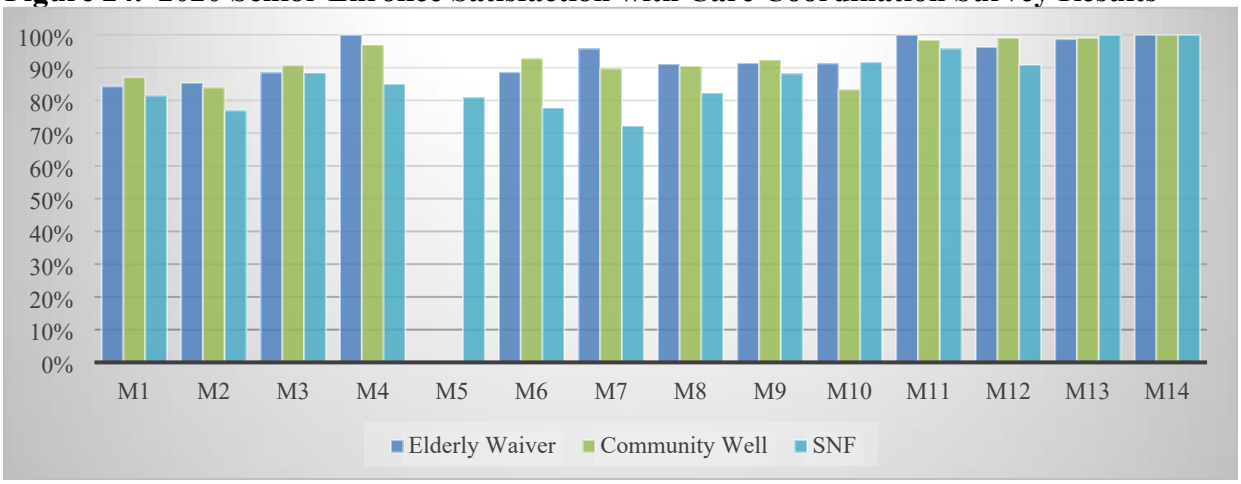
Table 2. Enrollee Satisfaction Survey Measures

M1. Do you know who your care coordinator is?
M2. Have you talked with your care coordinator in person or on the phone?
M3. Do you know how to reach your care coordinator?
M4. Does your care coordinator return your calls in a timely manner?
M5. If you reside in a skilled nursing facility, has your care coordinator attended a care conference with you?
M6. Did your care coordinator inform you of health and wellness opportunities that might be helpful to you?
M7. Did your care coordinator offer you choices about which services and supports are available to you?
M8. Did your care coordinator answer questions about services and supports that are available to you?
M9. Were you able to talk to your care coordinator about questions or concerns you have regarding your services & supports?

Table 2. Enrollee Satisfaction Survey Measures (continued)

M10. If you requested, did your care coordinator make changes to your services and supports?
M11. Has your care coordinator treated you with dignity and respect?
M12. How would you rate your overall satisfaction with your care coordinator?
M13. How would you rate your overall satisfaction with the services & supports you receive?
M14. How would you rate your overall satisfaction with the care you receive in your skilled nursing facility, foster care, adult day services or customized living facility?

Figure 24. 2020 Senior Enrollee Satisfaction with Care Coordination Survey Results



Enrollee Education Sessions

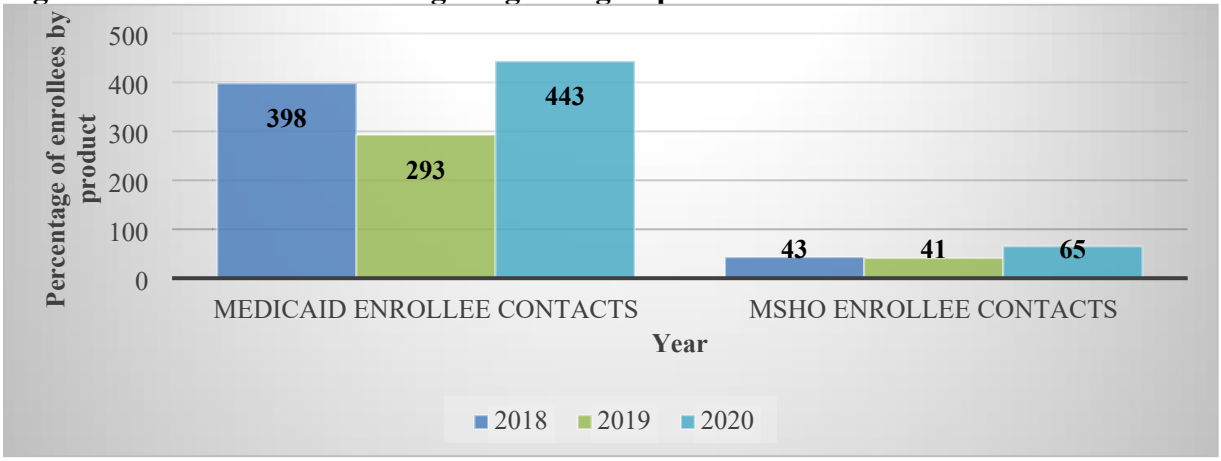
IMCare provides monthly enrollee education. Enrollees new to IMCare are notified in writing of the monthly education sessions when they receive their new IMCare medical cards. The purpose of the education is for enrollees to understand how to use their IMCare medical card, review of the Enrollee Handbook and to learn how to obtain medical care.

2020 Interventions:

- Written notification of monthly enrollee education was sent to individuals who were newly enrolled from January-March 2020.
- IMCare staff were available from 8am-8pm every day of the year to answer questions enrollees may have had regarding their IMCare benefits.

Due to the COVID-19 pandemic, enrollee education sessions were only held in person January-March of 2020. During this timeframe, five PMAP/MNCare enrollees attended enrollee education. During the pandemic, IMCare was able to address enrollee needs via the enrollee services line and tracking of contact logs (Figure 25).

Figure 25. IMCare Contact Logs Regarding Topics Covered in Enrollee Education



Customer Service Call Center Performance

IMCare must ensure that providers, enrollees, and staff members are able to reach the IMCare Customer Service Representatives (CSRs) according to regulatory and accreditation standards. IMCare must maintain low abandonment rates for customer services lines. CMS requires a disconnect rate of 5% or less. IMCare uses the CMS benchmark for internal monitoring.

2020 Interventions:

- IMCare Director, QI/UM Director and Compliance Officer were in close contact with First Call for Help (FCFH) during 2020 to discuss opportunities for improvement and communicated expectations via email, on an ongoing basis.
- IMCare QI/UM Director/s conducted routine monitoring of Prairie Fyre to review call abandonment rates and followed up with staff accordingly.
- IMCare required at least one CSR to be available during regular business hours, except for all-staff or CSR meetings, at which time calls were answered by alternative staff or FCFH.
- Additional IMCare staff were cross trained on addressing calls, to allow for additional coverage during high volume periods.

IMCare uses the CMS benchmark for internal monitoring. The call abandonment rate is not available at this time to determine if IMCare was below the 5% threshold. Per IMCare's internal call monitoring system, Prairie Fyre, only 1.09% of the 8,829 calls handled were abandoned during 2020.

Population Health Management (PHM)

In 2020, IMCare implemented a Population Health Management program to meet DHS Contracts section 7.3, utilizing NCQA PHM Standards. The primary areas of focus for the PHM program are:

- Keeping enrollees healthy
- Managing enrollees with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

Specific goals developed for the PHM program include the following:

1. Goal: Annual increase of enrollees in the target population receiving influenza vaccine.
   Target population: All enrollees enrolled in the plan who exceeded 6 months of age in the measurement year with or without risk factors.
2. Goal: Increase in annual age appropriate wellness exams for enrollees as captured in the following HEDIS measures: Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the 3rd-6th years of life (W34); and Adolescent Well-Care Visits (AWC).
   Target population: All enrollees enrolled in the plan who met age requirements within the measurement year.
3. Goal: Increase in annual age appropriate wellness exams for enrollees as captured in the following HEDIS measures: Breast Cancer Screening (BCS); Colorectal Cancer Screening (COL); Cervical Cancer Screening (CCS); and Chlamydia Screening in Women (CHL).
   Target population: All enrolled adults that meet age requirements in measurement year.
4. Goal: Improve statin therapy for enrollees with diabetes by two percentage points.
   Target population: Enrollees aged 40-75 with diabetes.
5. Goal: Increase follow up after ED visits for mental illness or substance use disorder (SUD) as identified by the following HEDIS measures: Follow-Up After ED Visit for Mental Illness (FUM) and Follow-Up after ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA).
   Target population: Enrolled individuals 13 years of age and older in the measurement year.
6. Goal: Annual reduction in inpatient readmissions in target population.
   Target population: Enrollees 18 years of age and older in the measurement year with two or more chronic illnesses.

2020 Interventions:

- IMCare MCNs were provided Case Management training in May of 2020. Complex Case Management is a component of the PHM program and addressed in the next section.
- IMCare collaborated with a network facility ED Care Coordinator to identify enrollees who frequented the emergency room for conditions secondary to mental health and/or substance use disorders.
- IMCare collaborated with a network facility on addressing enrollees with chronic conditions or frequent ED use through their Community Health Worker.
- Enrollee education via biannual enrollee newsletters included the following topics:
  - Preventing hospital readmissions
  - National Alliance on Mental Illness
  - Classes for chronic conditions and pain
  - The importance of influenza vaccinations
  - Maintaining routine care during the COVID-19 pandemic
  - Routine vaccine information
  - Itasca County Public Health vaccine clinics
- Provider education via biannual provider newsletters included the following topics:
  - New Population Health Management program

    - Case Management and Care Coordination
    - E-visits (another option for enrollees to manage chronic conditions)
- The Population Health Appraisal was made available on the IMCare website, for enrollees to complete a self-rating of their current health status.
- A PHM section was developed on the IMCare website with resources for enrollees regarding the following topics:
    - Child & Teen Checkups schedule
    - Birth to six years of age immunizations
    - Seven to 18 years of age immunizations
    - Adult immunizations
    - Preventative health screening for men
    - Preventative health screening for women

IMCare is required to evaluate effectiveness of the PHM program annually; however, HEDIS 2021 (2020 data) results will be utilized, which are not currently available. The initial report is due to DHS on 07/01/2021, and effectiveness of the IMCare PHM program will be evaluated at that time.

Complex Case Management

The IMCare Complex Case Management (CCM) program identifies enrollees with complex healthcare needs based upon their chronic condition, potential disability, health care activity or any other identified need for case management. The goal of CCM is to assist enrollees in regaining optimum health and/or improved functional capacity; educate enrollees regarding their condition; educate enrollees about self-management and preventative care; reinforce the primary care physician (PCP) prescribed treatment plan; and provide information on resources that are available to enrollees. IMCare assists enrollees with multiple or complex conditions, to obtain access to care and services and coordinate their care.

CCM conditions include, but are not limited to, the following:

- Cancer
- Substance Use Disorder
- Hepatitis C
- Mental health
- Pain
- Restricted Recipient
- Serious medical condition
- State Medical Review Team (SMRT) allowable conditions

IMCare utilizes two distinct processes to identify enrollees for enrollment in CCM that include both administrative/electronic data and/or referral sources. Administrative data reports are reviewed at least monthly and referrals sources are reviewed as received.

Electronic identification sources include:

- Claims data
- Pharmacy data
- Stop Loss Report

- Hospital admission data
- Compassionate Allowance Conditions Report
- Restricted Recipient Report
- Initial enrollee screening

Referral identification sources include:
- Provider referrals
- Discharge planner (inpatient case manager) referrals
- Enrollee service referrals
- Enrollee self–referrals

The CCM program involves a screening, a comprehensive initial assessment of the enrollee's condition, determination of available benefits and resources, development and implementation of a care plan and coordination of services. After an enrollee has been identified for CCM, a registered nurse (RN) will contact the enrollee to complete screening, offer case management services, complete an initial assessment and develop a plan of care as indicated. The RN case manager works closely with the enrollee, the enrollee's legal representative, the enrollee's PCP, and other providers identified by the enrollee's treatment team, to coordinate care and assist with access to needed services. The CCM program is an included benefit to the enrollee. Enrollees can voluntarily enroll with verbal and/or written consent. The program is most successful with participation of the enrollee's family, caregivers and other natural support systems as identified by the enrollee.

The CCM program utilizes a standardized case management process for all enrollees and consists of several key areas including, but not limited to:
- CCM screening to identify need for CCM
- Comprehensive initial assessment and/or reassessment of enrollee's health
- Development of an individualized care plan with Specific, Measurable, Achievable, Realistic and Timely (SMART) goals
- Facilitation of enrollee's referrals to resources
- Follow-up and communication with enrollees
- Self-management plans
- Assessment of progress against case management plans for enrollees

Case managers provide ongoing case management until goals are met, or for as long as the enrollee has identified needs and is willing to receive support and services from the program. Case managers maintain scheduled contact, with the frequency based on varying enrollee need. Generally, case managers provide the following to all enrollees enrolled in the program:
- Support enrollee's adherence to care plans to improve complexities
- Advocate to ensure appropriate services and resources are received
- Education and promotion of self-management in order to empower enrollees to take an active role in their care
- Coordinated and seamless integration of complex services and/or special needs
- Appropriate and timely communication with enrollees, PCPs and other identified team members

- Systematic approach to assessing, planning and provision of case management services to improve health outcomes
- Referral to appropriate medical, behavioral, social, substance use disorder services, specialists and community resources to address enrollee needs

Case management for MSC+ enrollees is the assignment of an individual who assesses the need for services, and coordinates Medicaid health and long-term services for an MSC+ enrollee receiving Elderly Waiver (EW) services and Medicare services, among different health and social service professionals and across settings of care. IMCare provides for case management for community non-EW MSC+ enrollees, community EW MSC+ enrollees, and MSC+ nursing facility residents.

Case Management for community non-EW MSC+ enrollees includes:

- Risk screening and assessment that addresses medical, social, environmental, and mental health factors
- Encouraging enrollees to establish a relationship with a PCP or clinic
- Establishing a communication system of significant health events (e.g., ED use, inpatient stays) between primary care and IMCare/Public Health

Case Management for community EW MSC+ enrollees includes:

- Risk screening and assessment that addresses medical, social, environmental, and mental health factors
- Case management requirements of the Home and Community Based Services (HCBS) waiver
- Assignment of a case manager to assist with coordination of EW services, state plan home care services and other informal or formal services
- Development of a care plan that incorporates an interdisciplinary, holistic and preventive focus and includes advance directive planning and enrollee/family participation
- Protocol to assure a regular schedule of case management contacts with each EW enrollee based on health, and long-term care needs
- Annual face-to-face reassessments (conducted over the phone during the COVID-19 pandemic)
- Communication of the care plan to the PCP
- Communication of significant health events, including ED use, hospital and nursing facility admissions between primary care and EW case managers
- Procedures for promoting rehabilitation of enrollees following acute events and for ensuring smooth transitions and coordination of information and services between acute, subacute, rehabilitation and nursing facilities and HCBS settings
- Facilitation of consumer and family involvement in care planning and preservation of consumer choices
- Provision of caregiver supports and facilitation of caregiver respite to assist enrollees with remaining at home
- Facilitation and coordination of informal supports and preservation of community relationships

- Provision that consumer directed options such as PCA Choice and consumer directed consumer supports waiver services are offered and facilitated at the consumer's choice
- Care plans that identify, address and accommodate the specific cultural and linguistic needs of MSC+ enrollees
- Designation of a case manager who has lead responsibility for creating and implementing the care plan
- Evaluation of the performance of individual case managers including enrollee input

Case Management for MSC+ nursing facility residents includes:

- Assistance with transition during placement of enrollees in nursing facilities and with discharges back to the community
- Periodic review to determine whether discharge to the community is feasible
- Relocation Targeted Case Management services for any nursing facility enrollee who is planning to return to the community and who requires support services to do so

Care Coordination

Care coordination is required for MSHO enrollees. Care coordination ensures access and integrates the delivery of all Medicare and Medicaid preventive, primary, acute, post-acute, rehabilitation, and long-term care services, including State Plan Home Care Services and Elderly Waiver Services. Care coordination ensures communication and coordination of an enrollee's care across the Medicare and Medicaid network provider types and settings, to ensure smooth transitions for enrollees who move among various settings, in which care may be provided over time, to strive to facilitate and maximize the level of enrollee self-determination and enrollee choice of services, providers and living arrangements. It also promotes and assures service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care, and fiscal and professional accountability. Each enrollee is provided a primary contact person who assists them in simplifying access to services and information. Care coordination includes:

- A comprehensive assessment that addresses medical, social and environmental and mental health factors, including the physical, psychosocial, and functional needs of the enrollee
- Comprehensive care plan development that incorporates an interdisciplinary/holistic and preventive focus and includes advance directive planning and enrollee participation
- Care plan implementation based on the needs assessment, the establishment of goals and objectives, the monitoring of outcomes through regular follow-up, and a process to ensure that care plans are revised as necessary
- Care plan evaluation that supports a proactive, preventive approach including an annual (or upon change of condition) comprehensive reassessment and risk assessment
- Establishment of care coordination caseload ratios
- Evaluation of care coordinator performance, including enrollee input

Other care coordination/case management requirements for MSHO include:

- Rehabilitative services following acute events, and ensuring smooth transitions and coordination of information between acute, subacute, rehabilitation, nursing facilities, and Home and Community Based Services settings

- Ensuring access to an adequate range of EW and nursing facility services and providing for appropriate choices among nursing facilities and/or EW services to meet the individual needs of enrollees who require a nursing facility level of care
- Coordinating the medical needs of an enrollee with his/her social service needs, including coordination with social service staff and other community resources such as Area Agencies on Aging
- Notification to enrollees of their care coordinator/case manager
- Coordination with the Veterans Administration
- Referrals to specialists
- Coordination with other care management and risk assessment functions conducted by appropriate professionals to identify special needs, such as common geriatric medical conditions, functional problems, difficulty living independently, polypharmacy problems, health and long-term care risks due to lack of social supports, mental and/or chemical dependency problems, mental retardation, high risk health conditions, and language or comprehension barriers
- Provision of Relocation Targeted Case Management services for any nursing facility resident enrollees who are planning to return to the community and who require support services to do so

Annually, IMCare completes a care plan audit for both internal care coordinators and Itasca County Public Health case managers, to ensure quality standards are met and opportunities for improvement are identified, and issues corrective action plans, if warranted. This facilitates an interdisciplinary, holistic and preventive approach to determine and meet the health care and supportive services needs of enrollees. IMCare randomly samples 30 cases of eligible EW and 30 cases of eligible CW MSHO and MSC+ care plans, 15 due for initial assessment and 15 due for reassessment during the measurement year, of which eight are randomly selected for review. If any of the eight records produce a "not met" score for any of the outcomes in the Audit Protocol/Data Collection Guide, then the remaining 22 files are examined for the outcome(s) resulting in the "not met" findings. Some elements pertaining to assessment apply only to new enrollees (new to IMCare within the last 12 months) and others apply to existing cases (enrolled for more than 12 months). IMCare ensures that there is an adequate number of cases to evaluate compliance per these elements. In 2020, Itasca County Public Health EW care plans were deficient in four elements that did not meet the 95% goal. Internal IMCare non-EW care plans were deficient in one element that did not meet the 100% goal. Corrective action plans were implemented.

2020 MSHO/MSC+ Transitions Report

In accordance with the DHS Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus Services (MSC+) contract and IMCare Model of Care (MOC), Care transition protocols were implemented to ensure continuity of care for MSHO and MSC+ enrollees who move from one care setting to another, related to changes in their health status (e.g., a hospital admission from their home, a hospital discharge to a nursing facility, or a facility discharge back to their home).

IMCare' s contracted providers are required to notify IMCare of planned and unplanned transitions of care within one business day of the transition. Care Coordinators (CC) are required

to complete specific tasks related to the transition, within one business day of the provider notification. The goal of these tasks is to reduce hospital readmissions and improve enrollee outcomes by providing consistent enrollee support during the transition.

IMCare analyzes transition data annually. Monitoring and managing care transitions reduces or eliminates unsafe and fragmented care, which may occur with poorly coordinated transitions of care. Care coordination activities, including transitions, are documented and tracked in CaseTrakker Dynamo (CTD). Entering real-time information in CTD allows IMCare to minimize unplanned transitions and work to maintain enrollees in the least restrictive setting of care. Standards and goals related to transitions were set. In 2020, data for transitions conducted in 2019 were audited. IMCare assessed and ensured that proper notification of transitions was received, and proper follow-up care was given to MSHO and MSC+ enrollees. The data was measured in comparison to the goals and standards, and opportunities for improvement were identified.

In 2019, letters were sent to providers, reminding them of the requirements listed in Chapter 13 of the IMCare Provider Manual (Inpatient Hospital Notification and Authorization), including the requirements for transition notification and sharing of information. In addition:

- IMCare provided CC training to our delegate on the transition process, the importance of each task, and required documentation.
- IMCare CCs attended the monthly MCO Care Coordination Workgroup meetings to exchange ideas and learn from other health plans.
- Annual MOC training was conducted with IMCare delegates.
- IMCare continued to develop relationships and communicated transition needs and requirements to facility discharge planners/social workers.

Adoption of Practice Guidelines

The adoption, dissemination and application of clinical practice guidelines are required by IMCare 2020 Families and Children and Seniors contracts with DHS and 42 CFR §438.236. Per Article 7.1.6 of the 2020 Seniors contracts, "The MCO shall adopt preventive and chronic disease practice guidelines appropriate for Enrollees age sixty-five (65) and older, consistent with accepted geriatric practices." Both contracts require that the practice guidelines:

- are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field;
- consider the needs of the MCO Enrollees;
- are adopted in consultation with contracting Health Care Professionals; and
- are reviewed and updated periodically as appropriate.

The guidelines must also be disseminated to all affected providers and, upon request, to enrollees and potential enrollees. In addition, IMCare must ensure that the practice guidelines are applied to utilization management decisions, coverage of service decisions, enrollee education, and any other applicable areas.

In 2020, IMCare adopted, disseminated and applied the following UpToDate evidence-based clinical practice guidelines:

- Overview of General Medical Care in Nonpregnant Adults with Diabetes Mellitus

- Overview of Preventive Care in Adults
- Geriatric Health Maintenance
- Screening Tests in Children and Adolescents
- Guidelines for Adolescent Preventive Services
- Prenatal Care: Initial Assessment
- Prenatal Care: Second and Third Trimesters

Delegation

Annually, IMCare performs certain oversight functions on vendors who have a contractual responsibility to carry out tasks on behalf of IMCare. IMCare contracts with three vendors to carry out various responsibilities, which are outlined in the CVS Caremark Prescription Benefit Service Agreement, the Delegation Agreement and the Addendum Part D Services for CVS Caremark; the Third Party Agreement (TPA) *State of Minnesota Memorandum of Agreement between the Minnesota Department of Human Services and Itasca Medical Care*; and the Provider Participation Agreement between Itasca Medical Care and Itasca County Public Health. IMCare's examination of delegates is based on three separate standards: NCQA Delegation Oversight Activities, DHS contract requirements, and the delegation agreement with the vendor.

CVS Caremark Delegation Agreement

IMCare is accountable for overseeing the delegated services outlined in the *Delegation Agreement Addendum to Pharmacy Benefit Services Agreement (PBSA)* with CVS Caremark. Each year, IMCare completes a performance review of CVS Caremark to assure all delegated services are being performed in accordance with national quality standards, applicable state and federal laws and regulations, contract terms, and other accrediting and regulatory agencies as appropriate. Additionally, IMCare reviews additional performance metrics to ensure timely delivery of services related to formulary operationalization, claims resolution, and reporting requirements. If it is found that CVS Caremark is not performing the delegated responsibilities, IMCare may require corrective action and repeal any portion of the delegation.

In 2020, thirteen categories were assessed as part of the CVS Caremark oversight process. Assessment was completed through review of each categorical material set which, in total, included over 20 reports and policy and procedure documents. The following is a summary of the oversight categories:

1. Establishing a Retail Pharmacy Network
2. Pharmacy Network Auditing
3. Custom Medicaid Formulary/Uniform PDL/Formulary Management
4. Pharmacy Helpdesk
5. Point of Sale Utilization Management
6. Maintaining Eligibility Data
7. Maintaining Point of Sale Claims Processing
8. Communication Materials
9. Standard Management and Utilization Reports
10. Quality Management Programs
11. DUR Services/Clinical Programs
12. Safety and Monitoring Solution Program
13. General Performance and Monitoring

a. MAC Performance Oversight
b. Encounter Data Review
c. Invoiced and Paid Amount Reconciliation

IMCare found CVS Caremark to be compliant with all oversight categories. There were no identified deficiencies or mandatory improvements.

Minnesota Department of Human Services (DHS) Memorandum of Agreement
MSHO is a program for dual-eligible enrollees who must be eligible for Medicare and Medicaid to voluntarily enroll in MSHO. Due to the need to be eligible for both programs, IMCare contracts with DHS to enroll individuals through CMS and the state eligibility program. DHS is responsible for performing all enrollment functions, including required notices, and submitting a file to IMCare for systems upload. IMCare performs monthly random audits on DHS enrollment files to ensure that all CMS requirements are met and documented as needed. Overall, DHS is not meeting the IMCare standards regarding their delegated responsibilities and IMCare is working to implement a corrective action plan with DHS.

Itasca County Public Health Provider Participation Agreement
IMCare contracts with Itasca County Public Health, as their one and only delegate, to provide care coordination and case management services to enrollees over the age of 65 utilizing EW services. IMCare monitors the timeliness and comprehensiveness of MN Choices assessments and enrollee care plans to facilitate an interdisciplinary, holistic, and preventive approach to determine and meet the health care and supportive services needs of enrollees. IMCare audits a random sample of care plans, using the DHS care plan audit protocol. Overall, Itasca County Public Health is meeting the requirements of care coordination for EW enrollees.

2020 Utilization Management Program Activities

Clinical Criteria for Utilization Management Decisions
At least annually, IMCare evaluates criteria used to make UM decisions. The IMCare Medical Director reviews the criteria used in previous years to determine the effectiveness of continued use. Other available sources are also reviewed. The Medical Director makes a recommendation to the PAC based on research and findings for clinical criteria use in the current year. The PAC is responsible for adopting the clinical criteria. Once adopted, the criteria is distributed to providers via provider update and provider newsletter. The criteria is also linked to the provider area of the IMCare website.

In 2020, IMCare utilized the following policies and guidelines when making UM authorization decisions:

- Centers for Medicare and Medicaid Services (CMS)
- Clinical Practice Guidelines (e.g., UpToDate)
- Community Standards
- Drug Coverage Criteria (e.g., MN Department of Human Services (DHS), CVS/Caremark)
- IMCare Medical, Behavioral, and Pharmacy Policies and Procedures
- Internet Evidence-Based Literature Search (e.g., PubMed)

- InterQual
- Minnesota Department of Human Services (DHS)

Annually, IMCare assesses the consistency in applying these criteria/policies for physician and non-physician reviewers through the interrater reliability review process.

Medicaid Under and Over Utilization
Ensuring appropriate utilization of services is required as per Article 7.1.4 of the 2020 DHS Families and Children contract, "The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*."" Pursuant to 42 CFR § 438.330(b)(3), this structure must include, "mechanisms to detect both underutilization and overutilization of services."

2019 Interventions:

- Enrollee newsletters were sent out in spring and fall of 2019. Article topics included information about preventative wellness visits and screening, vaccines, alternative pain management, cancer screenings, dental visits, opioid abuse, transportation information, and mental health awareness.
- Individual enrollee letters were sent out for well child reminders, mammograms, colonoscopy, and cervical screenings.
- IMCare developed a Facebook page to share upcoming vaccine clinics, preventative screening guidelines and health/wellness events within the community with enrollees and providers.
- IMCare continued the controlled substance (CS) focus study to identify those at risk for substance use conditions.
- IMCare continued the emergency department (ED) focus study to identify individuals who regularly visit the emergency room for mental health or substance use disorders, and made referrals as needed.

A majority of IMCare Medicaid HEDIS utilization measures met goal and were relatively static from 2019 to 2020 (Figures 26 and 27). The 2020 Children and Adolescents' Access to Primary Care Practitioners (CAP) rate was just below the MN state average for both PMAP and MNCare enrollees; however, there was a year-to-year increase for the MNCare population and a less than 1% decrease from 2019 for the PMAP population.

The Mental Health Utilization (MPT) goal was unmet for both PMAP and MNCare populations, as both were above the MN state average and had continued year-to-year increase in utilization. Due to the increase in new network mental health services, and overall improved access to those services, IMCare anticipates that the MPT measure may continue to increase annually. The measure is somewhat limiting in that it includes all levels of mental health care. This makes it difficult to distinguish what levels of care are being utilized by IMCare enrollees. Utilization of outpatient mental health services for the management of a mental health diagnosis is most cost-effective and can prevent the need for higher levels of care.

The Identification of Alcohol and Other Drug Services (IAD) measure did not meet goal for the PMAP population, as it fell just above the MN state average, with a 2% increase from 2019.

Much like the MPT measure, there has been an increase in the number and availability of Substance Use Disorder (SUD) services due to the SUD Reform led by DHS. IMCare also anticipates that IAD rates will continue with an upward trend in the next few years.

The Well-Child Visits in the 3rd-6th Years of Life (W34) rate was below goal for the MNCare population, but had a 6% increase from 2019 for the PMAP population. IMCare had increases in Well-Child Visits in the First 15 Months of Life (W15) and Adolescent Well-Care Visits (AWC) from 2019 to 2020. This may be a result of IMCare Well Child Visit individual outreach letters, preventative health visit reminders in the IMCare enrollee newsletters, and/or electronic reminders for enrollees from their primary network clinics.

IMCare Annual Dental Visit (ADV) rates continue to exceed the MN state average rate for both MNCare and PMAP populations. This is likely due to IMCare's strong dental network, consisting of providers that work collaboratively with one another and with IMCare to ensure enrollees have access to needed dental care.

Table 3. Medicaid Under and Over Utilization HEDIS Measurement Methodology

Measurement Methodology	Data Source
M1. Percentage of enrollees 12 months-6 years of age who had a visit with a PCP during the measurement year and 7-19 years of age who had a visit with a PCP during the measurement year or the year prior to the measurement year. (CAP)	HEDIS Data
M2. The percentage of enrollees 20 years and older who had an ambulatory or preventive care visit during the measurement year. (AAP)	HEDIS Data
M3. The percentage of enrollees who turned 15 months old during the measurement year and who had 0-6 well-child visits with a PCP during their first 15 months of life. (W15)	HEDIS Data
M4. The percentage of enrollees 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. (W34)	HEDIS Data
M5. The percentage of enrollees 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. (AWC)	HEDIS Data
M6. The percentage of enrollees 2-20 years of age who had at least one dental visit during the measurement year. (ADV)	HEDIS Data
M7. The percentage of enrollees receiving any mental health services during the measurement year (including inpatient, intensive outpatient or partial hospitalization, outpatient, ED, or telehealth). (MPT)	HEDIS Data
M8. The percentage of ED visits for enrollees 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 7 days. (FUM)	HEDIS Data
M9. The percentage of enrollees with an alcohol and other drug (AOD) claim who received any chemical dependency service during the measurement (including inpatient, intensive outpatient or partial hospitalization, outpatient or an ambulatory MAT dispensing event, ED, or telehealth). (IAD)	HEDIS Data
M10. The percentage of ED visits for enrollees 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days. (FUA)	HEDIS Data

Figure 26. 2018-2020 PMAP Under & Over Utilization HEDIS Results

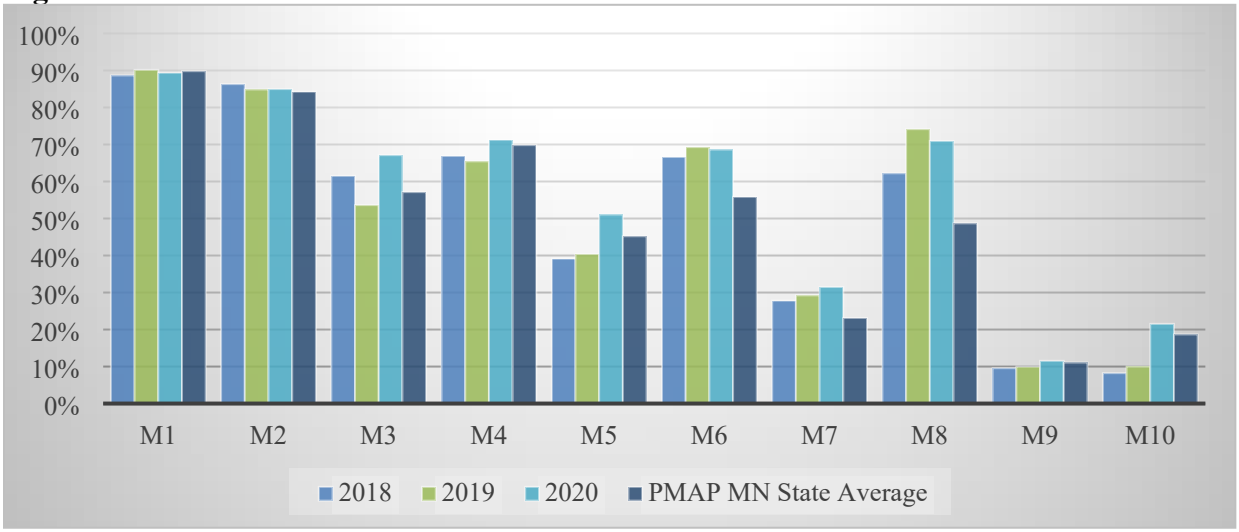
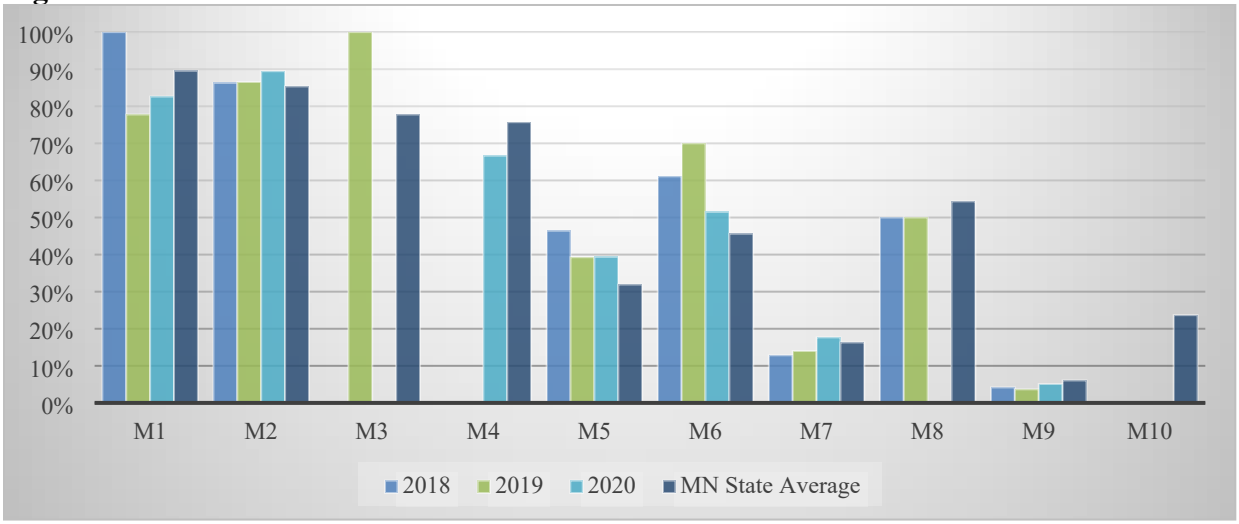


Figure 27. 2018-2020 MNCare Under & Over Utilization HEDIS Results



*Blank measures are data that was not recorded for one or all of the measurement years.

Medicare Under and Over Utilization

Ensuring appropriate utilization of services is required as per Article 7.1.4 of the 2020 DHS Seniors contract, "The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*."" Pursuant to 42 CFR § 438.330(b)(3), this structure must include, "mechanisms to detect both underutilization and overutilization of services."

2019 Interventions:

- Enrollee education regarding mental health care was included in the Spring/Summer and Fall/Winter 2019 enrollee newsletters.
- Enrollee education regarding senior care coordination was included in the Fall/Winter 2019 enrollee newsletter.

- Enrollee education regarding transitions of care was included in the Fall/Winter 2019 enrollee newsletter.
- MSHO enrollees who agreed to have a MNChoices or Health Risk Assessment (HRA) were screened for substance use and depression and educated on the importance of preventative care.
- Enrollee education regarding colorectal cancer screening was included in the Fall/Winter 2019 enrollee newsletter.
- The 2019 Medicare Under and Over Utilization Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/13/2019 and the IMCare External QI/UM Committee on 12/18/2019.

For 2020, IMCare had relatively stagnant year-to-year results for most measures, with a majority within 5% of the previous measurement year (Figure 28). The rate of outpatient visits (AAP) decreased slightly from 2019, but was within 1% of the MN state average. Mental Health Utilization (MPT) increased 1.1% from 2019, but continued to meet goal and fell just below the state average. Colorectal Cancer Screening (COL) fell just below the state average in 2020, but showed slight improvement from 2019. Transitions of Care (TRC), with four measurable components, met goal for all areas, except Receipt of Discharge Information. There was a significant year-to-year decrease in this component, which was attributed to a change in the wording of the technical specifications. The reviewers were very strict in their review in 2020. For next year, IMCare will request clarification from NCQA and/or the HEDIS auditor to determine what meets the standards.

One ongoing barrier to improvement and goal setting is the NCQA national benchmarks and thresholds, which are not available until March of the year following the end of the measurement year. This impedes the ability to implement new interventions for the current measurement year. IMCare will revisit this issue annually, but in the interim, will continue to use the MN state average HEDIS rates to measure under and over utilization.

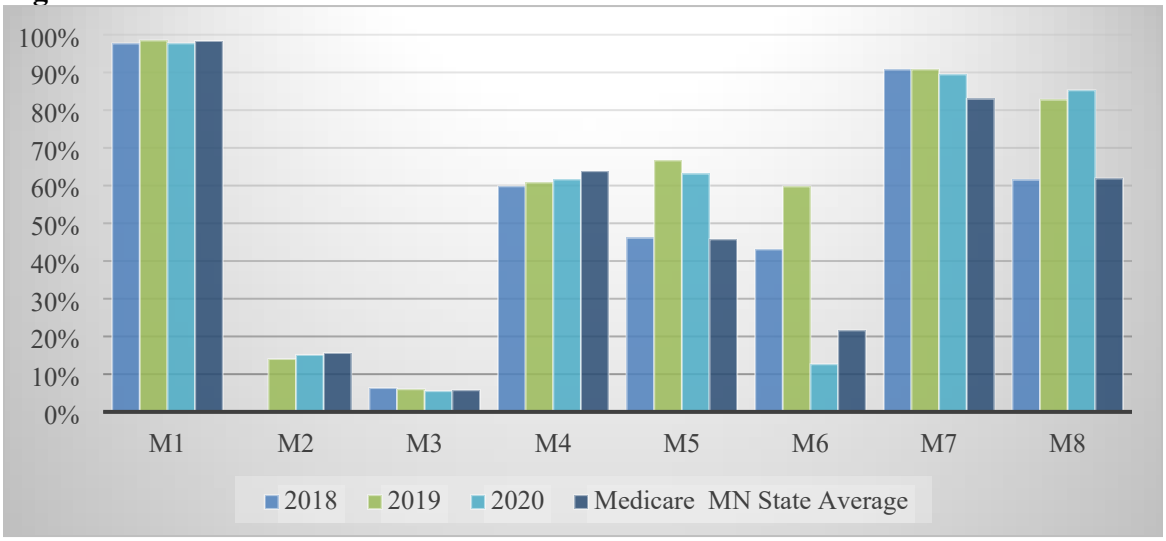
Table 4. Medicare Under and Over Utilization HEDIS Measurement Methodology

Measurement Methodology	Data Source
M1. The percentage of MSHO enrollees who had one or more ambulatory or preventive care visits during the measurement year. (AAP)	HEDIS Data
M2. The percentage of MSHO enrollees who received any mental health services during the measurement year (including inpatient, intensive outpatient or partial hospitalization, outpatient, emergency department and telehealth). (MPT)	HEDIS Data
M3. The percentage of MSHO enrollees with an alcohol and other drug (AOD) claim who received any chemical dependency service during the measurement year (including inpatient, intensive outpatient or partial hospitalization, outpatient or an ambulatory MAT dispensing event, ED, or telehealth). (IAD)	HEDIS Data
M4. The percentage of MSHO enrollees 65-75 years of age who had appropriate screening for colorectal cancer. (COL)	HEDIS Data
M5. The percentage of discharges for MSHO enrollees that had documentation of receipt of notification of inpatient admission on the day of admission or the following day. (TRC)	HEDIS Data
M6. The percentage of discharges for MSHO enrollees that had documentation of receipt of discharge information on the day of discharge or the following day. (TRC)	HEDIS Data
M7. The percentage of discharges for MSHO enrollees that had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. (TRC)	HEDIS Data

Table 4. Medicare Under and Over Utilization HEDIS Measurement Methodology (cont.)

Measurement Methodology	Data Source
M8. The percentage of discharges for MSHO enrollees that had documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). (TRC)	HEDIS Data

Figure 28. 2018-2020 Medicare Under and Over Utilization HEDIS Results



Medication Therapy Management (MTM) Program

The IMCare MTM program is a targeted medication therapy management program for Medicare Part D enrollees intended to optimize therapeutic outcomes through improved medication use. The program identifies individuals with multiple medications and complex health needs and offers them a comprehensive medication review to ensure their medications are working to improve their health. CMS requires that all Part D sponsors incorporate an MTM program into their plan's benefit structure, as described in § 423.153(d)(1). CMS defines MTM program eligibility requirements and core program components. In 2020, CVS Caremark's MTM vendor, for the third year, was Outcomes MTM.

In 2020, plan participants targeted for the IMCare MTM program were those individuals who met the following targeted eligibility criteria:

- Had three or more of the targeted chronic diseases (Asthma, Chronic Heart Failure, Depression, Diabetes, Cardiovascular Disorders, COPD and Osteoporosis-Arthritis-Bone Disease);
- Taking at least eight covered Part D maintenance medications; and
- Likely to incur annual costs for covered Medicare Part D drugs in excess of $4,255.

The MTM program targeted beneficiaries using the following three core interventional components:

- Interventions for both beneficiaries and prescribers
- A comprehensive medication review (CMR)
- Quarterly targeted medication reviews (TMRs) with follow up interventions when necessary

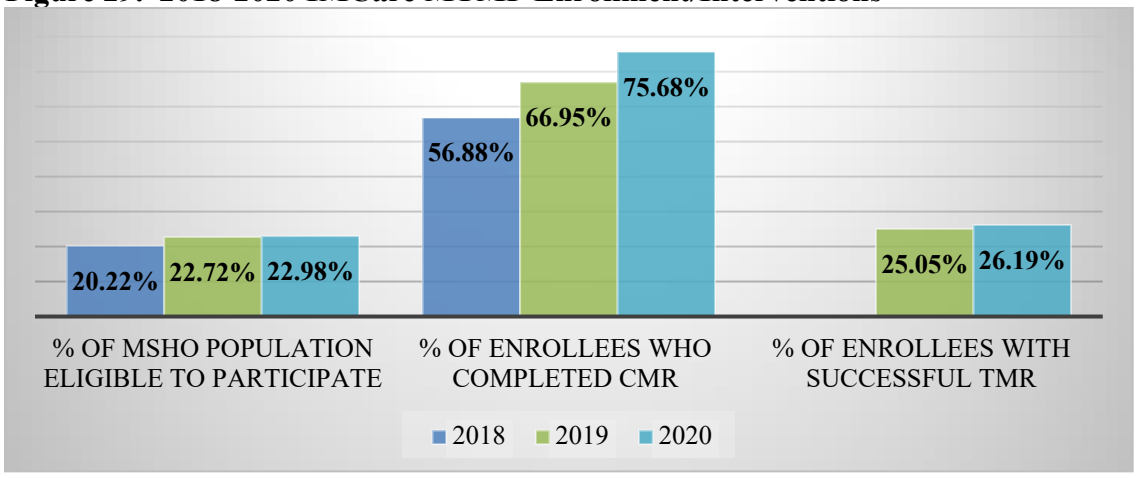
2020 Interventions:

- Comprehensive Medication Review (CMR) – A CMR is an interactive person-to-person or telehealth medication review and consultation conducted in real-time between the patient and/or other authorized individual, such as prescriber or caregiver, and the pharmacist or other qualified provider. The CMR is designed to improve patients' knowledge of their prescriptions, over-the-counter (OTC) medications, herbal therapies and dietary supplements; identify and address problems or concerns that patients may have; and empower patients to self-manage their medications and their health conditions. CMRs are how the MTM program offers interventions to beneficiaries.
- Targeted Medication Review (TMR) – TMR's identified and addressed prescriber opportunities to improve medication-related issues or unresolved issues post-CMR. TMR's are how the MTMP offers interventions to prescribers.
- Similar to 2019, in the first quarter of 2020, the Pharmacy Director shared a list of MTM program eligible enrollees with IMCare case managers. The intent was for nurse case managers to use the list to identify MTM program eligible enrollees currently in case management. The nurses provided education, as part of the annual visit, to enrollees eligible for the MTM program and offered referrals to a local pharmacist to complete a comprehensive medication review.

Overall, the number of complex cases targeted for the MTM program have remained consistent over time (Figure 29). In 2020, a similar percentage (22.98%) of the total IMCare MSHO population met MTM program targeting criteria. CMR completion rates exceeded the increased goal of 70% in 2020, and significantly improved over the previous year. Of the 111 targeted eligible enrollees, 75.67% completed a CMR with a pharmacist, compared to 66.95% in 2019. Local retail pharmacists and IMCare nurses continued to do a great job engaging patients, creating relationships, and completing cases.

In 2020, the TMR success rate was 26.19%. The most common TMR reasons were related to adherence to chronic drugs and use of a high-risk therapy (antidepressant). The most prevalent adherence related TMRs were for statins, inhaled steroids, beta blockers and long-acting insulin. Historically, adherence responds positively to patient engagement and education.

Figure 29. 2018-2020 IMCare MTMP Enrollment/Interventions



*CMR completion rate goal increased from 60% to 70% in 2020. CMS exclusions applied to denominator for 2020. CMS exclusions include those enrolled in MTM for less than 61 days without a CMR, less than 18 years of age, or member is in hospice. TMR success rate methodology changed from 2018.

Provider Satisfaction Survey

As per IMCare contracts with DHS, "The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*."" The Utilization Management (UM) Program Structure section (UM 1) requires that IMCare consider practitioners' experience data when evaluating the UM program. Annually, IMCare surveys network providers to assess their level of satisfaction with and knowledge of IMCare services. Survey questions cover topics such as authorizations, pharmacy management and overall satisfaction. Provider responses offer valuable information that is used by IMCare to make program changes, contributing to the overall goal of delivering optimal service to both enrollees and providers. The 2020 Provider Satisfaction Survey was mailed in January.

2019 Interventions:

- 2019 IMCare UM criteria sources were reviewed/approved by the IMCare PAC on 02/13/2019 and by the IMCare QI/UM Committee on 03/20/2019.
- IMCare authorization/referral requirements were updated throughout 2019 and changes were communicated to providers via provider updates/newsletter.
- Provider education regarding IMCare care coordination and case management services, and the process for referral, was included in the Spring 2019 provider newsletter.
- Annual comprehensive review of IMCare formularies and drug authorization requirements/process was completed and communicated to providers via provider update/newsletter.
- The IMCare website was regularly updated throughout 2019.
- Provider education regarding IMCare's QI Program efforts (e.g., focus studies, performance improvement projects, etc.) was included in the Spring 2019 provider newsletter.
- Provider education regarding the IMCare PHM program was included in the Fall/Winter 2019 provider newsletter.
- Throughout 2019, IMCare followed NCQA guidelines for credentialing individual practitioners and organizational providers.
- The 2019 IMCare Provider Satisfaction Survey Report was reviewed and approved by PAC on 05/8/2019 and the QI/UM Committee on 06/19/2019.

The 2020 Provider Satisfaction Survey had a response rate of 22% (Figure 30). The overall provider satisfaction rate was 98%, increased from 94% in 2019 (Figure 31). All but one 2020 survey question measurement exceeded goal. The only measurement that did not meet goal, provider satisfaction with the level of communication from IMCare's case managers/care coordinators, increased by 3% from 2019, and nearly met the 80% goal in 2020 at 79%. Variations in individual measurements are difficult to interpret due to relatively small denominators; however, IMCare continues to show a high level of overall provider satisfaction.

Figure 30. 2018- 2020 Provider Satisfaction Survey Response Rate by Provider Type

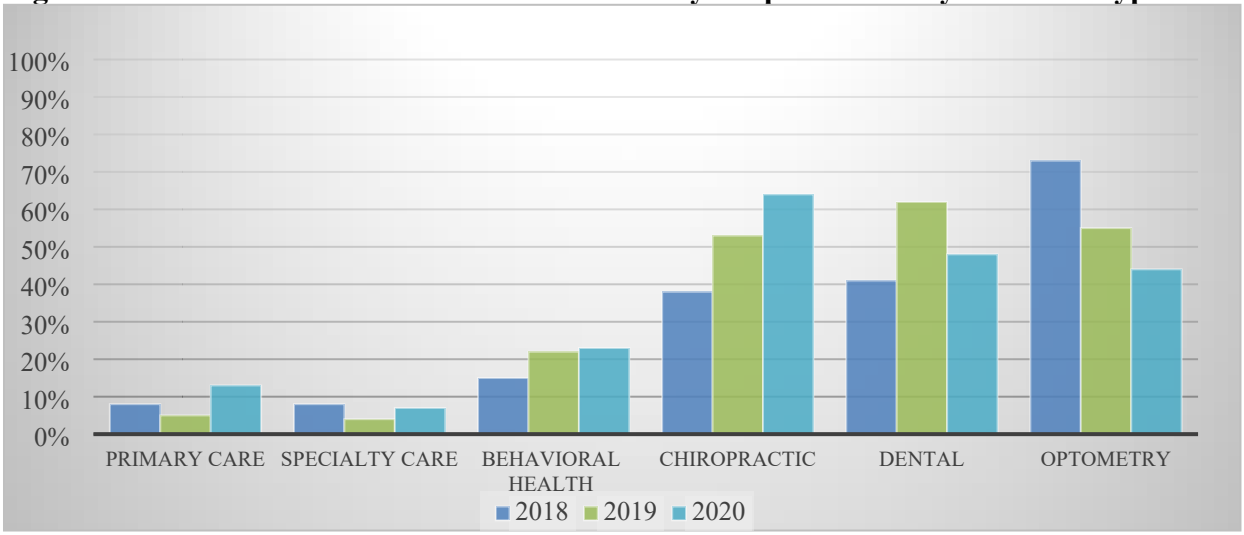
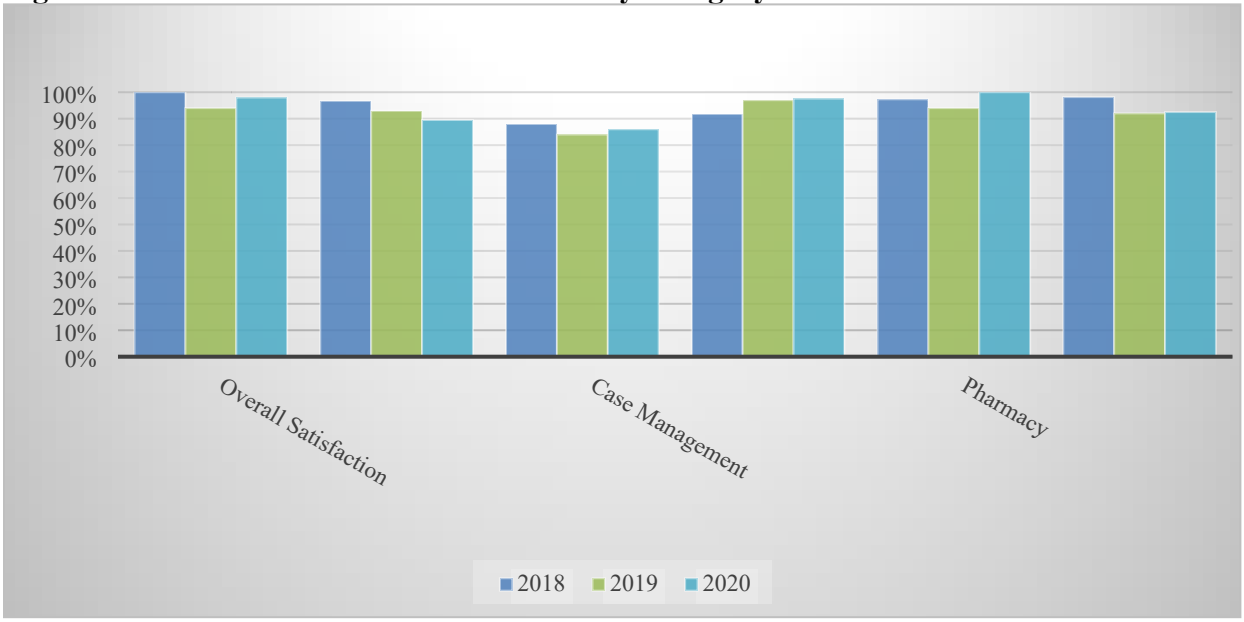


Figure 31. 2018-2020 Provider Satisfaction by Category



Communication Services: Access to Staff/Customer Service Call Center Performance
IMCare provides access to UM staff for enrollees and providers seeking information about the UM process and authorization of care through:

- IMCare staff is available at least eight hours a day during normal business hours for inbound calls regarding UM issues. Staffing varies, but the core hours are 8:00 AM to 4:30 PM. IMCare contracts with an agency to answer and triage after hours and weekend calls. Any UM issues can be forwarded to UM on-call staff.
- Staff is accessible to callers who have questions about the UM process. Enrollees and providers have direct access to UM staff.
- Staff can receive inbound communication regarding UM issues after normal business hours. IMCare accepts inbound communication 24/7 through telephone, email and fax.

The IMCare Director and QI/UM Director/s monitor incoming communication and involve UM staff and the Medical Director as necessary.

- Staff can send outbound communication regarding UM inquiries during normal business hours and after hours as necessary.
- Staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. IMCare provides a toll-free number and staff are available to accept collect calls regarding UM issues.
- IMCare offers TTY services for deaf, hard of hearing, or speech impaired enrollees through Minnesota Relay Service.
- Language assistance is available for enrollees through Language Line to discuss UM issues.

IMCare must ensure that providers, enrollees, and staff enrollees are able to reach the IMCare Customer Service Representatives (CSRs) according to regulatory and accreditation standards. IMCare must maintain low abandonment rates for customer services lines. CMS requires a disconnect rate of 5% or less. (See Customer Service Call Center Performance section for further details regarding 2021 information.)

Appropriate Professionals: Licensed Health Professionals and Review of Non-Behavioral Healthcare, Behavioral Healthcare and Pharmacy Denials

IMCare is required to ensure that qualified health professionals assess the clinical information used to support UM decisions, and that UM decisions are made by qualified health professionals. IMCare Policies and Procedures (P&Ps) require appropriately licensed professionals to supervise all medical necessity decisions, and specify which staff is responsible for each level of decision making. IMCare has several P&Ps to address UM decisions, including Pre-Service Review (Preauthorization or Service Authorization), Post-Service Review, and Concurrent Review. These P&Ps state that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Decisions will be made by qualified licensed health professionals. Appropriate professionals include the Medical Director, Dental Director, Behavioral Health Consultant, chiropractor, or other board-certified physicians contracted with IMCare. These professionals are involved in non-behavioral healthcare denials, behavioral healthcare denials, and pharmacy denials.

Affirmative Statement About Incentives

IMCare's policy states that no individual who is performing utilization review may receive financial incentive based on the number of denials or certifications made. IMCare reviews and updates its Affirmative Statement annually and distributes it to providers and enrollees through direct mail, newsletters, and the IMCare Provider Manual. The Affirmative Statement P&P is also posted on the IMCare website. In 2020, the Affirmative Statement was reviewed; included in the Spring/Summer and Fall/Winter IMCare enrollee and provider newsletters; and distributed with the IMCare privacy notice in all new enrollee and annual Member Handbook mailings.

Timeliness of Utilization Management Decisions

An initial determination on all standard (not expedited) requests for utilization review, including behavioral health and non-behavioral health requests, must be communicated to the provider and

enrollee within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to IMCare. An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted. Notification of an expedited initial determination to either certify or not to certify must be provided to the facility, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. For post-service decisions, IMCare makes determinations within 30 calendar days of receipt of the request.

IMCare utilizes CTD to manage authorization requests. CTD has been designed to track timeliness, including a technical denial option. A technical denial occurs when the set time for review of an authorization has expired. IMCare has never had a technical denial. UM reviewers can see the status of an authorization request in real-time, including time remaining to complete the request. CTD tracks pre-authorization requests, post-authorization requests, and concurrent review requests in an expedited or standard status in queues. The UM queues are monitored by the QI/UM Director/s and Contract Compliance Officer daily. IMCare met all timelines for UM decisions in 2020.

Notification of Utilization Management Decisions

When an initial determination is made to certify for standard requests, notification is provided promptly by written notification to the provider via facsimile. When an initial determination is made not to certify for standard requests, notification is provided by telephone, and by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional and hospital if applicable. Written notification must also be sent to the facility as applicable and attending healthcare professional if notification occurred by telephone. Written notification must be sent to the enrollee.

An expedited initial determination must be utilized if the attending healthcare professional believes that an expedited determination is warranted. Notification of an expedited initial determination to either certify or not to certify is provided to the facility, the attending healthcare professional, and the enrollee as expeditiously via phone, no later than 72 hours from the initial request. Upon request, IMCare must provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service, and identify the basis for the criteria. Written notice must also inform the enrollee and the attending healthcare professional of the right to submit an appeal to IMCare and includes the procedure for initiating an appeal.

IMCare monitors the timeliness of UM decision making and notifications for all requests, and calculates the percentage of decisions that adhere to timelines. CTD can be reviewed at any time by generating a search by authorization type and a date span. IMCare monitors timelines daily through frequent review of CTD pending authorization requests. IMCare met all timelines for notification of UM decisions in 2020.

Clinical Information and Interrater Reliability

The IMCare QI/UM Director regularly evaluates the consistency with which UM clinical staff (non-physician and physician reviewers) applies criteria; medical, pharmacy and behavioral

policies; regulatory directives; and benefits outlined in the benefit documents in their decision making. At least annually, IMCare assesses the consistency in applying these criteria/policies by physician and non-physician reviewers through the interrater review process. When inconsistencies are identified, corrective action plans are put into place to promote consistency.

A random sample of cases are reviewed for:

- Adequate information to make the determination (M1)
- Correct criteria set/policy used (M2)
- Nurse/physician applied criteria correctly (M3)
- Health care professional contacted by phone or fax within 24 hours (M4)

2020 Interventions:

- 2020 UM criteria were reviewed/approved by the PAC on 02/12/2020 and the External QI/UM Committee on 03/18/2020.
- InterQual criteria updates were loaded into CTD (authorization review system) as they became available, throughout 2020.
- CVS/Caremark drug criteria sets were updated in January of 2020, and as they became available thereafter.
- Monthly Utilization Management Operations Workgroup (UM Ops) meetings were held to evaluate, discuss and modify UM criteria, application of criteria and/or processes as needed.
- Interrater audit tool was updated in March 2020 and training provided at UM Ops.

In 2020, IMCare audited a total of 236 determinations with the following breakdown: MCNs were audited on 200 determinations; the Medical Director and QI/UM Physician Consultant were audited on 36 determinations. The MCNs met three of four measurement goals (Figure 32). The unmet area was notification to healthcare provider within 24 hours. Two notifications did not occur within the 24-hour period due to a technical issue with CTD creating documents on a specific date. The notifications occurred on the next business day once the technical issue was resolved. In each measure, the Medical Director and QI/UM Physician Consultant maintained the goal of 100% (Figure 33).

Figure 32. 2018-2020 Managed Care Nurse Interrater Reliability Audit Results

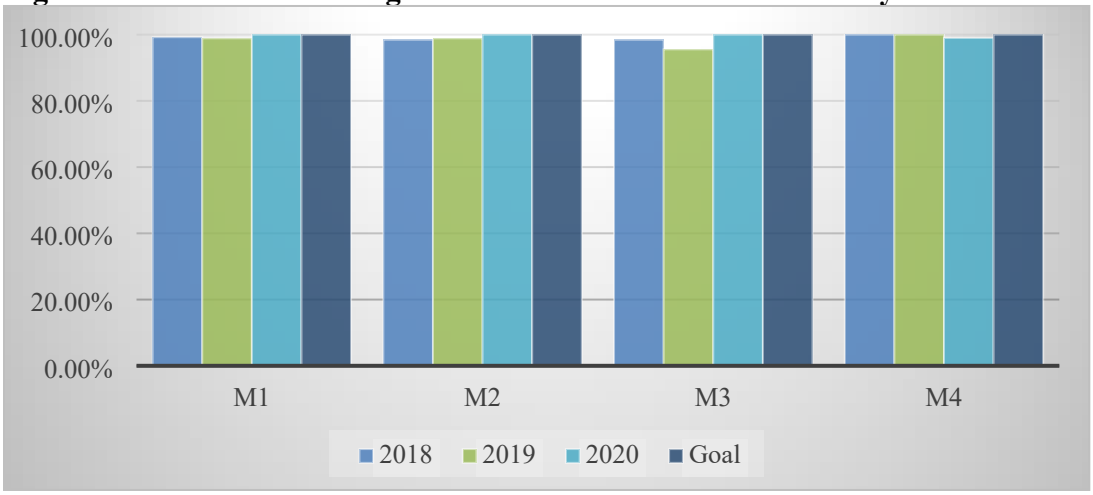
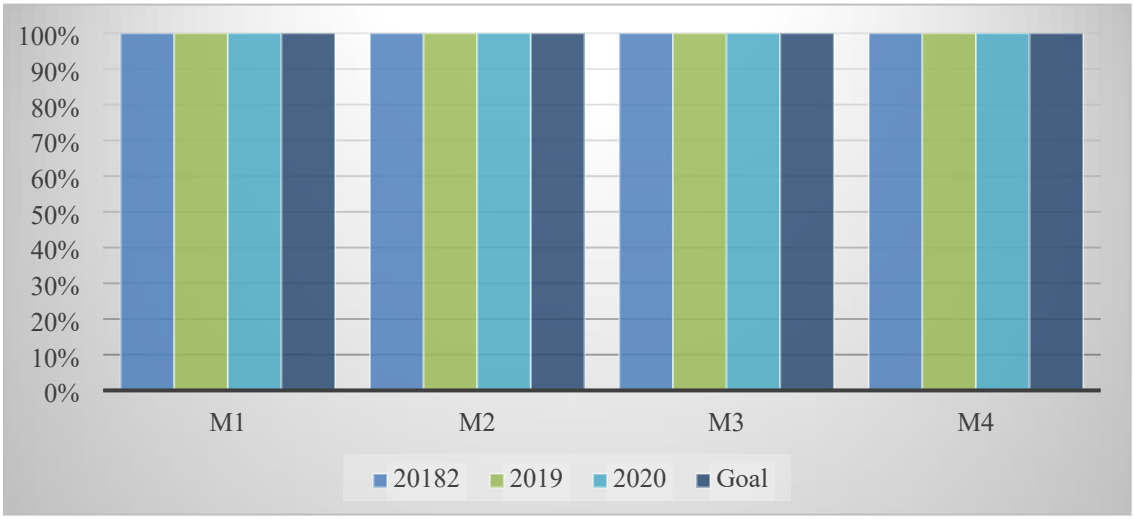


Figure 33. 2018-2020 Medical Director/Physician Consultant Interrater Reliability Audit Results



Denial Notices

IMCare's written Denial, Termination or Reduction (DTR) Notice of behavioral healthcare, non-behavioral healthcare and pharmacy denials that is provided to enrollees and their attending health care professionals must:

- Be understandable to a person who reads at the 7th grade reading level
- Be available in alternative formats
- Be approved in writing by the State
- Maintain confidentiality for Family Planning Services
- Be sent to the enrollee

IMCare uses the State approved format for all DTRs. The DTRs are prepared by the IMCare MCNs and are reviewed by the IMCare QI/UM Director, Health Plan Compliance Coordinator (HPCC), or IMCare Contract Compliance Officer. The HPCC maintains DTR files and is responsible for analyzing for trends, identifying issues, implementing corrective action as necessary, and reporting to the State on a quarterly basis.

2020 Interventions:

- The MCNs worked proactively with practitioners/practitioner staff on authorization requests to minimize lack of information denials.
- The 2019 DTR Report was reviewed/approved by the IMCare PAC on 02/12/2020 and the IMCare External QI/UM Committee on 03/18/2020.
- Continued collaboration with DHS via DHS/MCO workgroup to address service code mapping. Purpose was to align all MCO's service code reporting.
- Worked with claims vendor to identify misidentification of service categories and update claims system as necessary. IMCare now participates in classifying new CPT/HCPCS codes with claims vendor.

In 2020, IMCare sent 340 DTR Notices of action. Consistent with previous years, a majority of the DTRs were for Service Authorization (82%). Most of the remaining DTRs were requests for

services where more information was needed in order to make a decision, followed by the submitted records did not meet coverage criteria. This endorses IMCare's service and drug authorization requirements.

IMCare's 2020 DTR numbers were significantly less compared to previous years. This can be attributed to reduced requests for elective services and reduced change in service agreements for EW due to COVID-19. Dental denials were drastically reduced, and again, that can be attributed to COVID-19. The reduced number of dental preventive visits for a good portion of the year led to a reduced number of restorative services being requested.

An enrollee is assessed for eligibility of some services that are consumer driven services (e.g., EW and Personal Care Assistance (PCA)) and there are services for which Itasca County Health and Human Services determines eligibility (e.g., Mental Health Targeted Case Management (MH-TCM) for adults and children). These services are typically approved though a service agreement (service authorization), for a period of time. Denied, terminated or reduced services provided under a service agreement are largely enrollee choice, with the balance typically being loss of, or change in eligibility for the program. IMCare is required to issue notices, even when the services are denied, terminated or reduced upon enrollee request.

IMCare MCNs focus on provider outreach when processing drug and service authorizations, allowing them to inform practitioners of the requirements for requested procedures, medications, and/or services throughout the review process. In instances where there was lack of information or documentation to support a request, the nurses worked diligently to coordinate with the practitioner's support staff to complete the process. This outreach reduced the number of denials for lack of information, subsequently reducing appeals. In addition, the IMCare Pharmacy Director assists with practitioner and pharmacy education of the drug authorization request process. The experience and knowledge of the Pharmacy Director affords enhanced collaboration between IMCare, practitioners/pharmacies and CVS Caremark, IMCare's PBM.

Appeals

IMCare must investigate and respond to all appeals to remain compliant with federal and state statutes, rules and regulations, and CMS and DHS contracts. This includes establishing and implementing a corrective action plan when appropriate. An appeal can be initiated verbally or in writing by:

- An IMCare enrollee or an enrollee's authorized representative;
- The legal representative of a deceased enrollee's estate;
- The enrollee's attending healthcare professional for medical necessity; or
- A healthcare professional acting on behalf of the IMCare enrollee, with the enrollee's written consent.

MN Statutes, § 62Q.72 (Record Keeping; Reporting) and 62M.06 (Appeals of Determinations not to Certify), DHS Contracts (Families & Children/130029; Seniors/130037), Sections 8.4 (MCO Appeals Process Requirements), 8.6 (Maintenance of Grievance and Appeal Records) and 8.9 (Reporting of Appeals to the State); and, 42 CFR 438, Subpart F (Grievance and Appeal System) direct the IMCare appeals process.

The Health Plan Compliance Coordinator (HPCC) is responsible for coordinating the appeal process from the initial contact through enrollee notice of the final appeal resolution/ determination. The HPCC documents the entire process through reporting and maintenance of appeal records for future reference and audits.

An appeal is an oral or written request from the enrollee, an enrollee's representative or a provider acting on behalf of the enrollee with the enrollee's written consent, to IMCare for review of an adverse benefit determination by IMCare. IMCare has written procedures in place for thorough and consistent handling and response to appeals. Any reasonable assistance in completing forms and taking other procedural steps, including but not limited to providing interpreter services and toll-free numbers that have adequate TTY and interpreter capability is provided to enrollees.

If IMCare receives additional information and/or documentation that was not initially submitted in the original request, the information is used during the appeal investigation and review. All information and/or documentation that accompanies the appeal request is reviewed by the reviewer who made the initial determination. If the additional information and/or documentation does not reverse the initial adverse benefit determination, the appeal request must be reviewed by an independent physician, other than the physician who made the adverse benefit determination. IMCare must ensure the physician is in the same or a similar specialty as the requesting attending healthcare professional. IMCare has contracted with the Medical Review Institute of America (MRIoA) to conduct appeal reviews and determinations that cannot be conducted by the IMCare Medical Director, the IMCare QI/UM Consultant, or an IMCare dental reviewer.

IMCare utilizes a case management system (CTD) as the source of data collection and maintenance of appeals records. Quarterly and annual appeal reports are also generated from CTD.

IMCare has a full and fair process for resolving enrollee disputes and responding to enrollee requests to reconsider a decision they find unacceptable regarding their care and service. IMCare must resolve each appeal as expeditiously as the enrollee's health requires, but cannot exceed 30 days after receipt of a standard appeal and within 72 hours after receipt of an expedited appeal. An extension of 14 days is available for standard and expedited appeals if the enrollee requests the extension, or IMCare justifies both the need for more information and that an extension is in the enrollee's best interest. IMCare provides a written notice of resolution for all appeals and includes a copy of the enrollee rights notice and a language block. IMCare utilizes CTD to document, track and report appeals.

IMCare ensures that the individual making the decision on appeal was not involved in any previous level of review or decision-making. When deciding an appeal regarding denial of a service for medical necessity, IMCare ensures that the individual making the decision is a healthcare professional with appropriate clinical expertise in treating the enrollee's condition or disease. When a decision is reversed by the appeal process, IMCare complies with the appeal decision promptly and as expeditiously as the enrollee's health condition requires and pays for any services the enrollee received that are the subject of the appeal.

2020 Interventions:

- Developed staff education regarding appeals. Education included what appeals are, how they are applicable to each staff's job duties and how to elevate issues to the HPCC. Training was delivered in small groups to facilitate questions applicable to each department within IMCare. The training was conducted in January and February 2020.
- Presented an overview of the appeal program and initiatives happening within the program to the Itasca County Board of Commissioners (IMCare's governing body).
- A weekly internal Appeals and Grievances Workgroup (Internal AG) continued to monitor, review, discuss and analyze appeal documentation and processes as needed to identify potential issues and/or training needs.
- Continued to update the prior authorization list to streamline the process, and remove select authorization requirements.
- Continued collaboration with DHS and claims vendor to identify mis-identification of service categories and update systems as necessary.
- The 2019 Appeal Report was reviewed/approved by the IMCare PAC on 02/12/2020 and the IMCare QI/UM Committee on 03/18/2020.

In 2020, IMCare received 76 appeals due to billing & financial issues and eight appeals related to services and/or benefits. Categories of service were:

- Dental (3)
- DME (2)
- Emergency Room (5)
- Hospital (9)
- Pharmacy (2)
- Professional Medical Services (55)
- Therapies (1)
- Transportation – Ambulance (4)
- Vision Services (1)
- Elderly Waiver (2)

<u>Eight Service Appeals</u>

An enrollee's parent submitted an appeal on behalf of minor child. The septoplasty procedure was denied as not meeting InterQual criteria. Additional clinical documentation was obtained at the request of enrollee's parent and the denial was overturned.

A provider appealed denial of a diagnostic nerve block to determine whether surgery would be a viable option to help enrollee discontinue pain medication. InterQual criteria was not met after review by level 1 and 2 reviewers. Level 2 reviewer did not overturn the denial and appeal was sent to MRIOA to be reviewed due to the specialty of the requesting provider. It was found that the planned procedure was medically necessary, and the denial was overturned.

A provider appeal was for an epidural injection for spinal stenosis. The service was denied for not medical standard for condition and care requested would not maintain enrollee's health. Additional documentation was submitted by the provider and the denial was overturned.

An enrollee's parent submitted an appeal on behalf of minor child. The procedure was for a circumcision which was denied as not meeting medical necessity in UpToDate. Appeal was reviewed, the procedure was determined medically necessary due to a birth anomaly, not cosmetic in nature. The denial was overturned.

An enrollee appealed denial of dental crowns. The procedure was denied as not covered in enrollee's benefit set. Appeal was reviewed and the denial was upheld.

A provider appealed denial of open periprosthetic capsulotomy, breast (bilateral) and plastic, reconstructive, and aesthetic breast procedure with prosthetic implant (bilateral). The request was denied as the right side did not meet UpToDate criteria for medical necessity. The provider submitted a subsequent request for the left side only and it was approved. The enrollee had the procedure on both sides and the provider submitted additional documentation of clinical information that was found during the procedure that supported medical necessity. The denial was overturned.

IMCare received a state appeal from MN DHS. The appeal was regarding an LTC assessment and denial of initial EW services. IMCare contacted the MN DHS state appeal office as it was felt the appeal was assigned to IMCare incorrectly. MN DHS agreed and retracted the appeal from IMCare. IMCare dismissed the appeal.

A provider appealed denial of split prescription for 2 pairs of glasses. The request was denied as not meeting the dispensing standard for MDHS which allows for 1 pair of glasses every 2 years. Provider submitted additional information and the denial was overturned.

2020 General Appeal Information and Opportunities

IMCare's appeal and grievance program received a deficiency in the Triennial MDH Quality Assurance Examination (QAE) & DHS Triennial Compliance Audit (TCA) conducted by MDH in August 2018. Based on the audit findings, IMCare drafted a corrective action plan (CAP) that was accepted by MDH and DHS in January 2019. All objectives outlined in the CAP were completed in 2019 and 2020. A key component of the CAP was staff education. Staff training was developed and administered to all IMCare and Public Health nurse case managers early in 2020. The goal of the education was to help staff identify how their job intersects with enrollee grievances and appeals and the processes in place to elevate issues to the HPCC when appropriate. IMCare was required to participate in an MDH QAE & TCA mid-cycle examination in June 2020, to assess IMCare's progress with the deficiency. IMCare was found to have corrected the deficiency and to be compliant with all requirements in handling of appeals and grievances.

IMCare's 2020 appeal numbers were significantly higher than the previous year. This can be contributed to a change in process. There were 55 unique enrollees with appeals that accounted for 84 appeals. An example of why one complaint may generate multiple appeals would be if an enrollee receives one bill from a provider, but there were multiple claims that accounted for the bill. Per guidance, one appeal is processed for each claim.

Overall, IMCare has a thorough utilization review process that is reviewed regularly and adjusted as needed. An IMCare MCN reviews a request, and if the request does not meet medical necessity criteria, it is transferred to the IMCare Medical Director or QI/UM Consultant for further review in the timeframes set out in policy. This affords the member careful consideration to all available criteria and community standard resources by the physician reviewer. Upon adverse benefit (denial) determination, the Denial, Termination or Reduction (DTR) Notice is issued to the enrollee and attending healthcare professional. The DTR provides specific, clear information why the request was denied and contains health plan appeal rights should the enrollee choose to exercise the next level of appeal. Once a health plan appeal is processed a resolution letter is issued to the enrollee and attending healthcare professional which contains state appeal rights. If the enrollee feels the outcome is still adverse, they can file a state appeal and can request IMCare help them with that process. The attending healthcare professional can also file a state appeal with written permission from the enrollee.

The Utilization Review (UR) Workgroup continues to review requirements that inhibit payment of claims or were not flagging for utilization review in the adjudication process. Processes were developed to communicate with providers, especially those not in network, as to the outcome of submitted claims.

Emergency Services

Enrollees have the right to available and accessible emergency services, 24 hours a day and seven days a week. IMCare informs its enrollees, through the Member Handbook, how to obtain emergency care for treatment of emergency medical conditions. Emergency services are covered whether provided by participating or non-participating providers and whether provided within or outside of the IMCare service area. IMCare does not require a service authorization as a condition for providing medically emergent services; hold the enrollee liable for payment concerning the screening and treatment necessary to diagnose and stabilize the condition; or prohibit the treating provider from determining when the enrollee is sufficiently stabilized for transfer or discharge. IMCare claims procedures include reviewing for inappropriate denials in queued claims, prior to payment. IMCare QI/UM staff monitor claims to verify that all emergency room and stabilization of care services are paid according to benefit and not denied because of lack of service authorization. If claims have denied for lack of authorization, they are reprocessed.

IMCare monitors over-utilization of ED visits through the ED Utilization Focus Study. A report is generated monthly for all enrollees who have four or more ED visit claims paid in a calendar year. IMCare MCNs and/or Care Coordinators review the reports to identify enrollees for case management, fraud waste and/or abuse activities and enrollee education. Refer to the ED Utilization Focus Study section for further details.

Pharmaceutical Management

IMCare has developed and regularly reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence. P&P 2.07.17 titled Pharmacy Management identifies the clinical evidence to adopt pharmaceutical management procedures, including government agencies, medical associations, national commissions, peer-review journals and authorized compendia. IMCare collaborates with pharmacists, practitioners, and the

PBM (CVS Caremark) on the development of the formulary, within compliance of the DHS PDL and management procedures. Pharmaceutical management procedures are communicated to providers via direct mail, e-mail, fax, and the IMCare website.

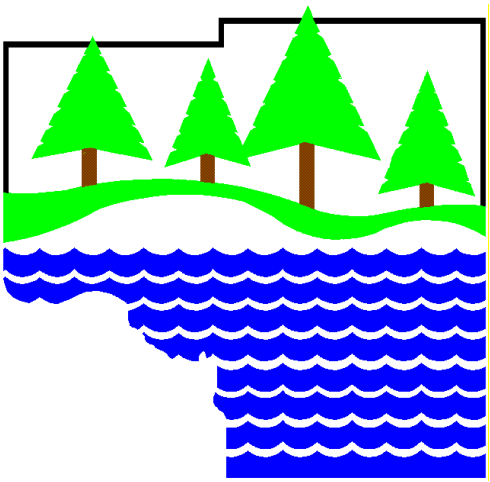
In 2020, Pharmaceutical and Pharmaceutical Management procedures were communicated to enrollees and prescribing practitioners. This information included co-payment information; prior authorization requirements; limits on refills, doses or prescriptions; use of generic substitutions; and covered pharmaceuticals. All information was available on the IMCare website as well.

CVS Caremark, on behalf of IMCare, identifies and notifies enrollees and prescribing practitioners affected by a Class II recall or voluntary drug withdrawal from the market for safety reasons. IMCare requires CVS Caremark to have an expedited process for prompt identification and notification of enrollees and prescribing practitioners affected by a Class I recall. Policies and procedures reflect this.

The IMCare Pharmacy Exceptions P&P 2.07.16 describes the process for exceptions, including making an exception request based on medical necessity; obtaining medical necessity information from the prescribing physician; using appropriate practitioners to consider exception requests; timely handling of requests; and communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request.

Contact Information

If you have questions or comments about any information contained in this report, please contact the IMCare QI/UM Director, Alexis Martire, at (218)327-6199, (800)843-9536 ext. 2199 email to alexis.martire@co.itasca.mn.us.



2021 ITASCA MEDICAL CARE UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Approved by:

IMCare External QI/UM Committee:
Itasca County Board of Commissioners:

Mission Statement...

The IMCare mission is to ensure access to high-quality, patient-centered, cost-effective health care for Itasca County residents through coordination and collaboration with local community partners and providers.

Utilization Management (UM) Program Description
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Introduction

The Itasca Medical Care (IMCare) program is administered by Itasca County Health and Human Services (ICHHS). IMCare enrollees are those who are eligible for benefits under the Minnesota Health Care Program (MHCP) Prepaid Medical Assistance Program (PMAP) and MinnesotaCare (MNCare). IMCare was established in 1982 with General Assistance Medical Care (GAMC). The Prepaid Medical Assistance Program (PMAP) was implemented on July 1, 1985, as a demonstration project and expanded to include MNCare in 1996. In 2001, IMCare become a County Based Purchasing (CBP) organization. Minnesota Senior Care Plus (MSC+) was added in June of 2005 and a Medicare Advantage product, Minnesota Senior Health Options (MSHO), was added in January of 2006.

Itasca County contracts with the Minnesota Department of Human Services (DHS) to provide PMAP, MNCare, MSHO, and MSC+ medical benefits through the IMCare program. IMCare receives monthly capitation from DHS for all IMCare enrollees. There is a Memorandum of Understanding (MOU) between Centers of Medicare and Medicaid Services (CMS), DHS and IMCare to administer the dual benefit, MSHO. The financial risk for medical services and behavioral health services is assumed by Itasca County. Itasca County dentists, chiropractors, and vision providers assume financial risk for their respective service groups, in their contract with IMCare. IMCare staff administer the program and pay claims to providers. IMCare staff are ICHHS employees. The administrative costs of the IMCare program are reimbursed to ICHHS out of the IMCare program funds. The IMCare program does not utilize Itasca County levy money.

IMCare network providers include:

- Primary care and multispecialty clinics within Itasca County and eight outlying clinics
- Hospitals within Itasca County and two outlying hospitals
- CVS National Network
- Substance Use Disorder (SUD) providers within Itasca County and one outlying provider
- Dental providers within Itasca County and two outlying providers
- Behavioral Health providers within Itasca County and nine outlying providers
- Vison providers within Itasca County and two outlying providers
- Chiropractic providers within Itasca County and two outlying providers

Purpose

IMCare and its network providers are committed to the delivery of optimal and cost-effective health care to its enrollees. IMCare strives for continuous improvement in the quality of health care services and the health status of the population served. A comprehensive utilization management (UM) program directs IMCare's efforts.

The scope of the UM program is designed to assess the accessibility of services, the quality of services, and the appropriateness of all health care services. Soliciting enrollee perceptions of the health care services they receive, as well as their interactions with IMCare, are vital components of the UM program.

The UM program encompasses all aspects of care delivered by providers, including medical, behavioral health, SUD, dental, vision, chiropractic and pharmacy services.

The UM Program Description is designed to meet state and federal regulations, and national accreditation standards. IMCare has a well-structured UM program and makes utilization decisions affecting the health care of enrollees in a fair, impartial and consistent manner.

Goals/Objectives

The goals and objectives of the IMCare UM Program include:

- To develop a meaningful and thoroughly executed UM Program.
- To implement a standardized, comprehensive, and consistent UM program, which directs appropriate, cost-effective care, and is responsive to the health care needs of enrollees.
- To create an effective UM program that allows for early detection and intervention of inappropriate utilization or waste.
- To ensure that enrollee receive care that aligns with evidence-based practice guidelines or community standards.
- To continually monitor, evaluate and optimize health care resource utilization in collaboration with contracted providers.
- To ensure that state and federal regulatory requirements are met, and that policies and procedures support the requirements.

UM Structure and Accountability

The IMCare UM Program is structured to both manage the utilization of resources and maximize the effectiveness of care and services provided to enrollees. Continuous improvement includes an ongoing effort to improve the efficiency, effectiveness, and/or performance of services, processes, capacities and outcomes. The program encompasses a broad spectrum of evaluation activities aimed at ensuring compliance with utilization standards.

IMCare utilizes an annual Quality Improvement/Utilization Management (QI/UM) work plan to direct activities. UM activities are performed by the IMCare Quality Improvement/Utilization Management (QI/UM) Director/s, Medical Director, Pharmacy Director, Behavioral Health Consultant, QI/UM Consultant, Managed Care Nurses (MCN), Senior Care Coordinators, Compliance staff and Data Project Coordinators, along with other administrative support staff.

The IMCare medical, dental and pharmacy directors provide doctoral level clinical leadership to the IMCare UM Program, through in-depth provider updates and provider feedback regarding system improvements; authorization and formulary development; education of staff, providers and pharmacists; staff training on new medical and pharmaceutical treatment paradigms; specialty pharmacy design/access; participation on state level formulary committees; one-on-one provider education regarding clinical-appropriateness of treatment and prescription medications; and, past working experience with providers, which aids in provider/facility cooperation with IMCare UM activities.

The IMCare Population Health Management (PHM), Case Management (CM) and UM programs have a symbiotic relationship, resulting in a continual referral stream between programs and enhanced services for enrollees. Through the UM program, enrollees may be identified for other IMCare programs, while MCNs are conducting medical necessity reviews for service or medication authorization requests. Additionally, IMCare has various utilization reports that identify enrollees with chronic conditions, specialty medication use, readmissions, and patterns of high utilization or high cost. This allows for early education of plan resources and appropriate utilization, as indicated. Conversely, enrollees who participate in IMCare CM or PHM programs that need additional services, durable medical equipment, or medications that have prior authorization requirements, can obtain assistance with coordinating the authorization process to prevent delay in obtaining necessary services. This reduces barriers to care and improves overall enrollee and provider satisfaction. Due to IMCare serving the local population and small staff size, enrollees receive a unique experience, in which staff assisting them have a greater understanding of their overall needs, due to the ability to work collaboratively. This collaboration focuses on five main goals:

- Continual reduction of the burden of conditions for enrollees;
- Safe, effective, patient-centered, timely and efficient delivery of care;
- Regular monitoring of enrollees and consistent follow-up;
- Incorporation of key concepts, including patient empowerment, shared knowledge and clinician cooperation; and
- Ongoing staff education on best practices and effective treatment methodologies through evidenced-based resources.

In addition, the close-working relationship between UM, PHM and CM allows for immediate consultation and problem-solving activities for rapid resolution of enrollee/provider issues and improved overall care. This collaborative team approach often results in program improvement ideas, which are then considered by the IMCare Leadership Team and/or oversight committees (e.g., the Provider Advisory Subcommittee (PAC), External Quality Improvement/Utilization Management (QI/UM) Committee and the Stakeholder Advisory Committee (SAC)).

The systems that support the IMCare UM Program include, but are not limited to, Amisys, CareAnalyzer, CaseTrakker Dynamo (CTD), Confluence, Microsoft SQL Server Reporting Services (SSRS), HealthX, JIRA and RxNavigator. CareAnalyzer is used as a predictive modeling tool. SSRS and Amisys reports are used to evaluate claims data. CTD contains CM and utilization review data. RxNavigator is used to evaluate pharmacy claims data.

The data collected through these various systems is utilized in a variety of ways. CareAnalyzer is used to identify enrollees with co-occurring health care conditions and/or certain utilization patterns, who may benefit from intensive CM. The MCN reaches out to identified enrollees and offers case management, outlining the benefits of these services to better manage their identified conditions/issues. CareAnalyzer is also used in a broader context for National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) activities. CTD is used to identify, track and monitor enrollee contacts, complaints and authorizations, and it also encompasses CM and PHM activities. SSRS and Amisys reports are accessed to obtain the enrollee's total cost of care, frequency of health care access and type of access, over and under-utilization (e.g., individual, specific or entire population, provider, etc.)

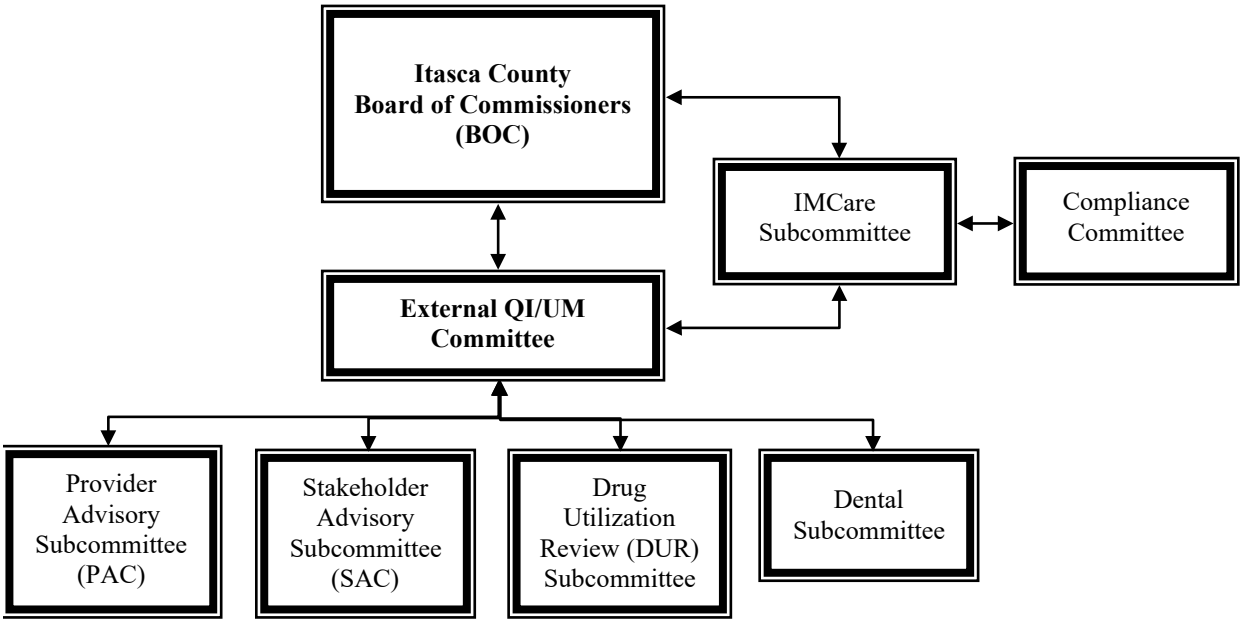
and various other ad hoc reports. RxNavigator is utilized for CM, monitoring for completion of treatment, medication adherence, and to screen for enrollees displaying patterns of medication misuse or abuse. A compilation of these reports is used by QI/UM staff to identify enrollees who have over or under utilization of services, and to refer enrollees to CM.

Data used for IMCare UM program activities is initially analyzed by an IMCare Data Project Coordinator, to ensure accuracy of the findings. The data is provided to the assigned QI/UM staff, who conducts a quantitative and qualitative analysis, and prepares a preliminary report. The report is presented to the various IMCare committees for review and identification of recommendations, interventions, and barriers to improvement. UM goals are also identified. A final report, including committee recommendations, is written and subsequently approved by the IMCare External QI/UM Committee and the Itasca County Board of Commissioners (BOC). A summary of the final results is included in the Annual UM Program Evaluation. Identified improvement goals are incorporated into the annual QI/UM work plan, to ensure continuous quality improvement.

Governing Body

Accountability for the management and improvement of the quality of clinical care and service provided to IMCare enrollee rests with the Itasca County BOC. The BOC consists of five county commissioners, and is responsible for ensuring the implementation of all aspects of the UM program. The BOC delegates day-to-day operational responsibilities for the program to the IMCare Director. Annually, the BOC reviews and approves the UM Program Description, QI/UM Work Plan, and QI/UM Program Evaluation.

Organizational Chart



Committee Structure

IMCare Subcommittee

The IMCare Subcommittee functions in an advisory capacity and reports to the Itasca County BOC. The subcommittee considers program proposals regarding fiscal arrangements; issues regarding management of the programs; maintenance of a comprehensive provider network of health care professionals to ensure enrollee access to services; provider quality; utilization of services; and other issues as needed. The subcommittee meets quarterly, and otherwise as needed.

Membership:

- IMCare Director (Chair)
- ICHHS Director
- Itasca County Administrator
- Two Itasca County Commissioners
- Itasca County Auditor
- Itasca County Attorney
- Two Itasca County residents (a retired Family Practice physician and a community health educator)

Compliance Committee

The Compliance Committee oversees the implementation and operation of the IMCare Compliance Plan. The committee reviews the results of the internal review programs, makes recommendations for improvements to the plan, and reports its activities to the IMCare Subcommittee of the Itasca County BOC, through the IMCare Director and/or ICHHS Director. The committee meets quarterly, and otherwise as needed.

Membership:

- IMCare Director (Co-Chair)
- IMCare Compliance Officer (Co-Chair)
- Itasca County Administrator
- ICHHS Director (HIPAA Privacy Officer)
- Information Systems Manager (HIPAA Security Officer)
- IMCare Medical Director
- IMCare Dental Director
- IMCare Pharmacy Director
- IMCare Claims Supervisor
- IMCare QI/UM Director/s
- IMCare Controller
- IMCare QI/UM Consultant

Responsibilities:

- Review and approve compliance plan and standards of conduct.
- Review internal review programs.
- Address compliance issues.

- Identify opportunities for improvement and possible intervention.

External Quality Improvement/Utilization Management (QI/UM) Committee

The IMCare External QI/UM Committee coordinates the actions of the IMCare clinical subcommittees. The committee is required by NCQA, and reports to the Itasca County BOC. The purpose of the External QI/UM Committee is to recommend policy decisions; review and evaluate QI/UM programs/functions; institute needed actions; and ensure follow-up, as needed. The committee meets quarterly, and otherwise as needed.

Membership:

- IMCare Director (Co-Chair)
- IMCare Medical Director (Co-Chair)
- IMCare Pharmacy Director
- IMCare QI/UM Consultant
- IMCare QI/UM Director/s
- IMCare Behavioral Health Consultant
- IMCare Dental Director
- IMCare Compliance Officer
- IMCare Controller
- IMCare Claims Supervisor
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Reviews and approves QI and UM program descriptions, the QI/UM Work Plan and the annual QI/UM Program Evaluation.
- Receives and reviews reports from IMCare subcommittees and the Compliance Committee.
- Oversees the quality of care and service delivered to enrollees, providers, and facilities, through review and analysis of QI and UM activity reports.
- Analyzes data, identifies opportunities for improvement, and charters teams to address identified QI or UM issues.
- Adopts new and revised clinical practice guidelines, medical necessity criteria, and medical and behavioral health policies recommended by the PAC.
- Monitors delegated functions and recommends actions to correct identified deficiencies.

Provider Advisory Subcommittee (PAC)

The purpose of the IMCare PAC is to provide direction and feedback on medical and behavioral health policies, utilization review criteria, clinical practice guidelines, and all clinically focused QI and UM activities. The PAC also ensures that providers and facilities meet IMCare criteria for participation in the network and conducts activities in accordance with local statutes and federal law found in the Health Care Quality Improvement Act of 1986. The subcommittee reports to the IMCare External QI/UM Committee and meets quarterly, and otherwise as needed.

Membership:

- IMCare Medical Director (Chair)
- IMCare Director
- IMCare Pharmacy Director
- IMCare Dental Director
- IMCare QI/UM Director/s
- IMCare Compliance Officer
- IMCare Controller
- IMCare Claims Supervisor
- IMCare Behavioral Health Consultant
- IMCare QI/UM Consultant
- Primary Care Providers
- Specialty Providers
- Facilities including behavioral health and skilled nursing facilities
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Initiate, develop and approve IMCare medical policies.
- Review and approve clinical practice guidelines.
- Review and recommend clinical QI and UM activities, including design of activity, measurements, and sampling methodology.
- Review and analyze QI and UM activity reports, including quantitative and qualitative analysis, identifying opportunities for improvement and possible interventions.
- Review provider and facility quality of care issues presented by the Medical Director.
- Distribute information to enrollees and providers, which facilitate informed decisions, based on safety.
- Distribute information to enrollees and providers, which improves knowledge regarding clinical safety as it relates to self-care.
- Review and approve credentialing policies and procedures.
- Credential and recredential network individual practitioners and organizational providers, according to State regulations, NCQA accreditation standards, and CMS requirements.
- Communicate and incorporate peer review findings in credentialing decisions.
- Provide peer review on potential quality of care and service issues.
- Recommend follow-up action on quality of care issues, through the review of medical records, results of care and service monitoring, and evaluation of quality of care issues identified by the IMCare QI/UM Department.
- Identify providers not complying with established quality standards, service standards, guidelines and/or policies and procedures.
- Develop, implement, and monitor corrective action plans for providers and facilities not meeting IMCare standards.
- Participate in the development of the annual QI/UM Work Plan.
- Report activities quarterly to the IMCare External QI/UM Committee.

Stakeholder Advisory Subcommittee (SAC)

The IMCare Stakeholder Advisory Subcommittee (SAC) is a collaborative, multidisciplinary committee, which may include enrollees, or individuals who work in the capacity to represent them. The subcommittee focuses primarily on seniors or enrollees receiving Long Term Services and Supports (LTSS), to provide direction and feedback on activities related to service and enrollee materials. The subcommittee reports to the IMCare External QI/UM Committee and meets semiannually, and otherwise as needed.

Membership:

- IMCare QI/UM Director/s (Chair)
- IMCare Health Plan Compliance Coordinator/s
- IMCare Care Coordinator/s
- ICHHS Adult Services Supervisor
- ICHHS PCA Assessor
- ICHHS Case Manager
- Home Care Manager
- Skilled Nursing Facility (SNF) Social Worker
- Enrollee and/or representative
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Review and analyze service activity reports, such as enrollee, provider or facility satisfaction results; complaint and appeal data; telephone responsiveness; accessibility of appointments; and availability of network providers.
- Identify opportunities for improvement and possible intervention.
- Review and provide feedback on proposed enrollee materials.
- Distribute information to enrollees and providers, which enables informed decisions, based on safety.
- Distribute information to enrollees and providers, which improves knowledge regarding clinical safety as it relates to self-care.
- Work to gather information regarding satisfaction with care, problem identification and suggestions for improvement of the delivery system.

Drug Utilization Review (DUR) Subcommittee

The IMCare DUR Subcommittee advises IMCare on prospective and retrospective DUR criteria and prescribing educational programs. The DUR Subommittee is comprised of IMCare staff and health care professionals appointed by the Pharmacy Director and includes physicians and pharmacists that actively practice and serve the Medicaid population in Itasca County. The subcommittee reports to the IMCare External QI/UM Committee and meets quarterly, and otherwise as needed.

Membership:

- IMCare Pharmacy Director (Chair)
- IMCare Medical Director
- IMCare Director

- IMCare QI/UM Director/s
- IMCare QI/UM Consultant
- Primary Care Providers
- IMCare network pharmacists
- CVS Caremark representatives
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Ensure appropriate therapy, while permitting sufficient professional prerogatives to allow for individualized drug therapy.
- Assess drug use information against predetermined standards.
- Make recommendations to IMCare concerning modification or elimination of existing predetermined standards or the addition of new ones.
- Advise IMCare on the establishment and implementation of medical standards and criteria for retrospective and prospective DUR programs.
- Review existing prospective and retrospective program reports and make recommendations to IMCare concerning the modification or elimination of existing DUR criteria.
- Advise IMCare on the development, selection, application, and assessment of educational interventions for physicians, pharmacists, and patients.
- Annually, review and approve pharmacy management policies and procedures.
- Collaborate on identifying network-wide safe clinical practices.
- Distribute information to enrollees and providers, which facilitates informed decisions based on safety.
- Distribute information to enrollees and providers, which improves knowledge regarding clinical safety as it relates to self-care.
- Recommend mechanisms for improving patient safety in existing IMCare UM activities.
- Develop UM activities relating to the distribution, administration, and use of medications.
- Evaluate and approve new pharmaceutical technologies.

Dental Subcommittee

The IMCare Dental Subcommittee addresses all matters pertaining to dental issues, and provides direction and feedback on dental policies and all dental focused QI and UM activities. The subcommittee reports to the IMCare External QI/UM Committee and meets semiannually, and otherwise as needed.

Membership:

- IMCare Dental Director (Chair)
- IMCare Director
- IMCare QI/UM Director/s
- All IMCare network dental providers
- IMCare Controller
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Review and approve dental criteria.
- Review dental fee schedules.
- Address dental issues, including access.
- Identify opportunities for improvement and possible intervention.
- Review and provide feedback on proposed enrollee materials.
- Distribute information to enrollees and providers, which enables informed decisions based on safety.

Staffing and Contractual Arrangements

IMCare contracts with the Medical Director, Dental Director, Behavioral Health Consultant, Pharmacy Director and QI/UM Consultant. This affords IMCare a diverse, comprehensive professional team of health care experts, and provides the required physician involvement in and oversight of IMCare QI/UM programs. The IMCare QI/UM team consists of the following:

- IMCare Director
- IMCare Medical Director
- IMCare Pharmacy Director
- IMCare Dental Director
- IMCare Behavioral Health Consultant
- IMCare QI/UM Consultant
- IMCare QI/UM Director/s
- IMCare MCNs
- IMCare Care Coordinators/Case Managers
- IMCare Compliance Officer
- IMCare Health Plan Compliance Coordinator/s
- IMCare Controller
- IMCare Data Project Coordinators
- IMCare Medical Support Specialists
- IMCare Office Support Specialist

Clinical Criteria for UM Decisions

IMCare utilizes written criteria, based on sound clinical evidence, and specifies procedures for properly applying the criteria when making utilization decisions. IMCare applies objective criteria and considers individual circumstances when determining the medical appropriateness of health care services.

At least annually, IMCare evaluates criteria used to make UM decisions. The IMCare Medical Director reviews the criteria used in previous years to determine the effectiveness of continued use. Other available sources are also reviewed. The Medical Director makes a recommendation to the PAC based on research and findings for clinical criteria use in the current year. The PAC is responsible for adopting the clinical criteria. Once adopted, the criteria is distributed to providers via provider update and provider newsletter. The criteria is also linked to the provider area of the IMCare website and available upon request.

In 2021, IMCare will utilized the following policies and guidelines when making UM authorization decisions:

- Centers for Medicare and Medicaid Services (CMS)
- Clinical Practice Guidelines (e.g., UpToDate)
- Community Standards
- Drug Coverage Criteria (e.g., MN Department of Human Services (DHS), CVS/Caremark)
- IMCare Medical, Behavioral, and Pharmacy Policies and Procedures
- Internet Evidence-Based Literature Search (e.g., PubMed)
- InterQual
- Minnesota Department of Human Services (DHS)

IMCare will assess the consistency in applying these criteria/policies for physician and non-physician reviewers through the interrater reliability review process.

Communication Services

IMCare provides access to UM staff for enrollees and providers seeking information about the UM process and authorization of care. Enrollees and providers have access to staff via email, telephone or facsimile. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. IMCare has a toll free number, a TTY service and language line services. IMCare uses Prairie Fyre software to track incoming and abandoned calls. An abandoned call is a call that goes unanswered or is disconnected.

CMS also performs their own monitoring of compliance, through a contracted vendor, for the IMCare Customer Service Call Center and the Pharmacy (CVS Caremark) Support Customer Service Call Center. IMCare does not use an Integrated Voice Response (IVR) system. The calls that come in through the local and 1-800 line are "bounced" between the medical support specialists. These calls are measured by Prairie Fyre and IMCare can access reports at any time to review activity. IMCare contracts with First Call for Help (FCFH) to answer phones after hours, weekends and holidays. In addition, IMCare has weekend and holiday UM staff coverage for after-hours UM determinations and/or questions. IMCare uses telephone, email or fax for after-hours communication, as appropriate.

Appropriate Professionals

The Itasca County BOC designates the Medical Director, Pharmacy Director, Dental Director, Behavioral Health Consultant and QI/UM Consultant, to advise, oversee, and actively participate in the implementation of the IMCare UM program. IMCare employs and/or contracts with appropriately licensed professionals to supervise all medical necessity decisions. These professionals include the IMCare Medical Director, Dental Director, Behavioral Health Consultant, QI/UM Consultant, QI/UM Director, and MCNs.

IMCare has written job descriptions with qualifications for practitioners who have responsibility for UM, and who review denials of care based on medical necessity. Although involved in the

authorization review, MCNs and social worker(s) cannot make adverse determinations for medical necessity.

IMCare Medical Director

Qualifications: Board-certified physician, licensed by the State of Minnesota
The IMCare Medical Director is responsible for:

- Monitoring the implementation of the QI Program.
- Chairing, co-chairing and participating in various IMCare committees/subcommittees.
- Providing clinical leadership and direction to the QI, UM, CM, credentialing, and PHM aspects of the program, and as a representative of IMCare, assisting in maintaining relationships with providers, managed care organizations, DHS, the Minnesota Department of Health (MDH) and CMS.
- Making medical necessity and appropriateness of care determinations for all authorization requests that cannot be approved by an MCN or QI/UM Director/s.
- Reviewing all requests for benefit exceptions.
- Interacting with providers and/or facilities regarding care/UM concerns.
- Assisting in the analysis of performance data of providers and facilities.
- Supporting state regulatory relationships; serving as the lead physician for state and federal medical management regulatory audits (including pre-audit preparation and information gathering); and actively supporting IMCare quality and compliance initiatives, to ensure that IMCare meets and exceeds medical management, regulatory, agency and quality standards.
- Conducting peer review of clinical quality of care issues, and making recommendations for action and follow-up monitoring.
- Participating in business development and program development for increased efficiency and effectiveness.

IMCare Pharmacy Director

Qualifications: Doctor of Pharmacy, registered with the Minnesota Board of Pharmacy
The IMCare Pharmacy Director is responsible for:

- Providing pharmaceutical leadership and direction to the QI, UM, CM and PHM aspects of the program and, as a representative of IMCare, assisting in maintaining relationships with pharmacists, managed care organizations, DHS, MDH and CMS.
- Chairing and participating in various IMCare committees/subcommittees.
- Participating and supporting communication, education, and maintenance of partnerships with contracted pharmacies.
- Working with IMCare staff and external partners to improve health care outcomes, optimize utilization of services, and maximize benefits for enrollees, while supporting the IMCare mission statement.
- Consulting on UM activities, such as: drug authorization process updates and training; review and applicable implementation of pharmacy related communication from CMS, DHS, the Food and Drug Administration (FDA), the Drug Enforcement Administration (DEA), and CVS Caremark; management of the CVS Caremark drug criteria folder; etc.

- Participating in QI activities, such as: review of potential inappropriate prescribing and recommending action as needed, reviewing overall utilization trends, and participating in other QI activities as needed.
- Actively supporting IMCare quality and compliance initiatives, to ensure that IMCare meets and exceeds medical management, regulatory, agency and quality standards, including ensuring the IMCare pharmacy benefit is compliant with State and Federal mandates and contract requirements, and conducting oversight of the PBM (CVS Caremark).
- Participating in business development and program development for increased efficiency and effectiveness.

IMCare Dental Director

Qualifications: Dentist, licensed in the State of Minnesota

The IMCare Dental Director is responsible for:

- Making medical necessity determinations for dental services.
- Chairing and participating in various IMCare committees/subcommittees.
- Providing leadership and direction of QI and utilization review for dental activities.
- Providing peer review of clinical quality of care issues, making recommendations for action and follow-up monitoring, and assisting with the resolution of grievances and appeals for dental services.
- Serving as the dental provider liaison.
- Analyzing and reviewing IMCare dental utilization to determine over and underutilization, barriers and interventions.
- Assisting in the development of written prior authorization policies and procedures, following regulatory rules, statutes and guidelines.
- Review dental policies and procedures annually and communicating processes to dental providers.

IMCare Behavioral Health Consultant

Qualifications: Board-certified psychiatrist, licensed in the State of Minnesota

The IMCare Behavioral Health Consultant is responsible for:

- Making medical necessity determinations for non-routine mental health prior authorization and referral requests.
- Assisting in arranging, and/or providing second opinions, as requested by enrollees or behavioral health providers.
- Assisting in arranging for behavioral health services not available within Itasca County.
- Participating in the resolution of enrollee complaints and appeals regarding behavioral health services.
- Providing direction and support for the mental health and substance use disorder aspects of the program through participation on IMCare committees/subcommittees.
- Providing peer review of clinical quality of care issues, and making recommendations for action and follow-up monitoring.

QI/UM Consultant

Qualifications: Board-certified physician, licensed in the State of Minnesota

The IMCare QI/UM Consultant is responsible for:

- Providing clinical leadership and direction to the QI, UM, CM, credentialing, and PHM aspects of the program.
- Making medical necessity and appropriateness of care determination for authorization requests that cannot be approved by an MCN or QI/UM Director/s.
- Conducting peer review of clinical quality of care issues, and making recommendations for action and follow-up monitoring.
- Assisting in arranging, and/or providing second opinions, and participating in the resolution of enrollee complaints and appeals.
- Providing direction and support through participation in IMCare committees/subcommittees.
- Being available in the Medical Director's absence.

IMCare QI/UM Director/s

Qualifications: Registered nurse, licensed in the State of Minnesota, and a minimum of a bachelor's degree in nursing, healthcare administration or related healthcare degree, with one or more years of clinical experience

The IMCare QI/UM Director/s are responsible for:

- Assessing needs, planning, developing, promoting and managing all facets of the QI/UM program, including all components of the annual program descriptions, the QI/UM Program Evaluation, the QI/UM Work Plan, and related reporting.
- Working collaboratively with providers to ensure cost-effective quality care for IMCare enrollees, including resolution of quality of care grievances.
- Chairing and participating in various IMCare committees/subcommittees.
- Managing and conducting multiple internal and external audits and surveys.
- Managing, implementing changes, and educating delegates.
- Preparing, managing and participating in all quality and utilization related aspects of the MDH Triennial Quality Assurance and Triennial Compliance audits.
- Overseeing all facets of the PHM program and senior care coordination/CM program, including maintenance of the Model of Care and other CMS documents and reports.
- Managing IMCare service authorization requirements, adoption of UM criteria, documentation, staff and provider training, resource management, and inter-rater reliability, in collaboration with the Medical Director as indicated.
- Managing IMCare clinical drug authorization requirements, coverage criteria, documentation, clinical formulary resources, staff and provider training, resource management, and inter-rater reliability, in collaboration with the medical and pharmacy directors as indicated.
- Overseeing the accessibility of services and adequacy of the IMCare provider network.
- Monitoring the IMCare grievance and appeal system for inclusion in management of the UM program.
- Managing the clinical component of the Restricted Recipient Program (RRP).
- Participating in business development and program development for increased efficiency and effectiveness.

IMCare Managed Care Nurse/s (MCN)

Qualifications: Registered nurse, currently licensed as a Registered Nurse (RN) in Minnesota, with either an associate degree in nursing and three years clinical nursing work experience, or a bachelor's degree in nursing or related health science field with at least one year of clinical nursing work experience

The IMCare MCNs are responsible for:

- Day-to-day tasks associated with the QI/UM Work Plan, including analyzing data and implementing, monitoring and preparing reports.
- Coordinating the delivery of care through assessment, planning, facilitation and patient advocacy to ensure cost-effective, quality outcomes of care.
- Reporting potential cases of fraud, waste and abuse to the Compliance Coordinator.
- Identifying at risk enrollees and enrolling them in CM.
- Providing CM services for enrollees with identified needs.
- Reviewing authorization requests for services using established criteria and medical policies (QI/UM nurses do not make adverse medical necessity determinations).
- Coordinating grievances with the Health Plan Compliance Coordinator (HPCC).

IMCare is required to ensure that qualified health professionals assess the clinical information used to support UM decisions, and that UM decisions are made by qualified health professionals. IMCare Policies and Procedures (P&Ps) require appropriately licensed professionals to supervise all medical necessity decisions, and specify which staff is responsible for each level of decision making. IMCare has several P&Ps to address UM decisions, including Pre-Service Review (Preauthorization or Service Authorization), Post-Service Review, and Concurrent Review. These P&Ps state that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Decisions will be made by qualified licensed health professionals.

Appropriate professionals include the Medical Director, Dental Director, Behavioral Health Consultant, chiropractor, or other board-certified physicians contracted with IMCare. These professionals are involved in non-behavioral healthcare denials, behavioral healthcare denials, and pharmacy denials. The IMCare Dental Director or other contracted dentists review all dental authorizations. Dental medical necessity denials are completed by the Dental Director.

Each UM denial file includes any of the following as documentation of appropriate professional review:

- The reviewer's signature or initials.
- The reviewer's unique electronic signature or identifier on the notation of denial in the file.
- A signed or initialed note from UM staff, attributing the denial decision to the professional who reviewed and decided the case.

IMCare has written procedures for using board-certified consultants, which include a policy that defines the use of board-certified consultants and a list of board-certified consultants. The policy and procedure direct the use of board-certified consultants to assist in making medical necessity determinations.

Annually, IMCare distributes the affirmative statement to enrollees, providers/facilities, and employees via direct mail, newsletters, bulletins, provider manual and/or website. The statement affirms the following:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

IMCare regularly monitors enrollee denials, terminations and reductions of services to determine whether there are any trends or opportunities for improvement. IMCare MCNs and the Medical Director work proactively with providers to obtain needed information for UM decisions and discuss identified issues. All documentation standards of UM reviewers are evident in enrollee records and in CTD. Providers and enrollees are encouraged to call IMCare if they require clarification or have additional question. For each non-medical necessity denial, IMCare documents within the CTD system the reason for the denial and the specific benefit provision, administrative procedure, or regulatory limitation used to classify the denial, and references the source (e.g. Member Handbook). IMCare includes this information in the denial notice sent to the enrollee (or the enrollee's authorized representative) and the provider.

Timeliness of UM Decisions

IMCare makes medical determinations in a timely manner to accommodate the clinical urgency of a situation. IMCare has written policies and procedures for each authorization review type, addressing required timeframes and notification of the attending health care provider/facility and enrollee. Timeframes for authorization requests include:

- For non-urgent pre-service (preauthorization) requests, IMCare requires providers to obtain approval for certain services, such as out-of-network services. The provider completes and faxes the appropriate referral form to IMCare; or facilities call or fax the form. IMCare responds to the request within ten business days, or as expeditiously as the enrollee's health condition requires. IMCare can extend the period up to 14 days for resolution if the provider or enrollee requests it, or if IMCare can justify the need for additional information and feels the extension is in the best interest of the enrollee. IMCare must notify the enrollee of the need to extend an authorization request timeframe, and the right to file a grievance if he/she disagrees with the decision to extend.

- An urgent pre-service (expedited) request is a request for authorization in which the provider requests an immediate determination or IMCare determines that a non-urgent timeframe would jeopardize the enrollee's life or health. IMCare makes the determination and notifies the enrollee and provider within 72 hours of receipt of the request.

The UM department performs concurrent review for all out-of-network inpatient stays, primarily for the purpose of assessing appropriate level of care, discharge planning, and coordination of

care with the primary care provider following discharge. An MCN requests information from the inpatient facility and reviews the information against established criteria, taking into consideration the needs of the enrollee and the local delivery system. If the MCN can approve the stay, she/he notifies the facility of the next concurrent review date. If the MCN cannot authorize continued stay, the Medical Director, QI/UM Consultant or Behavioral Health Consultant is contacted. The determination and notification is made within 24 hours of notification of services/request for authorization. If additional information is needed, IMCare extends the determination up to 72 hours based on written policies and procedures. For previously authorized services, IMCare mails the denial, termination or reduction notice to enrollees ten days prior to the proposed action.

For post service reviews, the UM department performs retrospective reviews within 30 days from receipt of necessary clinical information.

The IMCare Drug Utilization Review (DUR) Committee reviews and recommends drugs requiring prior authorization, while complying with the DHS Preferred Drug List (PDL). The DUR Committee establishes general criteria, including step therapy, prior authorization or monthly drug limits, to be applied to the formulary.

A pharmacy exception allows providers and/or enrollees access to non-formulary medications or exceptions to IMCare's pharmacy management policy. IMCare's process for exceptions includes:

- Making an exception request based on medical necessity.
- Obtaining medical necessity information from the prescribing practitioner.
- Using appropriate practitioners to consider exception requests.
- Timely handling of requests.
- Communicating the reason for a denial and an explanation of the appeal process when an exception request is denied.

IMCare processes requests for non-formulary pharmaceuticals, and exceptions to pharmacy management procedures such as quantity limits, step therapy requirements, vacation overrides, and generics, as outlined in the Drug Authorization Process and Early Refill Policy. As long as a medication is clinically appropriate, IMCare promptly grants an exception to the IMCare formulary for an enrollee when the health care provider prescribing the drug indicates to IMCare that the formulary drug causes an adverse reaction in the enrollee; the formulary drug is contraindicated for the enrollee; and/or the health care provider demonstrates to IMCare that the prescription drug must be dispensed as written to provide maximum medical benefit to the enrollee.

Prior authorization is not required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness, if there is no generically equivalent drug available, and the drug was initially prescribed for the enrollee prior to July 1, 2003, or the drug has been a part of the enrollee's current course of treatment for the last 90 days. IMCare provides coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether it is on the formulary, or if the formulary changes and the drug is no longer on the formulary. This applies if the health care provider prescribing the drug indicates to the

dispensing pharmacist that the prescription must be dispensed as communicated and certifies in writing to IMCare that all equivalent drugs in the formulary have been considered and the drug prescribed will best treat the enrollee's condition.

IMCare is not required to provide coverage for a drug if the drug was removed from the formulary for safety reasons.

An expedited initial medication determination must be utilized if the attending health care professional believes that an expedited review is warranted. Determination and notification to the enrollee and prescribing physician is completed within 24 hours.

A response for standard initial medication determinations is provided within 24 hours of having all required clinical documentation to make a determination; not to exceed 72 hours from the time it is received by IMCare.

Clinical Information

IMCare ensures that necessary information is available for all behavioral, non-behavioral healthcare, and pharmacy utilization review decisions; that enrollee privacy is respected; and that administrative efficiencies are adopted. When making a determination of coverage based on medical necessity, IMCare obtains relevant clinical information and consults with the treating practitioner.

IMCare staff involved in UM functions obtains only the relevant information necessary to conduct review activities. Data requirements are limited to those set forth in Minnesota Statutes, section 62M.04, subdivision 2. Medical records are not routinely requested for all enrollees reviewed. Copies of pertinent portions of the medical record may be requested, when there is difficulty certifying the medical necessity or appropriateness of the service requested.

Additional information, including second opinion information, may be required for other specific review functions and/or to support benefit plan requirements. Additional information may also be requested when there is significant lack of agreement between IMCare and the provider regarding the appropriateness of certification. For UM purposes, "significant lack of agreement," means that IMCare has tentatively determined, through its professional staff, that a service will not be approved; and the case is referred to the Medical Director, QI/UM Consultant, Dental Director, or contracted Behavioral Health Consultant for review, and is discussed or attempted to be discussed with the attending health care professional to obtain further information.

IMCare may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance review, ensuring compliance with the terms of either the health benefit plan or the provider contract, and compliance with utilization review activities. IMCare staff share available clinical and demographic information on individuals internally to avoid duplication.

Denial Notices

IMCare clearly documents in writing and communicates by telephone the reason(s) for each pharmaceutical, behavioral and non-behavioral healthcare denial, to ensure enrollees and practitioners receive sufficient information to understand and decide whether to appeal a decision to deny care or coverage. IMCare monitors enrollee denials, terminations and reductions of services quarterly, to determine whether there are any trends or opportunities for improvement. IMCare notifies the treating practitioner about the opportunity to discuss a medical necessity denial, in the denial notification and by telephone. Each denial file includes the time and date of the denial notification.

Each denial notification includes the specific reasons for the denial in easily understandable language; a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based; and notification that the enrollee can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request. IMCare provides practitioners with the opportunity to discuss any healthcare UM denial decision with a physician, dentist or appropriate behavioral healthcare reviewer.

In addition, each denial notification includes a description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal; an explanation of the appeal process, including the right to enrollee representation and timeframes; a description of the expedited appeal process for urgent pre-service or urgent concurrent denials; and notification that expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.

Policies for Appeals

IMCare has written policies and procedures for thorough, appropriate and timely resolution of enrollee appeal(s), utilizing a full and fair process for resolving enrollee disputes, and responding to enrollee requests to reconsider a decision they find unacceptable, regarding their care and service. There is an established, impartial process for resolving enrollee disputes and responding to enrollee requests to reconsider a decision they find unacceptable regarding their care and/or service.

An enrollee, or provider acting on behalf of an enrollee with the enrollee's written consent, may file an appeal within 60 days of the DTR Notice of Action, or for any other action taken by IMCare. In addition, attending health care professionals may appeal utilization review decisions to IMCare without the written signed consent of the enrollee. Appeals to IMCare may be filed orally or in writing.

IMCare handles all appeals in a respectful manner and always maintains the confidentiality of its enrollees, throughout and after the appeal process is completed. It is the responsibility of the IMCare HPCC/Compliance Officer to ensure that confidentiality is maintained, documentation is complete and accurate, and the appeal process is implemented and completed according to policies and procedures.

IMCare tracks appeals and monitors trends, in order to initiate corrective action as necessary. Contact logs are reviewed weekly at an internal appeals and grievances workgroup, to determine if they contain possible appeals or grievances. Additionally, the HPCC provides annual training to all care coordination, enrollee services and UM staff for further identification of appeals and grievances. Appeal data is reported to and evaluated by the PAC and the External QI/UM Committee. IMCare's appeal procedures are designed to be in compliance with NCQA guidelines, federal regulations, Minnesota Statutes and Minnesota DHS contract requirements.

IMCare policies and procedures for registering and responding to oral and written appeals include:

- Documentation of the substance of appeals and actions taken.
- Full investigation of the substance of appeals, including any aspect of clinical care involved, including but not limited to, the enrollee's reason for appealing the previous decision and additional clinical or other information provided with the appeal request.
- Appeal policies and procedures specify that documentation of actions taken includes, but is not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal.
- The opportunity for the enrollee to submit written comments, documents or other information relating to the appeal.
- Appointment of a new person to review an appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.
- Appointment of at least one person to review an appeal who is a practitioner in the same or a similar specialty.
- The decision for a preservice appeal and notification to the enrollee within 30 calendar days of receipt of the request.
- The decision for a post service appeal and notification to the enrollee within 30 calendar days of receipt of the request.
- The decision for an expedited appeal and notification to the enrollee within 72 hours of receipt of the request.
- Notification to enrollees of the disposition of appeals and the right to further appeal, as appropriate.
- Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based.
- Giving enrollees reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.
- Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- Allowing an authorized representative to act on behalf of the enrollee.
- Providing notices of the appeals process to enrollees in a culturally and linguistically appropriate manner.
- Continued coverage pending the outcome of an appeal.

The enrollee, or the provider acting on behalf of the enrollee with the enrollee's written consent, may file an appeal within 60 days of the DTR Notice of Action, or for any other action taken by IMCare, as defined in 42 CFR § 438.400(b). In addition, attending health care professionals may appeal utilization review decisions to IMCare without the written, signed consent of the enrollee, in accordance with Minnesota Statutes, § 62M.06 (medical necessity).

Timeframe for Resolution of Appeals

Type of Appeal	Timeframe, no extension	Timeframe, with extension
Expedited		
Oral and Written	Oral and written notice within 72 hours	14 days with extension letter
Denial of Expedited Appeal Request	Orally within 24 hours, and followed with written notice within two calendar days	
Standard	Within 30 calendar days	14 days with extension letter

IMCare allows for extension of the timeframes for resolution of appeals of 14 days for standard and expedited appeals if the enrollee requests the extension, or if IMCare justifies both the need for more information and that an extension is in the enrollee's interest. IMCare must provide written notice to the enrollee and the attending health care professional of the reason for the decision to extend the timeframe, if IMCare determines that an extension is necessary. IMCare's extension notice must notify the enrollee of the right to file a grievance if he/she disagrees with IMCare's decision to extend. IMCare must issue a determination no later than the date the extension expires. The State may review IMCare's justification.

Timeframe for Resolution of Expedited Appeals:

- IMCare must resolve and provide written notice of resolution for both oral and written appeals as expeditiously as the enrollee's health condition requires, not to exceed 72 hours after receipt of the appeal.
- If IMCare denies a request for an expedited appeal, IMCare shall transfer the denied request to the standard appeal process, preserving the first filing date of the expedited appeal. IMCare must notify the enrollee of that decision orally within 24 hours of the request, and follow up with written notice within two days.
- When a determination not to certify a health care service is made prior to or during an ongoing service, and the attending health care professional believes that an expedited appeal is warranted, IMCare must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone. In such an appeal, IMCare must ensure reasonable access to IMCare's consulting physician or health care provider.

Timeframe for Resolution of Standard Appeals: IMCare must resolve each appeal as expeditiously as an enrollee's health requires, and must notify the enrollee and the attending health care professional within (not to exceed) 30 calendar days after receipt of the appeal.

Subsequent Appeals: If an enrollee appeals a decision from a previous appeal on the same issue, and IMCare decides to hear it, for purposes of the timeframes for resolution, this will be considered a new appeal.

If a denial is not reversed through the appeal process, IMCare informs the enrollee and the attending health care professional, in writing, of their right to appeal to MDH. For expedited appeals, IMCare allows a provider with knowledge of the enrollee's condition to act as the enrollee's authorized representative.

All oral inquiries challenging or disputing a DTR Notice of Action or any action are treated as an oral appeal. IMCare sends a written acknowledgment within ten days of receiving the request for an appeal, and may combine it with the notice of resolution (Acknowledge & Resolved Letter – Appeal) if a decision is made within the ten days.

IMCare gives enrollees any reasonable assistance required in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

IMCare ensures that the individual making the decision was not involved in any previous level of review or decision-making. If IMCare is deciding an appeal regarding denial of a service based on lack of medical necessity, IMCare ensures that the individual making the decision was not involved in any previous level of review or decision-making, and is a health care professional with appropriate clinical expertise, in a same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion, in treating the enrollee's condition or disease. IMCare ensures that its reviewers are reasonably available to review cases. Prior to upholding a denial for medical necessity, IMCare ensures that there is review of the documentation by a physician who did not make the initial determination to deny.

IMCare provides the enrollee with a reasonable opportunity to present evidence and allegations of fact or law, in person, by telephone, as well as in writing. For expedited appeal resolutions, IMCare must inform the enrollee of the limited time available to present evidence in support of the appeal. IMCare provides the enrollee, and his/her representative, an opportunity before and during the appeal process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process. Enrollees may obtain copies of all documents relevant to their appeal, free of charge, and upon request. IMCare includes as parties to the appeal, the enrollee, his/her representative, or the legal representative of a deceased enrollee's estate.

IMCare does not take punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal. IMCare may require copies of part or all of the medical record and a written statement from the attending health care professional as documentation for their review.

Appropriate Handling of Appeals

IMCare adjudicates enrollee appeals in a thorough, appropriate and timely manner, and utilizes a full and fair process for resolving enrollee disputes and responding to enrollee requests to reconsider a decision they find unacceptable regarding their care and/or services.

IMCare takes enrollee appeals seriously, and has written procedures in place for a thorough and consistent investigation and response to appeals, including appeals filed with participating providers. IMCare handles all appeals in a respectful manner and maintains the confidentiality of its enrollees at all times throughout and after the appeal process is completed. It is the responsibility of the HPCC/Compliance Officer to ensure that confidentiality is maintained, documentation is complete and accurate, and the appeal process is implemented and completed according to policies and procedures.

IMCare utilizes written policies and procedures for thorough, appropriate and timely resolution of enrollee appeals; and has a thorough and consistent process for addressing enrollee service and payment appeals.

IMCare policies and procedures for registering and responding to oral and written appeals include:

- Documentation of the substance of appeals and actions taken.
- Investigation of the substance of appeals, including any aspect of clinical care involved.
- Notification to the enrollee of the disposition of appeals and the right to further appeal, as appropriate.
- Standards for timeliness, including standards for clinically urgent situations.
- Provisions of language services for the appeal process.

An enrollee, or provider acting on behalf of an enrollee with the enrollee's written consent, may file an appeal within 60 days of the DTR Notice of Action, or for any other action taken by IMCare. In addition, attending health care professionals may appeal utilization review decisions to IMCare without the written signed consent of the enrollee. Appeals to IMCare may be filed orally or in writing.

IMCare tracks appeals and monitors trends in order to initiate corrective action as necessary. Appeal data is reported to and evaluated by the PAC and the External QI/UM Committee. IMCare's appeal procedures are designed to be in compliance with NCQA guidelines, federal regulations, Minnesota Statutes and Minnesota DHS contract requirements.

IMCare's grievance system, which includes appeals, is subject to approval by the State.

- Any proposed changes to the appeal system must be approved by the State prior to implementation.
- IMCare will send written notice to enrollees of significant changes to the appeal system at least 30 days prior to implementation.
- IMCare will provide information specified in 42 CFR 438.10(g)(1) about the appeal system to providers and subcontractors at the time they enter into a contract.

- Within 60 days after the extension of a contract with a provider (e.g., hospitals, individual providers, and clinics), IMCare must inform the provider of the programs under the contract, and specifically provide an explanation of the Notice of Rights and Responsibilities, and Grievance, Appeal and State Fair Hearing Rights of Enrollees and Providers under the contract.

Evaluation of New Technology

IMCare has a formal mechanism to evaluate and address new developments in technology for inclusion in its benefit plan, to keep pace with changes, and to ensure that enrollees have equitable access to safe and effective care.

The IMCare Medical Director will make the final determination for benefit exceptions based on the strength of evidence and internal criteria outlined in this policy. For behavioral healthcare services, the IMCare Behavioral Health Consultant is involved in the decision-making process. For pharmaceuticals, the IMCare Pharmacy Director is involved in the decision-making process as needed. A policy has been developed to address medical procedures, behavioral health procedures, pharmaceuticals and devices.

IMCare has a written evaluation process, including the process and decision variables the organization uses to make determinations, a review of information from appropriate government regulatory bodies, a review of information from published scientific evidence, and a process for seeking input from relevant specialists and professionals who have expertise in the technology.

The designation of the term "investigative" or "experimental" may include new technologies, as well as new applications of existing technologies, that are in various stages of study, a drug, device, medical treatment, diagnostic procedure, or procedure that is experimental, investigative, or unproven as defined in MN Rule part 4685.0100, subpart 6a. Technologies will remain investigative or experimental until safety and efficacy are evaluated and are considered generally accepted care.

Strength of Evidence
Evidence is graded A or B using the following general qualifications. Evidence A is the strongest evidence and Evidence B, the weakest.

Strength of Evidence A: Final approval from the appropriate government regulatory agency, if approval is required. Published, well-designed and adequately controlled clinical trials performed in relevant patient populations with appropriate analyses of results which are directly applicable to the issue under review. Consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals, or the reports of clinical trial committees and other technology assessment bodies. This category also includes established guidelines and standards that are broadly recognized as appropriate and based largely on appropriate trials and other studies.

Strength of Evidence B: Published, appropriately designed, executed and analyzed cohort studies, retrospective analyses and studies performed using large data repositories. Consensus

opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers.

Satisfaction with Utilization Management Process

IMCare continually assesses enrollee and provider satisfaction with the UM process and services to identify areas of improvement, set priorities, and decide which opportunities to pursue, based on analysis of enrollee complaint/appeal data, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, and the provider satisfaction survey.

IMCare assessment of satisfaction with the UM process includes:

- Collecting and analyzing data on enrollee and provider experience to identify improvement opportunities.
- Taking action designed to improve enrollee and provider experience based on the assessment of enrollee/provider data.
- Identifying barriers to enrollee and provider satisfaction.

To assess enrollee satisfaction with its services, IMCare annually evaluates enrollee and provider-reported complaints and appeals using the following methods:

- Identifies the appropriate population.
- Includes the entire affected population; does not sample.
- Collects valid data for each of the five required categories.
- Performs an annual assessment.

IMCare annually assesses behavioral healthcare services and opportunities for improvement using the following methods:

- Evaluates enrollee complaints and appeals, including provider-reported complaints.
- Conducts an enrollee experience survey.
- Assesses data from complaints/appeals or enrollee survey.
- Identifies opportunities for improvement.
- Implements interventions.
- Measures effectiveness of interventions.

IMCare annually evaluates enrollee and practitioner satisfaction with the UM process using the following:

- Specific UM questions/composite from the enrollee CAHPS survey conducted by DHS.
- Provider survey conducted by IMCare.
- Enrollee and provider reported grievances.
- Input from SAC regarding the UM process.

When possible, IMCare surveys all appropriate providers/primary care sites. All provider reported enrollee grievances regarding UM will be assessed.

The IMCare External QI/UM Committee, the SAC and the PAC review evaluation findings and take action when performance falls below performance goals and/or opportunities for improvement are identified; approve reports or make recommendations for change; identify opportunities for improvement; re-measure satisfaction annually to determine effectiveness of interventions, barrier analysis and opportunities for improvement; and review survey tools, with the exception of CAHPS.

Emergency Services

IMCare ensures, through written policies and procedures, that its enrollees have access to emergency, post stabilization, and urgent care services in and out of the IMCare provider network, by participating and non-participating providers. IMCare enrollees have the right to available and accessible emergency services, 24 hours a day, seven days a week. Enrollees are informed how to access emergency services through the Member Handbook.

Medical emergency, post-stabilization care and urgent care services are available 24 hours per day, seven days per week, including a 24 hour per day number for enrollees to call in case of a medical emergency. Emergency services are covered, whether provided by network or non-network providers, and whether provided within or outside IMCare's service area. When services are provided by a non-participating provider, with or without prior authorization, IMCare does not impose coverage restrictions or limitations that are more restrictive than those that apply to emergency services received from a participating provider. Cost-sharing (co-pays), as applicable, are the same, whether provided by a participating or non-participation provider.

An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency services, with respect to an emergency medical condition, means:

- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical conditions; and
- Within the capabilities of the staff and facilities available at the hospital and required to stabilize the patient.

Stabilize, with respect to an emergency condition, means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or, with respect to an emergency medical condition of a pregnant woman and her unborn child, to deliver (including the placenta).

Stabilized, with respect to an emergency condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the

transfer of the individual from a facility, or, with respect to a pregnant woman and her unborn child, that the woman has delivered (including the placenta).

IMCare does not require a service authorization as a condition for providing a medical emergency service; hold the enrollee liable for payment concerning the screening and treatment necessary to diagnose and stabilize the condition; or prohibit the treating provider from determining when the enrollee is sufficiently stabilized for transfer or discharge.

In reviewing a denial for coverage of emergency services, IMCare must consider the following factors:

- A reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment;
- The time of day and day of the week the care was provided;
- The presenting symptoms, including but not limited to, severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis;
- The enrollee's efforts to follow IMCare's established procedures for obtaining medical care; and
- Any circumstances that precluded use of IMCare's established procedures for obtaining emergency care.

When processing claims, IMCare may obtain sufficient information from the provider of emergency care, including the presenting symptoms, to enable IMCare to make an informed determination as to whether reimbursement as emergency care is appropriate.

Procedures for Pharmaceutical Management

IMCare ensures that its policies and procedures for pharmaceutical management promote the clinically-appropriate use of pharmaceuticals, including the use of clinical evidence from appropriate external organizations. IMCare has also developed formal policies and procedures that address the accessibility of non-formulary medications and exceptions to providers and/or enrollees. IMCare processes requests for non-formulary pharmaceuticals, and exceptions to pharmacy management procedures, including quantity limits, step therapy requirements, vacation overrides and generics.

IMCare enrollees are notified through mail within 30 days regarding any recalls/withdrawals related to medication safety issues.

IMCare has a DUR Committee that reviews pharmacy related policies and procedures. The IMCare Pharmacy Director and Medical Director are both on the committee. The IMCare DUR Committee reviews and, in compliance with the DHS PDL, recommends which drugs require UM edits (e.g., prior authorization), and establishes general criteria to be applied to the formulary. The DUR Committee also reviews pharmacy utilization patterns and makes recommendations to implement UM edits or formulary changes as indicated or necessary.

Pharmacy Exception allows providers and/or enrollees access to non-formulary medications or exceptions to IMCare's pharmacy management policy. The IMCare process for exceptions includes:

- Making an exception request based on medical necessity.
- Obtaining medical necessity information from the prescribing practitioner.
- Using appropriate practitioners to consider exception requests.
- Timely handling of requests.
- Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request.

IMCare processes requests for:

- Non-formulary pharmaceuticals
- Exceptions to pharmacy management procedures, such as quantity limits, step therapy requirements, vacation overrides, and generics, as outlined in policy and procedure

IMCare must promptly grant an exception to IMCare's formulary, including the DHS PDL, for an enrollee when the health care provider prescribing the drug indicates to IMCare that:

- The formulary drug causes an adverse reaction in the enrollee.
- The formulary drug is contraindicated for the enrollee.
- The health care provider demonstrates to IMCare that the prescription drug must be dispensed as written to provide maximum medical benefit to the enrollee.

Prior authorization is not required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

- There is no generically equivalent drug available; and
- The drug was initially prescribed for the enrollee prior to July 1, 2003; or
- The drug is part of the enrollee's current course of treatment for the last 90 days.

IMCare must provide coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether it is on the formulary or if the formulary changes and the drug is no longer on the formulary. This applies if the health care provider prescribing the drug indicates to the dispensing pharmacist that the prescription must be dispensed as communicated, and certifies in writing to IMCare that all equivalent drugs in the formulary have been considered and the drug prescribed will best treat the enrollee's condition.

IMCare is not required to provide coverage for a drug if the drug was removed from the formulary for safety reasons.

2021 UM Activities

Under and Over Utilization

Ensuring appropriate utilization of services is required as per Article 7.1.4 of the 2021 DHS Families and Children contract. "The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "*Standards and Guidelines or the Accreditation of Health Plans*." This structure must include an effective mechanism and written description to detect both under- and over-utilization of services. [42 CFR

§438.330(b)(3)]. The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under- and over-utilization. The MCO shall:

(1) Choose the appropriate number of relevant types of utilization data to monitor, including one type related to behavioral health;
(2) Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under- and over-utilization;
(3) Examine possible explanations for all data not within thresholds;
(4) Analyze data not within threshold by medical group or practice; and
(5) Take action to address identified problems of under- and over-utilization and measure the effectiveness of its interventions."

IMCare will evaluate under and over utilization on an ongoing basis through daily authorization reviews, monthly stop loss reports, and monthly Emergency Department Utilization Focus Study and Controlled Substance Focus Study reports. IMCare will continue periodic monitoring of diagnostic assessment use through the Utilization Review Workgroup, and other behavioral health services will be considered for review. At least annually, IMCare will evaluate HEDIS utilization measures and/or claims data to evaluate patterns in utilization and identify opportunities for improvement.

Evaluation of Inpatient Readmissions

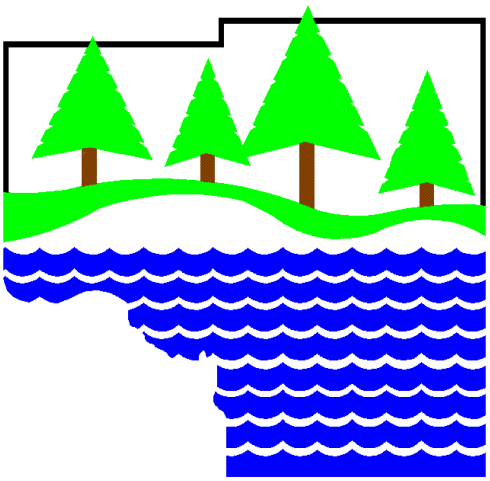
IMCare Data Project Coordinators will evaluate inpatient claims data quarterly, and all enrollees with inpatient stays less than 15 days apart for same or similar diagnoses will be referred to an MCN. The MCN will review all applicable clinical documentation to determine the relationship between the multiple inpatient stays, and will consult the Medical Director if the initial admission, or status upon discharge of the initial admission, caused readmission. During this process, the MCN will screen the enrollee for case management and PHM services. This program aims to recuperate inpatient costs, and promote patient safety and positive health outcomes with early intervention.

Medication Therapy Management (MTM) Program

The IMCare MTM Program is a targeted medication therapy management program for Medicare Part D enrollees, intended to optimize therapeutic outcomes, through improved medication use. The program identifies individuals with multiple medications and complex health needs, and offers them a comprehensive medication review, to ensure their medications are working to improve their health. CMS requires that all Part D sponsors incorporate an MTM program into their plan's benefit structure, as described in § 423.153(d)(1). CMS defines MTM program eligibility requirements and core program components.

Contact Information

If you have questions or comments about any information contained in this report, please contact IMCare QI/UM Director, Alexis Martire, at (218)327-6199, (800)843-9536 ext. 2199, or by email to alexis.martire@co.itasca.mn.us.



2021 ITASCA MEDICAL CARE QUALITY IMPROVEMENT PROGRAM DESCRIPTION

Approved by:

IMCare External QI/UM Committee:
Itasca County Board of Commissioners:

Mission Statement...

- The IMCare mission is to ensure access to high-quality, patient-centered, cost-effective health care for Itasca County residents through coordination and collaboration with local community partners and providers.

Quality Improvement Program Description
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Introduction

The Itasca Medical Care (IMCare) program is administered by Itasca County Health and Human Services (ICHHS). IMCare enrollees are those who are eligible for benefits under the Minnesota Health Care Program (MHCP) Prepaid Medical Assistance Program (PMAP) and MinnesotaCare (MNCare). IMCare was established in 1982 with General Assistance Medical Care (GAMC). The Prepaid Medical Assistance Program (PMAP) was implemented on July 1, 1985, as a demonstration project and expanded to include MNCare in 1996. In 2001, IMCare become a County Based Purchasing (CBP) organization. Minnesota Senior Care Plus (MSC+) was added in June of 2005 and a Medicare Advantage product, Minnesota Senior Health Options (MSHO), was added in January of 2006.

Itasca County contracts with the Minnesota Department of Human Services (DHS) to provide PMAP, MNCare, MSHO, and MSC+ medical benefits through the IMCare program. IMCare receives monthly capitation from DHS for all IMCare enrollees. There is a Memorandum of Understanding (MOU) between Centers of Medicare and Medicaid Services (CMS), DHS and IMCare to administer the dual benefit, MSHO. The financial risk for medical services and behavioral health services is assumed by Itasca County. Itasca County dentists, chiropractors, and vision providers assume financial risk for their respective service groups, in their contract with IMCare. IMCare staff administer the program and pay claims to providers. IMCare staff are ICHHS employees. The administrative costs of the IMCare program are reimbursed to ICHHS out of the IMCare program funds. The IMCare program does not utilize Itasca County levy money.

IMCare network providers include:

- Primary care and multispecialty clinics within Itasca County and eight outlying clinics
- Hospitals within Itasca County and two outlying hospitals
- CVS National Network
- Substance Use Disorder (SUD) providers within Itasca County and one outlying provider
- Dental providers within Itasca County and two outlying providers
- Behavioral Health providers within Itasca County and nine outlying providers
- Vison providers within Itasca County and two outlying providers
- Chiropractic providers within Itasca County and two outlying providers

Purpose

IMCare and its network providers are committed to the delivery of optimal and cost-effective health care to its enrollees. IMCare strives for continuous improvement in the quality of health care services and the health status of the population served. A comprehensive quality improvement (QI) program directs IMCare's efforts.

The scope of the QI program is designed to assess the accessibility of services, the quality of services, and the appropriateness of all health care services. Soliciting enrollee perceptions of the health care services they receive, as well as their interactions with IMCare, are vital components of the QI program.

The QI program encompasses all aspects of care delivered by providers, including medical, behavioral health, SUD, dental, vision, chiropractic and pharmacy services. In addition to continuous assessment of the clinical elements of health care, the QI program looks at administrative and service issues that affect the delivery of care.

The QI program outlines the scope of activities in the following functional areas:

- Quality Improvement (QI) focused on improving the care and services enrollees receive from IMCare and its providers.
- Utilization Management (UM) structured to both manage the utilization of resources and maximize the effectiveness of care and services provided to enrollees.
- Care Coordination/Case Management (CM) designed to coordinate and manage the use of health care and community-based services, resulting in optimal, cost-effective outcomes for enrollees identified as high-risk, high-cost, and/or requiring special needs.
- Population Health Management (PHM) is a discipline within the healthcare industry that studies and facilitates care delivery across the general population or a group of individuals. The ultimate goal of PHM is to improve the quality of care, while reducing costs and closing care gaps.
- The QI Program Description is designed to meet state and federal regulations, and national accreditation standards.

Philosophy

IMCare is a County-Based Purchasing (CBP) organization, designed to provide healthcare to Itasca county residents, using the best of local resources. We are connected to the people we serve and ensure that enrollees have access to appropriate, quality care; providers are satisfied with the IMCare program; and the value of health care delivery is maximized for Itasca County residents and taxpayers.

The IMCare mission is to ensure that the residents of Itasca County have access to high-quality, patient-centered, cost-effective health care through coordination and collaboration with local community partners and providers by:

- Assuring improved access to providers and community resources;
- Improving coordination of health and social service needs;
- Stabilizing and supporting existing community provider networks;
- Reinvesting resources into Itasca County to improve access and quality of care for rural MHCP participants;
- Controlling health care costs and reducing preventable health care service utilization;
- Assuring consistent participation in a rural county setting and providing stability to residents;
- Bringing health care reform, such as accountable care and value-based reimbursement, to rural areas;
- Responding to the specific needs of Itasca County through the development of unique programs and services; and
- Providing transparency so that our enrollees, providers, the State, CMS and legislators can readily assess cost versus benefit for public programs.

Goals

IMCare goals include:

- To develop a comprehensive, meaningful, and thoroughly executed QI, UM, CM and PHM strategy;
- To integrate a QI approach to all aspects of health plan management;
- To sustain a standardized and comprehensive QI program, which will address and be responsive to the health care needs of enrollees;
- To maintain an effective QI program with a proactive approach to health care, emphasizing prevention and health promotion;
- To monitor, measure, and improve performance of medical and behavioral health care in key aspects of clinical and service quality for enrollees and providers;
- To demonstrate improved outcomes in medical and behavioral health care services to its enrollees;
- To foster a collaborative and supportive environment, which assists providers in improving the safety and outcome of their clinical practice;
- To sustain a standardized, comprehensive, and consistent UM program, which will direct appropriate, cost-effective care and be responsive to the health care needs of enrollees;
- To maintain an effective UM program that allows for early detection and intervention of inappropriate utilization or waste;
- To ensure that enrollees are receiving care that aligns with evidence-based practice guidelines or community standards;
- To continually monitor, evaluate and optimize health care resource utilization in collaboration with contracted providers; and
- To ensure that state and federal regulatory requirements are met, and IMCare policies and procedures support the requirements.

Objectives

The following objectives were designed to assist IMCare in meeting its goals:

- Develop an annual QI/UM work plan that outlines activities, objectives, responsible person(s), and timeframes, which is monitored on a quarterly basis;
- Develop, implement, and monitor action plans to improve medical and behavioral health care;
- Integrate mechanisms for evaluating clinical safety into existing QI activities;
- Implement, per DHS contract, performance improvement projects (PIP);
- Identify and implement a PHM program relevant to the populations served;
- Conduct a health appraisal assessment, health risk assessment (HRA), or MNChoices assessment of all new enrollees. Identify enrollees who would benefit from CM and enrollees with complex health needs, to determine if existing CM processes, including access to a qualified and contracted network, and service provisions are comprehensive and effective in meeting the identified needs of the population IMCare serves;
- Develop and distribute enrollee information that improves knowledge regarding clinical safety, as it relates to self-care and clinical practice guideline compliance;

- Include network providers in the development, monitoring, and evaluation of PIPs, policies, procedures, guidelines, standards, and interventions, to improve outcomes;
- Facilitate continuity of care between providers and facilities to promote exchange of information, appropriate diagnosis, treatment, and referral of medical, as well as behavioral, health disorders;
- Complete a comprehensive analysis of all QI/UM studies, monitoring results against performance goals, benchmarks when available, and previous performance;
- Identify barriers to improvement and opportunities to pursue and take action when performance goals are not met;
- Monitor and improve compliance with accreditation standards and regulatory requirements governing IMCare; and
- Identify and assist enrollees with racial, ethnic, cultural and linguistically diverse needs.

QI Structure and Accountability

The IMCare QI Program activities are aimed at continuous study and improvement of the processes of providing services to meet the needs of enrollees, with the overall goal of performance improvement. Continuous QI includes an ongoing effort to improve the efficiency, effectiveness, quality, and/or performance of services, processes, capacities and outcomes. The program encompasses a broad spectrum of evaluation activities, aimed at ensuring compliance with quality standards and effectiveness of interventions.

IMCare utilizes an annual QI/UM work plan to direct all quality activities throughout the year. The work plan is a dynamic tool for continuous QI and includes the following strategy to direct and monitor progress:

- Activities – Overall project description or initiative.
- Goals – What are we trying to accomplish?
- Tasks – What exact interventions do we need to implement to ensure we reach our goals?
- Outcome Measures – How will we know that a change is an improvement?
- Data/Information Source – What document or information source will substantiate that the task is complete, or intervention has been implemented?
- Progress/Results – Once the task is complete, what is the outcome and does it reflect the intended outcome measures?

Quality activities are performed by the IMCare QI/UM Directors, Managed Care Nurses (MCN), Senior Care Coordinators, Compliance staff, and Data Project Coordinators, along with other administrative support staff. The QI/UM Director/s oversee QI projects, as well as daily activities; with insight from the Medical Director as needed.

The IMCare PHM and CM programs have a symbiotic relationship, resulting in continual QI in both areas for enrollees. Whereas PHM primarily focuses on health, wellness, and prevention, the partnership and information sharing between PHM and CM is crucial to the enhancement of both programs, particularly when enrollees suffer from multiple chronic conditions. This partnership focuses on five main goals:

- Continual reduction of the burden of conditions for enrollees;
- Safe, effective, patient-centered, timely and efficient delivery of care;

- Continual stratification or monitoring of enrollees;
- Incorporation of key concepts, including patient empowerment, shared knowledge and clinician cooperation; and
- Ongoing staff education on effective treatment methodologies and current clinical practice guidelines.

In addition, the collaborative relationship between PHM and CM allows for immediate consultation and problem-solving activities for rapid resolution of enrollee/provider issues and improved overall care. This partnership often results in program improvement ideas, which are considered by IMCare management and/or quality oversight committees (i.e., the Provider Advisory Subcommittee (PAC), Quality Workgroup, External QI/UM Committee and the Stakeholder Advisory Committee (SAC)).

The IMCare PHM program was implemented in January of 2020, to be in compliance with 2020 DHS contracts, section 7.3. The PHM program allows IMCare to evaluate the overall population; define areas of emerging risk for those served by IMCare and develop interventions that address those needs; and enhance quality outcomes throughout the entire population. The PHM program has a strong focus on health promotion and preventative care; providing enrollees with the tools necessary to lead healthier lifestyles and assume ownership of their health outcomes. In addition, PHM has four key areas of focus:

- Managing enrollees with emerging risk;
- Reducing healthcare disparities that enrollees face;
- Patient safety or outcomes across settings; and
- Managing multiple chronic illnesses.

IMCare data collection and reporting systems support the information needs of program activities. The systems listed below support business processes for collection of data, statistics, QI activities and reporting capabilities.

Amisys is a comprehensive system used to manage membership, providers, authorizations, benefits, and pricing; and it is a claims processing engine. It provides interfaces to other IMCare systems and is the source data system.

CareAnalyzer is a solution used to evaluate enrollee health. It allows IMCare to be proactive in PHM, providing the tools needed to evaluate patient risk and make recommendations for better enrollee care. It also enables MCNs to evaluate gaps in care, in the context of an enrollee's overall clinical profile, rather than narrowly focusing on a specific gap in care. In this way, MCNs can identify patients at high risk for hospitalization or complications, and minimize that risk with appropriate, proactive interventions. CareAnalyzer helps reduce risk by:

- Identifying enrollee-level care gaps;
- Avoiding unnecessary utilization by identifying high-risk enrollees for proactive, targeted intervention; and
- Providing insight into provider performance and engaging providers to efficiently deliver the highest quality of care.

In addition, CareAnalyzer is a National Committee for Quality Assurance (NCQA) certified Healthcare Effectiveness Data and Information Set (HEDIS) software solution, that measures and reports quality standards using industry accepted HEDIS methodology. The software enables IMCare to:

- Measure, monitor, and manage HEDIS compliance status throughout the year;
- Satisfy the manual source code portion of the HEDIS compliance audit; and
- Remain current with latest specifications.

This software offers a unique analytic approach, that combines elements of regulatory reporting, predictive modeling, provider network evaluation, and risk adjustment, in a single integrated system.

CVS Caremark Client Care Access (CCA) is a website that allows IMCare to manage enrollees' pharmacy benefit program. Online access to CCA allows IMCare to review and manage pharmacy point-of-sale claims.

CaseTrakker Dynamo (CTD) is comprehensive care management software used to ensure that IMCare has up-to-date information and the tools to manage enrollees efficiently. It is a solution used for tracking medical management operations, such as UM, CM, care coordination, PHM, restricted recipient program (RRP), provider management, appeals, grievances, contact logs and enrollee services. IMCare has configured the software to track timelines for authorization requests, grievances, appeals, restrictions and transitions. It also maintains record of communications sent to enrollees and providers by IMCare.

Confluence is an information sharing forum. It allows all departments to communicate efficiently. It is used to track business processes and rules with regards to claims payments. It has a dynamic dashboard and offers reporting and analysis. It is the system that allows IMCare to communicate and document configuration changes for Amisys.

Microsoft SQL Server Reporting Services (SSRS) is a web-based tool used for creating and maintaining database reports. IMCare has created customized reports to query the database on all data stored in Amisys, including enrollment, providers, and claims. IMCare has defined the parameters per business rules and reporting requirements. This system is used to create ad-hoc and standard timely reports for QI, UM, care coordination, CM, PHM, etc. In addition, this system is used to meet many reporting requirements imposed by regulatory agencies.

HealthX is an online provider portal. This system allows IMCare to stay connected and engaged with providers and is the primary communication tool between claims staff and providers. Claims and eligibility information is available for providers within this system.

JIRA is a workflow solution and project management tool. It allows all departments to communicate efficiently. It is able to manage and track all projects and tasks in one place. It has a dynamic dashboard and offers reporting and analysis. It is the system that allows IMCare to communicate and document configuration changes for Amisys and CTD. In addition, IMCare uses this as a regulatory tracking tool, capturing all actions and responses on communications from CMS.

RxNavigator is a CVS Caremark web-based tool used for creating and maintaining database reports. IMCare has created customized reports to query the database on all data stored in point-of-sale pharmacy claims. IMCare has defined the parameters per business rules and reporting requirements. This system is used to create ad-hoc and standard timely reports for QI, UM, care coordination, CM, PHM, denial management, encounter data, etc. In addition, this system is used to meet many reporting requirements imposed by regulatory agencies.

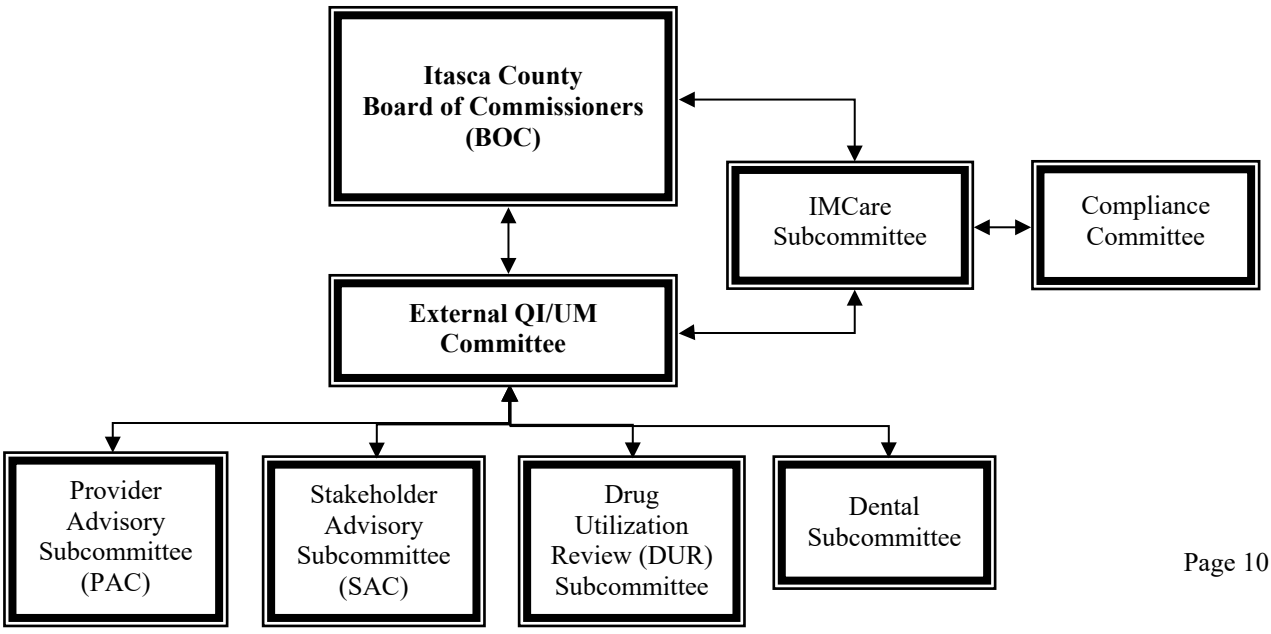
UpToDate is an online clinical decision support resource that includes drug information and evidence-based clinical practice guidelines. It is one of the resources used by IMCare to design, implement and evaluate QI and UM program activities.

Data used for IMCare QI program activities is initially analyzed by an IMCare Data Project Coordinator, to ensure accuracy of the findings. The data is provided to the assigned MCN, who conducts a quantitative and qualitative analysis, and prepares a preliminary QI report. The report is presented to the various IMCare committees for review and identification of recommendations, interventions, and barriers to improvement. QI goals are also identified. A final report, including committee recommendations, is written and subsequently reviewed/approved by the IMCare External QI/UM Committee and the Itasca County Board of Commissioners. A summary of the final results is included in the Annual QI Program Evaluation. Identified improvement goals are incorporated into the annual work plan to ensure continuous QI. IMCare continually assesses data, systems, programs and new technologies to obtain efficiencies.

Governing Body

Accountability for the management and improvement of the quality of clinical care and service provided to IMCare enrollees rests with the Itasca County Board of Commissioners (BOC). The BOC consists of five county commissioners, and is responsible for ensuring the implementation of all aspects of the QI program. The BOC delegates day-to-day operational responsibilities for the program to the IMCare Director. Annually, the BOC reviews and approves the QI Program Description, Work Plan, and Program Evaluation.

Organizational Chart



Committee Structure

IMCare Subcommittee

The IMCare Subcommittee functions in an advisory capacity and reports to the Itasca County BOC. The subcommittee considers program proposals regarding fiscal arrangements; issues regarding management of the programs; maintenance of a comprehensive provider network of health care professionals to ensure enrollee access to services; provider quality; utilization of services; and other issues as needed. The subcommittee meets quarterly, and otherwise as needed.

Membership:

- IMCare Director (Chair)
- ICHHS Director
- Itasca County Administrator
- Two Itasca County Commissioners
- Itasca County Auditor
- Itasca County Attorney
- Two Itasca County residents (a retired Family Practice physician and a community health educator)

Compliance Committee

The Compliance Committee oversees the implementation and operation of the IMCare Compliance Plan. The committee reviews the results of the internal review programs, makes recommendations for improvements to the plan, and reports its activities to the IMCare Subcommittee of the Itasca County BOC, through the IMCare Director and/or ICHHS Director. The committee meets quarterly, and otherwise as needed.

Membership:

- IMCare Director (Co-Chair)
- IMCare Compliance Officer (Co-Chair)
- Itasca County Administrator
- ICHHS Director (HIPAA Privacy Officer)
- Information Systems Manager (HIPAA Security Officer)
- IMCare Medical Director
- IMCare Dental Director
- IMCare Pharmacy Director
- IMCare Claims Supervisor
- IMCare QI/UM Director/s
- IMCare Controller
- IMCare QI/UM Consultant

Responsibilities:

- Review and approve compliance plan and standards of conduct.
- Review internal review programs.
- Address compliance issues.

- Identify opportunities for improvement and possible intervention.

External Quality Improvement/Utilization Management (QI/UM) Committee

The IMCare External QI/UM Committee coordinates the actions of the IMCare clinical subcommittees. The committee is required by NCQA, and reports to the Itasca County BOC. The purpose of the External QI/UM Committee is to recommend policy decisions; review and evaluate QI/UM programs/functions; institute needed actions; and ensure follow-up, as needed. The committee meets quarterly, and otherwise as needed.

Membership:

- IMCare Director (Co-Chair)
- IMCare Medical Director (Co-Chair)
- IMCare Pharmacy Director
- IMCare QI/UM Consultant
- IMCare QI/UM Director/s
- IMCare Behavioral Health Consultant
- IMCare Dental Director
- IMCare Compliance Officer
- IMCare Controller
- IMCare Claims Supervisor
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Reviews and approves QI and UM program descriptions, the QI/UM Work Plan and the annual QI/UM Program Evaluation.
- Receives and reviews reports from IMCare subcommittees and the Compliance Committee.
- Oversees the quality of care and service delivered to enrollees, providers, and facilities, through review and analysis of QI and UM activity reports.
- Analyzes data, identifies opportunities for improvement, and charters teams to address identified QI or UM issues.
- Adopts new and revised clinical practice guidelines, medical necessity criteria, and medical and behavioral health policies recommended by the PAC.
- Monitors delegated functions and recommends actions to correct identified deficiencies.

Provider Advisory Subcommittee (PAC)

The purpose of the IMCare PAC is to provide direction and feedback on medical and behavioral health policies, utilization review criteria, clinical practice guidelines, and all clinically focused QI and UM activities. The PAC also ensures that providers and facilities meet IMCare criteria for participation in the network and conducts activities in accordance with local statutes and federal law found in the Health Care Quality Improvement Act of 1986. The subcommittee reports to the IMCare External QI/UM Committee and meets quarterly, and otherwise as needed.

Membership:

- IMCare Medical Director (Chair)
- IMCare Director
- IMCare Pharmacy Director
- IMCare Dental Director
- IMCare QI/UM Director/s
- IMCare Compliance Officer
- IMCare Controller
- IMCare Claims Supervisor
- IMCare Behavioral Health Consultant
- IMCare QI/UM Consultant
- Primary Care Providers
- Specialty Providers
- Facilities including behavioral health and skilled nursing facilities
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Initiate, develop and approve IMCare medical policies.
- Review and approve clinical practice guidelines.
- Review and recommend clinical QI and UM activities, including design of activity, measurements, and sampling methodology.
- Review and analyze QI and UM activity reports, including quantitative and qualitative analysis, identifying opportunities for improvement and possible interventions.
- Review provider and facility quality of care issues presented by the Medical Director.
- Distribute information to enrollees and providers, which facilitate informed decisions, based on safety.
- Distribute information to enrollees and providers, which improves knowledge regarding clinical safety as it relates to self-care.
- Review and approve credentialing policies and procedures.
- Credential and recredential network individual practitioners and organizational providers, according to State regulations, NCQA accreditation standards, and CMS requirements.
- Communicate and incorporate peer review findings in credentialing decisions.
- Provide peer review on potential quality of care and service issues.
- Recommend follow-up action on quality of care issues, through the review of medical records, results of care and service monitoring, and evaluation of quality of care issues identified by the IMCare QI/UM Department.
- Identify providers not complying with established quality standards, service standards, guidelines and/or policies and procedures.
- Develop, implement, and monitor corrective action plans for providers and facilities not meeting IMCare standards.
- Participate in the development of the annual QI/UM Work Plan.
- Report activities quarterly to the IMCare External QI/UM Committee.

Stakeholder Advisory Subcommittee (SAC)

The IMCare Stakeholder Advisory Subcommittee (SAC) is a collaborative, multidisciplinary committee, which may include enrollees, or individuals who work in the capacity to represent them. The subcommittee focuses primarily on seniors or enrollees receiving Long Term Services and Supports (LTSS), to provide direction and feedback on activities related to service and enrollee materials. The subcommittee reports to the IMCare External QI/UM Committee and meets semiannually, and otherwise as needed.

Membership:

- IMCare QI/UM Director/s (Chair)
- IMCare Health Plan Compliance Coordinator/s
- IMCare Care Coordinator/s
- ICHHS Adult Services Supervisor
- ICHHS PCA Assessor
- ICHHS Case Manager
- Home Care Manager
- Skilled Nursing Facility (SNF) Social Worker
- Enrollee and/or representative
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Review and analyze service activity reports, such as enrollee, provider or facility satisfaction results; complaint and appeal data; telephone responsiveness; accessibility of appointments; and availability of network providers.
- Identify opportunities for improvement and possible intervention.
- Review and provide feedback on proposed enrollee materials.
- Distribute information to enrollees and providers, which enables informed decisions, based on safety.
- Distribute information to enrollees and providers, which improves knowledge regarding clinical safety as it relates to self-care.
- Work to gather information regarding satisfaction with care, problem identification and suggestions for improvement of the delivery system.

Drug Utilization Review (DUR) Subcommittee

The IMCare DUR Subcommittee advises IMCare on prospective and retrospective DUR criteria and prescribing educational programs. The DUR Subommittee is comprised of IMCare staff and health care professionals appointed by the Pharmacy Director and includes physicians and pharmacists that actively practice and serve the Medicaid population in Itasca County. The subcommittee reports to the IMCare External QI/UM Committee and meets quarterly, and otherwise as needed.

Membership:

- IMCare Pharmacy Director (Chair)
- IMCare Medical Director
- IMCare Director

- IMCare QI/UM Director/s
- IMCare QI/UM Consultant
- Primary Care Providers
- IMCare network pharmacists
- CVS Caremark representatives
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Ensure appropriate therapy, while permitting sufficient professional prerogatives to allow for individualized drug therapy.
- Assess drug use information against predetermined standards.
- Make recommendations to IMCare concerning modification or elimination of existing predetermined standards or the addition of new ones.
- Advise IMCare on the establishment and implementation of medical standards and criteria for retrospective and prospective DUR programs.
- Review existing prospective and retrospective program reports and make recommendations to IMCare concerning the modification or elimination of existing DUR criteria.
- Advise IMCare on the development, selection, application, and assessment of educational interventions for physicians, pharmacists, and patients.
- Annually, review and approve pharmacy management policies and procedures.
- Collaborate on identifying network-wide safe clinical practices.
- Distribute information to enrollees and providers, which facilitates informed decisions based on safety.
- Distribute information to enrollees and providers, which improves knowledge regarding clinical safety as it relates to self-care.
- Recommend mechanisms for improving patient safety in existing IMCare UM activities.
- Develop UM activities relating to the distribution, administration, and use of medications.
- Evaluate and approve new pharmaceutical technologies.

Dental Subcommittee

The IMCare Dental Subcommittee addresses all matters pertaining to dental issues, and provides direction and feedback on dental policies and all dental focused QI and UM activities. The subcommittee reports to the IMCare External QI/UM Committee and meets semiannually, and otherwise as needed.

Membership:

- IMCare Dental Director (Chair)
- IMCare Director
- IMCare QI/UM Director/s
- All IMCare network dental providers
- IMCare Controller
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Review and approve dental criteria.
- Review dental fee schedules.
- Address dental issues, including access.
- Identify opportunities for improvement and possible intervention.
- Review and provide feedback on proposed enrollee materials.
- Distribute information to enrollees and providers, which enables informed decisions based on safety.

Staffing and Contractual Arrangements

IMCare contracts with the Medical Director, Dental Director, Behavioral Health Consultant, Pharmacy Director and QI/UM Consultant. This affords IMCare a diverse, comprehensive professional team of health care experts, and provides the required physician involvement in and oversight of IMCare QI/UM programs. The IMCare QI/UM team consists of the following:

- IMCare Director
- IMCare Medical Director
- IMCare Pharmacy Director
- IMCare Dental Director
- IMCare Behavioral Health Consultant
- IMCare QI/UM Consultant
- IMCare QI/UM Director/s
- IMCare MCNs
- IMCare Care Coordinators/Case Managers
- IMCare Compliance Officer
- IMCare Health Plan Compliance Coordinator/s
- IMCare Controller
- IMCare Data Project Coordinators
- IMCare Medical Support Specialists
- IMCare Office Support Specialist

QI/UM Department Functions

The QI/UM team is responsible for the following:

- Providing both clinical and administrative support for the External QI/UM Committee and IMCare subcommittees.
- Maintaining and updating the QI Program Description, QI/UM Work Plan, and department policies and procedures at least annually, and otherwise as needed.
- Conducting a comprehensive annual program evaluation and presenting the written program evaluation document to the External QI/UM Committee for feedback and additional analysis.
- Presenting the final program documents to the Itasca County BOC for review, approval, and adoption.
- Ensuring that DHS and CMS requirements related to quality are addressed in the QI/UM Work Plan.

- Performing the initial quantitative and qualitative analysis for all QI activities, such as HEDIS, the Health Outcomes Survey (HOS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, accessibility, availability, enrollee and provider satisfactions surveys, medical record documentation reviews, and grievances and appeals.
- Coordinating follow-up of actions recommended by the External QI/UM Committee and Itasca County BOC.
- Researching potential clinical and service projects based on claims data, literature review, and regulatory requirements.
- Analyzing enrollee input from sources, such as surveys, grievances and appeals.
- Disseminating communication materials to providers and enrollees via direct mail, the IMCare website, newsletters and/or bulletins.
- Conducting pre-service, concurrent and retrospective review, as outlined in Utilization Management policies and procedures.
- Assessing returned enrollee screening forms and contacting appropriate enrollees for a health risk assessment.
- Identifying enrollees who would benefit from case management and enrolling them in the IMCare CM program.
- Providing case management, as outlined in CM policies and procedures.
- Participating in the implementation and ongoing monitoring of population health.

Participating Provider Requirements for Quality Improvement

- IMCare network clinics must have an active QI program in place. This may include conducting medical record reviews on clinic records, and/or planning and conducting focus studies related to clinic interests.
- Participating providers must cooperate with IMCare QI activities, including making medical records available for IMCare chart abstractors.
- Participating providers must cooperate with any corrective action resulting from IMCare QI and/or UM audits.
- Participating providers must subject individual practitioners to applicable lMCare credentialing processes, prior to their providing care to enrollees.
- Participating providers must maintain records in compliance with IMCare's medical record policy.
- Participating providers must maintain a systematic process for responding to and reporting complaints received from IMCare enrollees, in compliance with DHS requirements.
- Participating providers must have a policy and procedure for release of medical records, in accordance with state and federal regulations.

Communication

The IMCare QI/UM Department communicates results from QI activities to enrollees, providers, and facilities, using any of the following avenues: written reports, presentations, educational forums, published articles, newsletters, direct mail, social media, and/or web.

IMCare distributes the Provider Manual via the IMCare website. The Provider Manual and provider contracts encompass component requirements relating to UM decisions and cooperation with the IMCare QI program.

Scope of QI Program Activities

IMCare QI Program measurements are identified and collected annually, and as needed. This ensures that clinical and service quality is monitored and evaluated, and opportunities for improvement are identified. Issues selected for special studies or ongoing monitoring reflect the population served, satisfaction data, service data, high volume procedures/conditions, high risk procedures/conditions, and areas that may be amenable to actions for improvement, which result in system-wide improvements in the health care delivery system.

Clinical program activities include, but are not limited to, the following:

- Clinical QI studies
- QI clinical activities or performance improvement projects recommended by IMCare subcommittees, based on the results of IMCare performance data, which may include:
    - HEDIS and other clinical indicators
    - Clinical practice guideline monitoring
    - Under and over utilization data
    - PHM trends
    - Care coordination/case management
    - Quality of care reviews
    - Continuity and coordination of care
    - Complaint, grievance and appeal data, including provider reported grievances

Analysis of the above performance data supports evaluation of required clinical activities, including but not limited to:

- Acute hospital services
- Hospital readmissions
- Ambulatory health care services
- Emergency services
- Behavioral health services
- Preventative health care services
- Chemical dependency services
- Chiropractic services
- Vision services
- Dental services
- Home health care services
- Durable medical equipment utilization
- Skilled nursing care services

IMCare QI organizational components include areas that affect the accessibility, availability, comprehensiveness, and/or continuity of health care. Consumer components include all aspects

related to the quality of IMCare services. Organizational and consumer QI program activities include, but are not limited to, the following:

- QI studies
- QI activities recommended by IMCare subcommittees based on the results of IMCare performance data in areas such as:
    - Accessibility of appointments
    - Availability of network providers and facilities
    - Enrollee satisfaction surveys
    - Provider or facility satisfaction surveys
    - Grievances and appeals
    - Timeliness of medical, behavioral health, dental, and pharmacy authorization request review and determination
    - Inter-rater reliability testing/peer review
    - Under and over utilization of services
    - Care coordination/case management
    - PHM

Analysis of the above performance data supports evaluation of required organizational components, including:

- Referrals
- CM
- Discharge planning
- Appointment scheduling and wait times
- Second opinions
- Prior authorizations
- Provider reimbursement arrangements
- Administrative components that affect delivery of care

Analysis of the above performance data supports evaluation of required consumer components, including:

- Enrollee satisfaction surveys that meet validity standards
- Enrollee complaints

IMCare fosters a supportive environment to assist practitioners and providers in maintaining patient safety and facilitating care coordination/case management between county-based programs through ICHHS, IMCare case/care management programs, and IMCare's Pharmacy Benefit Manager (PBM), CVS Caremark. IMCare's commitment to patient safety includes, but is not limited to, the following:

- Distributing information to enrollees, providers, and facilities that improves knowledge regarding clinical safety as it relates to self-care.
- Existing QI activities focus on improving patient safety.
- Distributing information to enrollees, providers, and facilities that support informed decisions, based on safety.
- Addressing enrollee written comments/questions.
- Addressing enrollee verbal comments/questions.

Peer Review Activities

Peer review is the process of rating clinical or professional compliance with industry developed standards. The primary function of peer review is to routinely and consistently evaluate outcomes of clinical and administrative activities. Peer review allows IMCare to examine performance and identify opportunities for improvement. It constitutes a form of self-regulation by qualified enrollees of a profession. IMCare employs peer review methods to maintain standards of QI performance and provide credibility. IMCare peer review activities include, but are not limited to:

- Inter-rater reliability – evaluates clinical decision making
- Credentialing – Credentialing Committee reviews process and individual applications
- Performance-based measures – providers receive their score and comparison to peers (e.g., HEDIS results)
- Internal evaluation – comparison of IMCare measures to CMS and/or DHS performance outcomes and other health plans

Documentation of Responsibility

IMCare assumes full responsibility for the evaluation of the quality of care provided to its enrollees. QI Program activities are reported at least quarterly to the Itasca County BOC, IMCare's governing body. The BOC reviews and approves the Quality Program Description, UM Program Description, QI/UM Work Plan, and QI/UM Program Evaluation. Board meetings are open to the public, and quality activities are included in official proceedings and minutes. Provider Participation Agreements address quality assurance authority, function and responsibility.

Quality Improvement Appointed Entity

The Itasca County BOC designates the IMCare External QI/UM Committee responsible for operations of QI program activities. The IMCare External QI/UM Committee designates the IMCare Director, who is a Co-Chair of the committee, to report QI activities to the BOC at least quarterly.

Provider Participation

The Itasca County BOC designates the Medical Director, Pharmacy Director, Dental Director, Behavioral Health Consultant and QI/UM Consultant, to advise, oversee, and actively participate in the implementation of the IMCare QI program. The following are the qualifications and responsibilities of these roles.

IMCare Medical Director

Qualifications: Board-certified physician, licensed by the State of Minnesota
The IMCare Medical Director is responsible for:

- Monitoring the implementation of the QI Program.
- Chairing, co-chairing and participating in various IMCare committees/subcommittees.

- Providing clinical leadership and direction to the QI, UM, CM, credentialing, and PHM aspects of the program, and as a representative of IMCare, assisting in maintaining relationships with providers, managed care organizations, DHS, MDH and CMS.
- Making medical necessity and appropriateness of care determinations for all authorization requests that cannot be approved by an MCN or QI/UM Director/s.
- Reviewing all requests for benefit exceptions.
- Interacting with providers and/or facilities regarding care/UM concerns.
- Assisting in the analysis of performance data of providers and facilities.
- Supporting state regulatory relationships; serving as the lead physician for state and federal medical management regulatory audits (including pre-audit preparation and information gathering); and actively supporting IMCare quality and compliance initiatives, to ensure that IMCare meets and exceeds medical management, regulatory, agency and quality standards.
- Conducting peer review of clinical quality of care issues, and making recommendations for action and follow-up monitoring.
- Participating in business development and program development for increased efficiency and effectiveness.

IMCare Pharmacy Director

Qualifications: Doctor of Pharmacy, registered with the Minnesota Board of Pharmacy

The IMCare Pharmacy Director is responsible for:

- Providing pharmaceutical leadership and direction to the QI, UM, CM and PHM aspects of the program and, as a representative of IMCare, assisting in maintaining relationships with pharmacists, managed care organizations, DHS, MDH and CMS.
- Chairing and participating in various IMCare committees/subcommittees.
- Participating and supporting communication, education, and maintenance of partnerships with contracted pharmacies.
- Working with IMCare staff and external partners to improve health care outcomes, optimize utilization of services, and maximize benefits for enrollees, while supporting the IMCare mission statement.
- Consulting on UM activities, such as: drug authorization process updates and training; review and applicable implementation of pharmacy related communication from CMS, DHS, the Food and Drug Administration (FDA), the Drug Enforcement Administration (DEA), and CVS Caremark; management of the CVS Caremark drug criteria folder; etc.
- Participating in QI activities, such as: review of potential inappropriate prescribing and recommending action as needed, reviewing overall utilization trends, and participating in other QI activities as needed.
- Actively supporting IMCare quality and compliance initiatives, to ensure that IMCare meets and exceeds medical management, regulatory, agency and quality standards, including ensuring the IMCare pharmacy benefit is compliant with State and Federal mandates and contract requirements, and conducting oversight of the PBM (CVS Caremark).
- Participating in business development and program development for increased efficiency and effectiveness.

IMCare Dental Director

Qualifications: Dentist, licensed in the State of Minnesota

The IMCare Dental Director is responsible for:

- Making medical necessity determinations for dental services.
- Chairing and participating in various IMCare committees/subcommittees.
- Providing leadership and direction of QI and utilization review for dental activities.
- Providing peer review of clinical quality of care issues, making recommendations for action and follow-up monitoring, and assisting with the resolution of grievances and appeals for dental services.
- Serving as the dental provider liaison.
- Analyzing and reviewing IMCare dental utilization to determine over and underutilization, barriers and interventions.
- Assisting in the development of written prior authorization policies and procedures, following regulatory rules, statutes and guidelines.
- Review dental policies and procedures annually and communicating processes to dental providers.

IMCare Behavioral Health Consultant

Qualifications: Board-certified psychiatrist, licensed in the State of Minnesota

The IMCare Behavioral Health Consultant is responsible for:

- Making medical necessity determinations for non-routine mental health prior authorization and referral requests.
- Assisting in arranging, and/or providing second opinions, as requested by enrollees or behavioral health providers.
- Assisting in arranging for behavioral health services not available within Itasca County.
- Participating in the resolution of enrollee complaints and appeals regarding behavioral health services.
- Providing direction and support for the mental health and substance use disorder aspects of the program through participation on IMCare committees/subcommittees.
- Providing peer review of clinical quality of care issues, and making recommendations for action and follow-up monitoring.

IMCare QI/UM Consultant

Qualifications: Board-certified physician, licensed in the State of Minnesota

The IMCare QI/UM Consultant is responsible for:

- Providing clinical leadership and direction to the QI, UM, CM, credentialing, and PHM aspects of the program.
- Making medical necessity and appropriateness of care determination for authorization requests that cannot be approved by an MCN or QI/UM Director/s.
- Conducting peer review of clinical quality of care issues, and making recommendations for action and follow-up monitoring.
- Assisting in arranging, and/or providing second opinions, and participating in the resolution of enrollee complaints and appeals.
- Providing direction and support through participation in IMCare committees/subcommittees.

- Being available in the Medical Director's absence.

Staff Resources

To support the above provider leadership roles and ensure that there is adequate administrative staff with the required knowledge and expertise to assist in executing QI activities, IMCare employs, at a minimum, the following:

IMCare Director

Qualifications: Minimum of a bachelor's degree in business administration, accounting, public health, health administration or closely related field

The IMCare Director is responsible for:

- Assessing needs, planning, developing, promoting and managing all facets of the program.
- Representing IMCare on Federal and State legislative levels.
- Completing requests for proposals and negotiating contracts as required at the Federal and State levels.
- Providing a monthly update to the Itasca County BOC on all aspects of IMCare.
- Negotiating contracts with contracted personnel (e.g., Medical Director, Pharmacy Director, Dental Director, QI/UM Consultant, and Behavioral Health Consultant).
- Negotiating contracts with providers and vendors.
- Planning, developing, coordinating and assuring implementation of IMCare programs within state, federal or county guidelines.
- Evaluating programs to determine service effectiveness, need for service improvements or modifications, or new services.
- Co-chairing and participating in IMCare committees/subcommittees.
- Participating in various DHS workgroups.
- Managing IMCare personnel.
- Fiscal management.
- Leading business development and program development for increased efficiency and effectiveness.

IMCare QI/UM Director/s

Qualifications: Registered nurse, licensed in the State of Minnesota, and a minimum of a bachelor's degree in nursing, healthcare administration or related healthcare degree, with one or more years of clinical experience

The IMCare QI/UM Director/s are responsible for:

- Assessing needs, planning, developing, promoting and managing all facets of the QI/UM program, including all components of the annual program descriptions, the QI/UM Program Evaluation, the QI/UM Work Plan, and related reporting.
- Working collaboratively with providers to ensure cost-effective quality care for IMCare enrollees, including resolution of quality of care grievances.
- Chairing and participating in various IMCare committees/subcommittees.
- Managing and conducting multiple internal and external audits and surveys.
- Managing, implementing changes, and educating delegates.
- Preparing, managing and participating in all quality and utilization related aspects of the

MDH Triennial Quality Assurance and Triennial Compliance audits.

- Overseeing all facets of the PHM program and senior care coordination/CM program, including maintenance of the Model of Care and other CMS documents and reports.
- Managing IMCare service authorization requirements, adoption of UM criteria, documentation, staff and provider training, resource management, and inter-rater reliability, in collaboration with the Medical Director as indicated.
- Managing IMCare clinical drug authorization requirements, coverage criteria, documentation, clinical formulary resources, staff and provider training, resource management, and inter-rater reliability, in collaboration with the medical and pharmacy directors as indicated.
- Overseeing the accessibility of services and adequacy of the IMCare provider network.
- Monitoring the IMCare grievance and appeal system for inclusion in management of the UM program.
- Managing the clinical component of the Restricted Recipient Program (RRP).
- Participating in business development and program development for increased efficiency and effectiveness.

IMCare Managed Care Nurse/s (MCN)

Qualifications: Registered nurse, currently licensed as a Registered Nurse (RN) in Minnesota, with either an associate degree in nursing and three years clinical nursing work experience, or a bachelor's degree in nursing or related health science field with at least one year of clinical nursing work experience

The IMCare MCNs are responsible for:

- Day-to-day tasks associated with the QI/UM Work Plan, including analyzing data and implementing, monitoring and preparing reports.
- Coordinating the delivery of care through assessment, planning, facilitation and patient advocacy to ensure cost-effective, quality outcomes of care.
- Reporting potential cases of fraud, waste and abuse to the Compliance Coordinator.
- Identifying at risk enrollees and enrolling them in CM.
- Providing CM services for enrollees with identified needs.
- Reviewing authorization requests for services using established criteria and medical policies (QI/UM nurses do not make adverse medical necessity determinations).
- Coordinating grievances with the Health Plan Compliance Coordinator.

IMCare Care Coordinator

Qualifications: Registered nurse or social worker, licensed in the State of Minnesota, with one or more years of experience in care coordination/case management

The IMCare Care Coordinators/Case Managers are responsible for:

- Day-to-day assessment, care plan and management of enrollees participating in IMCare care coordination/case management programs.
- Working collaboratively with ICHHS care coordination/case management staff and programs, and MCN staff, including monitoring service delivery.
- Approving requests for services using established criteria and policies (care coordinators do not make adverse determinations).

- Coordinating, with a multi-disciplinary team, individual enrollee care coordination plans to ensure 1) appropriateness, 2) quality, and 3) cost effectiveness of services provided to enrollees.
- Ensuring access and integration of the delivery of all Medicare and Medicaid services to meet state and federal regulations.
- Ensuring smooth transitions and coordination of information and services between acute, sub-acute, rehabilitation, nursing facility and Home and Community Based Services settings.
- Designing, implementing, monitoring, measuring and reporting on care coordination programs.

IMCare Compliance Officer

Qualifications: Bachelor's degree in business management, accounting, public healthcare or related field, or two-year degree involving business or healthcare applications with three years current experience in a healthcare related field

The IMCare Compliance Officer is responsible for:

- The IMCare Fraud, Waste and Abuse Program, including the development of policies and procedures for the fraud integrity program, according to the BBA, and CMS and DHS contract requirements.
- Investigating and resolving cases of potential fraud, waste or abuse of IMCare program funds.
- Overseeing IMCare compliance activities and actions to deliver a compliant, publicly funded, health care program.
- Assuring that IMCare meets DHS contract reporting requirements and deadlines; monitoring, analyzing and responding to federal and state legislation and regulations to ensure compliance by coordinating IMCare activities.
- Overseeing the reporting of information and documentation to maintain files of contract compliance data; developing and maintaining tracking systems to document contract compliance; and working with IMCare staff in the compilation of data and preparation of required reports.
- Assuring that IMCare meets contract reporting requirements and deadlines, including maintenance of documentation and tracking systems.
- Monitoring IMCare contracts with subcontractors and vendors to ensure that contracted responsibilities are performed according to IMCare needs and expectations.
- Participating in business development and program development for increased efficiency and effectiveness.

IMCare Health Plan Compliance Coordinator (HPCC)

Qualifications: Bachelor's degree in business management, accounting, public healthcare or related field with one-year current experience in a healthcare related field, or two-year degree involving business or healthcare applications with three years current experience in a healthcare related field

The HPCC is responsible for:

- IMCare grievance and appeal processes, in accordance with DHS contracts, and working in collaboration with the Compliance Officer on other compliance activities.

- Assisting with design, implementation, monitoring, measuring and/or reporting of the IMCare Integrity Program as directed.
- Analyzing data to identify fraud, waste and abuse and/or QI opportunities, and working with the IMCare Compliance Officer to investigate reported and identified cases of fraud, waste and/or abuse and/or QI opportunities.
- Monitoring and tracking the RRP.
- Maintaining knowledge of current compliance and regulatory guidelines related to QI activities, and implementing processes to ensure regulatory requirements are met.
- Creating, maintaining and implementing IMCare policies and procedures for third party liability and subrogation, and responding to and tracking subrogation requests, including claim review, requests for updated subrogation interest, document development, and filing of necessary paperwork, as directed.
- Developing, reviewing and obtaining appropriate level of approval for enrollee communication materials.
- Assisting the IMCare Compliance Officer in meeting statutory and regulatory requirements to ensure IMCare is in compliance with state and federal contracts and audits.

IMCare Data Project Coordinator

Qualifications: Bachelor's degree and one-year current experience in healthcare data systems, or associate degree involving business and three years current work experience in healthcare data systems

The Data Project Coordinator is responsible for:

- Designing, formatting and generating custom reporting for financial, UM, quality, compliance and other various needs.
- Preparing reporting for internal and external committees and DHS and CMS reporting.
- Participating in CMS/DHS/ MDH meetings and workgroups, and completing auditing and reporting for performance improvement projects, QI projects, HEDIS, and MN Community Measurement.
- Completing data validation, and other mandatory CMS monitoring and reporting projects.
- Maintaining IMCare membership data, including loading data, working files, troubleshooting issues and reconciliation.

IMCare Medical Support Specialist

Qualifications: High school graduate or equivalent, one-year post-secondary education in medical secretarial coursework or related field, or two years medical administrative support work experience

The IMCare Medical Support Specialist is responsible for:

- Receiving, triaging and assisting with calls from IMCare enrollees and providers.
- Entering referral and prior authorization (PA) requests in the data system, collecting associated information if needed, and preparing referral and PA requests for review by an MCN, the Medical Director, the QI/UM Consultant or the Dental Director.
- Recording initial enrollee complaints and concerns, problem-solving, and educating enrollees as indicated, and assisting the Compliance Coordinator in enrollee complaint resolution, reporting, and tracking.

- Preparing letters, committee minutes, and other correspondence, and coordinating meetings.
- Assisting with drafting and maintenance of QI/UM policies and procedures, staff resources, enrollee and provider education materials, completion of provider credentialing and other program materials.
- Maintaining QI/UM tracking systems, compiling statistical data, and assisting in preparation of reports.

Delegated Activities

IMCare maintains accountability for the delivery of care and service, which it has delegated to:

- CVS Caremark for Pharmacy Benefit Manager (PBM) services
- Minnesota DHS for MSHO enrollment
- ICHHS Public Health Division for care coordination of IMCare enrollees on the Elderly Waiver
- Cirdan for administrative services

At a minimum, the following requirements are used to establish and monitor a delegated entity's performance, including:

- A mutually agreed upon arrangement that describes the responsibilities of the organization and the delegated entity; the delegated activities; required reporting and annual evaluation; and the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.
- A pre-capacity assessment to delegation to determine if the delegate has devoted sufficient resources and appropriate qualified staff to perform the function(s).
- Routine reporting.
- Annual comprehensive evaluation of the delegated entity by IMCare.

The External QI/UM Committee is responsible for directing and performing delegation oversight to ensure compliance with DHS, CMS and compliance-related contractual requirements.

CVS Caremark - IMCare Pharmacy Benefit Manager (PBM)

CVS Caremark delegated functions and responsibilities include:

- Establishing a Retail Pharmacy Network
    - Making the on-line point-of-sale pharmacy billing and IMCare formulary computerized application available to IMCare pharmacies.
    - Holding the provider contracts with the pharmacies identified by IMCare for IMCare's primary pharmacy network.
    - Making available the CVS Caremark pharmacy network for IMCare out of network pharmacy needs.
    - Making payment and adjustments to pharmacies for IMCare services provided and invoicing IMCare for costs.
- Pharmacy Network Auditing
    - Performing claim audits on reimbursements to pharmacies, collecting any overpayments, and reporting all material discrepancies to IMCare.

    - Assisting IMCare with related audits, including but not limited to: CMS Part D data validation, CMS financial audits, Prescription Drug Event (PDE) audits, CMS Part D Transition Monitoring Program, MDH audits, CMS Timeliness Monitoring Projects, MN Office of Legislator Auditor audits, etc.
- Custom Medicaid Formulary/Uniform PDL/Formulary Management
    - Assisting IMCare with formulary development and management, DUR committee recommendations, pharmacy network education and formulary coding updates.
- Pharmacy Help Desk
    - Providing a pharmacy help desk and Voice Response Unit.
    - Channeling enrollee calls to the IMCare HelpDesk.
- Point of Sale Utilization Management
    - Developing, implementing and/or maintaining policies and procedures for pharmaceutical management that promote the clinically-appropriate use of pharmaceuticals.
- Maintaining Eligibility Data
    - Sending the Eligibility File Validation report for monthly IMCare review.
- Maintaining Point of Sale Claims Processing
    - Managing True Out of Pocket (TROOP) costs balances and accepting and remitting balance information from/to Relay Health.
    - Managing direct and indirect remuneration (DIR).
- Communication Materials
    - Disseminating mutually agreed upon enrollee and/or provider communication materials on IMCare's behalf.
- Standard Management and Utilization Reports
    - Producing utilization reports for IMCare use and making available CVS Caremark's web-based reporting tool for IMCare use.
- Quality Management Programs
    - Maintaining and administering the Plan Participant Safety and Quality Management Program.
    - Administering the CVS Caremark Closing Gaps in Medication Therapy Program, including sending regular program activity reports to IMCare.
- DUR Services/Clinical Programs
    - Assisting IMCare with DUR Subcommittee recommendations and reports and pharmacy network education.
    - Sending quarterly Point-of-Sale (POS) DUR Program outcome reports to IMCare for review.
- Safety and Monitoring Solution (SMS) Program
    - Administering CVS Caremark SMS and Enhanced Safety and Monitoring Solution (ESMS) programs for IMCare, including quarterly reporting to IMCare.
- General Performance and Monitoring
    - Maximum Allowable Cost (MAC) Performance Oversight
        - Provide MAC Performance Reporting and reconcile, at least annually.
    - Encounter Data Review
        - Submit PDE files to CMS and correct any subsequent errors for resubmission.
        - Assist IMCare with any issues resulting from PDE audits.

        - Review PDE response and error files to ensure encounters are submitted to CMS correctly.
    - Invoiced and Paid Amount Reconciliation
        - Send bi-weekly invoices to IMCare for pharmacy claims paid by CVS Caremark on IMCare's behalf.
        - Maintain a transparent pricing reimbursement model.

IMCare performance review of CVS Caremark includes:

- Establishing a Retail Pharmacy Network
    - Pharmacy network adequacy is assessed both locally and nationally utilizing GeoAccess surveys. IMCare reviews local pharmacy participation in Itasca County, IMCare' s immediate service area, and national network accessibility.
    - IMCare reviews credentialing files of participating pharmacies to ensure pharmacy providers have the necessary credentialing documentation, which includes a signed provider agreement, DEA registration, state licensure, adequate liability insurance and current exclusion status.
    - In addition to reviewing the credentialed pharmacy exclusion status, IMCare reviews the monthly Provider Exclusion file to ensure pharmacies providing services to its enrollees are not on the CMS exclusion list.
- Pharmacy Network Auditing
    - On a quarterly basis, IMCare receives and reviews a CVS Caremark Audit Summary report, detailing the pharmacies audited and any findings and/or recoveries.
    - IMCare reviews client audit summaries, which are generated as a of result of an adverse action taken by CVS and CVS's Audit Standard policy and procedure.
- Custom Medicaid Formulary/Uniform PDL/Formulary Management
    - IMCare reviews IMCare's Formulary Management Standard Operating Procedure, the CVS Caremark policy and procedure for standard Managed Medicaid template, and IMCare's Uniform PDL Compliance Policy and Procedure.
- Pharmacy Help Desk
    - On a quarterly basis, IMCare calls the CVS helpdesk to ensure they are routing calls appropriately.
- Point of Sale Utilization Management
    - At least annually, IMCare chooses random National Drug Codes (NDCs) on the Medicaid List of Covered Drugs and Uniform PDL and compares them to the Formulary Product Spreadsheet file (a file which details utilization coding status of formulary drugs), and the CVS point-of-sale adjudication system, to determine if UM is coded correctly.
- Maintaining Eligibility Data
    - IMCare reviews eligibility load reports, and compares data sent to data loaded, to ensure eligibility data was complete.
- Maintaining Point of Sale Claims Processing
    - IMCare reviews the CVS Caremark Medicaid and Medicare Claims Adjudication Policy and Procedure.

    - Copay accuracy is validated by reviewing random generic and brand claims, to ensure that enrollees are paying the appropriate out-of-pocket amount, according to the applicable IMCare eligibility matrix.
    - Rejected claims are periodically reviewed to ensure that claims processed correctly, and enrollee medications were not inappropriately disrupted.
    - To determine if Uniform PDL status is coded correctly, IMCare chooses random NDCs from the Medicaid List of Covered Drugs and Uniform PDL, and compares them to the Formulary Product Spreadsheet file (a file which details utilization coding status of formulary drugs) and the CVS point-of-sale adjudication system.
- Communication Materials
    - IMCare regularly reviews information received from CVS to maintain its website and 2020 drug recall and withdrawal notices.
- Standard Management and Utilization Reports
    - Quarterly, IMCare reviews RxInsights reports prepared and provided to IMCare by CVS Caremark.
- Quality Management Programs
    - The IMCare Pharmacy Director reviews the content and timing of the CVS Caremark Closing Gaps in Medication Therapy activity reports and RxInsights reports.
- DUR Services/Clinical Programs
    - IMCare reviews quarterly Point-of-Sale (POS) DUR Program outcome reports prepared and provided to IMCare by CVS Caremark.
- Safety and Monitoring Solution (SMS) Program
    - IMCare reviews quarterly SMS program outcome reports and annual ESMS program reports prepared and provided to IMCare by CVS Caremark.
- General Performance and Monitoring
    - MAC Performance Oversight
        - The IMCare Pharmacy Director reviews the MAC performance report and compares the contracted rate to the actual rate.
    - Encounter Data Review
        - The IMCare Pharmacy Director reviews monthly encounter data to determine if PDEs are being submitted correctly for National Council for Prescription Drug Programs (NCPDP) encounters with assigned error penalties.
    - Invoiced and Paid Amount Reconciliation
        - The IMCare Pharmacy Director reviews monthly CVS Caremark invoice recap, pulls a DHS Finance Report out of RxNavigator for the corresponding timeframe, and compare the paid amounts to the invoiced amounts.
        - Periodically, the IMCare Pharmacy Director chooses random paid claims and sends them to the CVS Caremark account team, who compares the amounts paid to the pharmacy with the amounts billed to IMCare. IMCare takes the provided financial information from the claims and retrieves the applicable encounter data submitted to DHS, to compare the reported paid amounts by CVS Caremark to the “client net due amount” in the CET/Encounter File.

Minnesota Department of Human Services (DHS) - MSHO Enrollment

The Minnesota DHS MSHO enrollment delegated functions and responsibilities include:

- Verifying eligibility
- Entering data in the Medicaid Management Information System (MMIS)
- Sending applicant/enrollee notices
- Sending the Accrete file
- Tracking enrollees who lose special needs status
- Completing batch completion status summary files
- Working Transaction Reply Reports
- Working the Full/Special Enrollment file
- Processing disenrollment's
- Reviewing PDE error files
- Certifying enrollment data
- Audit preparation
- Adjustments
- Creating monthly membership reports
- Complying with Medicare Part D reporting requirements
- Developing and maintaining policies and procedures

IMCare performance review of DHS MSHO enrollment includes:

- IMCare staff monitors administration on an on-going basis, and as needed, through meetings with DHS to conduct business review.
- IMCare receives reporting from DHS on a regular basis to demonstrate compliance.
- IMCare conducts an annual performance review and implements a corrective action plan if indicated.

ICHHS Public Health Division - EW Care Coordination

ICHHS Public Health Division delegated functions and responsibilities include:

- Completing Long Term Care Consultation screenings.
- Providing Elderly Waiver (EW) and/or Nursing Home Certifiable (NHC) case management for MSHO and MSC+ enrollees assessed as qualified for Home and Community Based Services (HCBS).
- Performing assessments and reassessments on potential/current EW enrollees.
- Providing care coordination services to MSHO EW enrollees, and CM services to MSC+ EW enrollees.

IMCare performance review of ICHHS Public Health Division EW care coordination includes:

- IMCare performs an annual care plan audit, consistent with current DHS guidelines. If deficiencies are noted, a corrective action plan may be implemented to deter future repeat deficiencies.

Cirdan - Administrative Services

Cirdan administrative services delegated functions and responsibilities include:

- Encounter and RAPS Data Submission Services

    - Encounter Submissions for Medical and Dental claims processed by IMCare and Pharmacy claims processed by CVS Caremark data, and MDH encounter data. These submissions will include:
        - DHS Encounter Data Files – 837I, 837P, 837D, and NCPDP.
        - DHS RHC Data Files – 837P and 837D. Cirdan will submit these files weekly within seven calendar days of the "check-cut" or EFT Equivalent date assuming timely receipt of the claim extracts.
        - CMS 5010 X12 Encounter Data Files – 837I and 837P (professional and DME).
        - MDH Encounter Data Files – including medical and pharmacy claims, and enrollment data, submitted on a semi-annual schedule.
    - Encounter Data Management
    - Encounter Data Quality Control
    - RAPS Submissions for claims processed by IMCare
- Financial Consulting Services - Prepare Annual and Quarterly NAIC Statutory Rate Filings
    - Annual Statement Instruction Review
    - Prepare and complete Statements
    - Prepare and Complete MDH Supplemental Statements
- Actuarial Consulting Services
    - Load and Map Claims Data
    - Medicare Support
    - Bid Preparation
    - Bid Audit Support
    - MLR Reports
    - Commerce Audits
    - DHS Rate Negotiations
        - Analysis
        - Negotiation Support
        - Rate Adequacy Analyses
        - DHS Rate Development Review
        - Rate Meeting Attendance
        - DHS Rate Setting Method Changes
    - Medicaid MLR Reports
    - DHS Data Submissions
        - Rate Cell Experience
        - Product Experience
        - Aggregate Payment Report
        - Medicare/Medicaid Allocation
        - IHP Data Request
        - Other Data
    - Actuarial Support for Annual Statement
        - Annual Statement Instruction Review
        - Part D Liabilities
        - IBNP Liability
        - Premium Deficiency Reserve

        - Risk Adjustment Revenue
        - Provider Incentives and IHP Arrangements
        - Withhold Returns
    - Actuarial Support for Monthly and Quarterly Reporting
        - IBNP Estimates
        - Key Insights
        - Restate Reserves
        - Part D Reconciliations
        - Reserve Adequacy Review
    - Provider Contracting Support
        - Provider Contracting Support
        - Value-Based Purchasing Support
    - Data Requests from Regulatory Agencies
    - Other Services as Requested by IMCare

Cirdan is not responsible for any management or financial decisions.

IMCare performance review of Cirdan administrative services includes:

- IMCare staff monitors administration on an on-going basis, and as needed, through meetings with Cirdan to conduct business review.
- Frequent project updates are provided on-line.
- IMCare receives reporting on a regular basis, to demonstrate compliance.
- IMCare conducts a performance review annually and implement a corrective action plan if indicated.

Health Information Systems

Data Sources

IMCare data collection and reporting systems support the information needs of QI program activities. The QI program has immediate access to medical record data, including data by diagnosis, procedure, patient and/or provider.

IMCare utilizes multiple data sources in its QI program, including the following:

- CAHPS
- Health Outcomes Survey (HOS)
- Enrollee satisfaction surveys
- HEDIS data
- Grievance/appeals data
- Enrollee Initial Screening Survey
- Enrollment reports
- Health Risk Assessments (HRAs)
- Contact logs
- Utilization reports
- Claims
- Care coordination/case management reports
- Published patient safety data
- CMS reports
- Disenrollment reports
- CTD
- PHM appraisals

System Resources

System resources currently available for support of IMCare QI activities include the following:

- Enrollment – Used to implement targeted enrollee interventions.

- Provider network – Used to implement targeted provider interventions and assess the availability of the IMCare network.
- Claims data – General-purpose ad hoc reporting tool, which allows claims to be selected, sorted, and subtotaled on combinations of data elements, including diagnosis, procedure, enrollee and provider.
- UM and grievance and appeal databases – Used to track authorizations, referrals, grievances and appeals; includes primary and secondary type coding for report generation used in tracking and trending of data.
- CM databases – Used to track CM activities and generate CM reports.

Program Evaluation

At least annually, IMCare conducts an evaluation of the QI program. The written QI plan is amended when there is no clear evidence that a program continues to be effective in improving care. The External QI/UM Committee reviews and approves the program description, work plan and annual evaluation documents, annually and as needed. The Itasca County BOC is responsible for final annual review, approval and adoption.

Quality evaluation steps, in accordance with Minnesota Rules Part 4685.1120, include the following:

- Problem identification
- Problem selection
- Corrective action
- Evaluation of corrective action

The annual written evaluation includes the following:

- A description of completed and ongoing QI activities that address quality and safety of clinical care, and quality of services.
- Trending of goals/outcomes, which assesses performance in the quality and safety of clinical care, and quality of services.
- Analysis and evaluation of the overall effectiveness of the QI program and its progress toward influencing network-wide safe clinical practices.

IMCare reports on QI program initiatives to the PAC, External QI/UM Committee, and the Itasca County BOC, at least quarterly. One of the key responsibilities of these committees is to assist IMCare in identifying opportunities for improvement and to suggest possible interventions.

Complaints

IMCare investigates and responds to all grievances/complaints to remain compliant with federal and state statutes, rules and regulations, and CMS and DHS contracts. A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination (denial). This may include, but is not limited to, the quality of care or services provided, and aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the enrollee's rights, regardless of whether the enrollee requests remedial action. In addition, it includes an enrollee's right to dispute an extension of time proposed by IMCare to

make an authorization decision. IMCare has written procedures in place for thorough and consistent investigation and response to all grievances, including establishing and implementing a corrective action plan when appropriate.

Initiation of grievances can occur verbally or in writing by:

- An IMCare enrollee or an enrollee's authorized representative;
- The legal representative of a deceased enrollee's estate;
- The enrollee's attending healthcare professional for medical necessity; or
- A healthcare professional acting on behalf of the IMCare enrollee, with the enrollee's written consent.

The HPCC is responsible for coordinating the grievance process, from the initial contact through enrollee notice of final grievance determination. IMCare utilizes CTD as the source of data collection and maintenance of grievances records, and generates quarterly and annual grievance reports from CTD. IMCare reports all grievances to the PAC and the External QI/UM Committee quarterly, to determine if further intervention is required. All grievances are also evaluated annually, to identify patterns and/or opportunities for improvement. In addition to the grievance process, enrollees with concerns about overall IMCare policies, procedures or access to services within the IMCare network may attend SAC meetings. There is a telephone option for enrollees that are unable to attend in person. If an enrollee has a concern but does not wish to attend SAC, they may submit their concern via telephone, or in writing, to the QI/UM Director at any time, to be discussed at the next SAC meeting.

Provider Selection (Qualifications) and Credentialing

IMCare has a comprehensive credentialing program for the evaluation and selection of licensed independent practitioners and organizational providers who provide services to IMCare enrollees. IMCare follows NCQA credentialing standards, to ensure a consistent, thorough credentialing process that meets community standards and current contractual and legal requirements.

Individual Practitioner Credentialing

IMCare credentials/recredentials individual practitioners who:

- are licensed, certified or registered by Minnesota to practice independently;
- have an independent relationship with IMCare; and
- provide medical, dental or behavioral healthcare services to IMCare enrollees.

Credentialed practitioners may work in a variety of settings, including individual practices, group practices, facilities and/or telemedicine. IMCare credentials/recredentials medical doctors, oral surgeons, chiropractors, osteopaths, podiatrists, advanced practice registered nurses (including clinical nurse specialists, certified nurse practitioners and certified nurse midwives), physician assistants, dentists, optometrists, psychiatrists and other behavioral healthcare physicians, addiction medicine specialists, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional clinical counselors.

IMCare does not credential:

- individual practitioners who practice exclusively in an inpatient setting (e.g., hospitalists);
- individual practitioners who practice exclusively in free-standing facilities and provide care to IMCare enrollees only because enrollees are directed to the facility; or
- covering individual practitioners (e.g., locum tenens).

IMCare requires initial credentialing for individual practitioners new to IMCare, as well as practitioners with any break in network participation. Practitioners must complete the IMCare credentialing process prior to providing care to IMCare enrollees. IMCare recredentials individual practitioners at least every 36 months. In addition, IMCare performs ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when quality issues are identified.

IMCare informs practitioners of their rights at the time of initial credentialing and recredentialing. IMCare completes all required credentialing/recredentialing verifications internally and does not delegate any NCQA-required credentialing activities. All credentialing/ recredentialing applications are reviewed by the Medical Director and Director, who have the authority to approve clean files. At their discretion, files that are not deemed clean may be granted provisional approval, pending review by the PAC, which serves as the IMCare Credentialing Committee. All files not deemed clean by senior management are referred to the PAC for review and recommendations. The IMCare Director considers the Medical Director and/or PAC recommendations and makes the final determination.

Reasons for denial of an initial credentialing application for participation may include, but are not limited to:

- Suspension of a practitioner's license to practice
- Sanctions by Medicare or Medicaid
- Opting-out of the Medicare program (for certain practitioner types)
- Misrepresentation of facts on an application without an acceptable explanation
- Quality concerns that may put IMCare enrollees in danger
- Conviction relating to patient abuse
- Conviction relating to health care fraud
- Conviction relating to controlled substance

In order to protect IMCare enrollees from practitioner incompetence or misconduct, which could endanger or cause harm to enrollees, IMCare may restrict, suspend or terminate participation. IMCare may restrict/suspend/terminate participation of a practitioner who:

- has had his/her license suspended or revoked;
- has been sanctioned by Medicare or Medicaid;
- has opted-out of the Medicare program;
- fails to continuously meet the criteria for participation as an IMCare practitioner;
- has engaged in conduct that IMCare deems may endanger or cause harm to enrollees;
- misrepresents facts on a recredentialing application without an acceptable explanation; and/or

- is convicted of program-related crimes, patient abuse, health care fraud or an offense related to controlled substances.

IMCare provides an opportunity for practitioner applicants and current participants to appeal an adverse action regarding the practitioner's application for participation with IMCare or restriction, suspension, or termination for cause. Objective evidence and patient-care considerations are used to decide the appropriate course of action for denying a new practitioner's request for membership, or altering the relationship with a currently credentialed practitioner who no longer meets IMCare credentialing and/or quality standards.

Credentialing processes are conducted in a nondiscriminatory manner. In addition, IMCare has credentialing system controls in place to ensure the integrity, accuracy, confidentiality and security of credentialing processes and all related information.

Timeliness of Individual Practitioner Credentialing Appointments/Reappointments

IMCare makes the final decision whether to approve or deny a practitioner's initial credentialing application within 180 calendar days of the practitioner's signed attestation date on the application. Should a need be identified to credential the practitioner before the process is complete, provisional approval may be granted by the Medical Director.

IMCare recredentials individual practitioners at least every 36 months. NCQA requires that the 36-month timeframe begins on the date of the previous credentialing decision and is counted to the month, not the day. IMCare only extends the recredentialing cycle length when a practitioner cannot be recredentialed due to active military assignment, medical leave (e.g., maternity leave) or sabbatical. In these instances, practitioners are recredentialed within 60 calendar days of his/her return to practice. Timeliness of credentialing appointments/reappointments is reported quarterly to the IMCare PAC.

Organizational Provider Credentialing

Organizational provider quality is evaluated at the time of initial credentialing, during recredentialing every 36 months thereafter, and ongoing as quality concerns/issues arise. Network organizational providers credentialed by IMCare include licensed hospitals, Medicare certified home health agencies, skilled nursing facilities, free-standing surgical centers, and certain behavioral healthcare providers.

Prior to contracting and at least every 36 months thereafter, IMCare verifies that the organizational provider:

- Is in good standing with state and federal regulators.
- Has been approved by an appropriate accrediting body.
- Passes an onsite quality assessment (if not accredited).

All organizational provider credentialing/recredentialing applications are reviewed by the Medical Director, who makes a recommendation. At the discretion of the Medical Director or Director, the PAC may be asked to review an organizational provider credentialing/ recredentialing application and make a recommendation. The IMCare Director considers the Medical Director and/or the PAC recommendation and makes the final determination.

IMCare may terminate organizational providers for multiple reasons. The procedure for doing so varies significantly, depending upon whether the termination is for cause (e.g., identified quality concerns) or not for cause (e.g., business closure). For cause reasons for denial of an initial organizational provider credentialing application or restriction/suspension/termination of an already contracted organizational provider include, but are not limited to:

- License adverse action/s
- Medicare/Medicaid sanction/s
- Misrepresentation of facts on a credentialing/recredentialing application without an acceptable explanation
- Quality concerns that may put IMCare enrollees in danger

Site Visit Audit

IMCare ensures that all network office sites meet defined standards by performing/reviewing site visit audits, in order to assess the quality, safety and accessibility of office sites where care is delivered. IMCare audits the office sites of individual practitioners:

- Prior to the completion of the initial credentialing process.
- When a practitioner relocates or opens an additional office.
- When a complaint is received about an office site.
- When office site issues are identified during other quality improvement activities.

IMCare performs an onsite quality assessment of organizational providers (including hospitals, Medicare-certified home health agencies, skilled nursing facilities, free-standing surgical centers and behavioral healthcare facilities):

- Prior to the completion of the initial credentialing process and at least every three years thereafter.
- When a practitioner relocates or opens an additional office.
- When a complaint is received about an office site.
- When office site issues are identified during other quality improvement activities.

IMCare is not required to perform routine site visits if an organizational provider is currently accredited by an applicable accrediting body or is in a rural area, as defined by the U.S. Census Bureau. For unaccredited providers, IMCare may use a state or federal quality review in lieu of a site visit, if the review is no more than three years old, and IMCare obtains the survey report/letter stating that the provider was reviewed and passed inspection.

IMCare utilizes a site visit audit tool to assess standards and thresholds for clinical environment (handicapped accessibility, appearance, space, safety and infection control); patient rights (patient rights statement, wait times and complaint system); care delivery (emergency preparedness, medication administration and ancillary services); provider accessibility (appointment availability), medical records (security, confidentiality, organization and presence of a Health Insurance Portability and Accountability Act (HIPAA) policy); quality management (quality program, work plan, committee and peer review process); and human resources (verification of employee credentials, criminal background check and staff development and performance evaluations). A score of 80% or above meets IMCare standards. A score below 80% requires a corrective action plan to address noted deficiencies. The severity of the

deficiencies are taken into account in the development of the corrective action plan. At a minimum, follow-up site visits are completed every six months until the deficiencies have been corrected.

Between credentialing cycles, IMCare continually monitors enrollee complaints regarding practitioner/provider office sites through the grievance and appeal system and performs a site visit within 60 calendar days of submission of a quality of care grievance related to the quality of a practitioner/provider office site. The same scoring and process is used to address deficiencies as during credentialing/recredentialing. If subsequent to correcting a deficiency, IMCare receives a new complaint regarding the office site, a follow-up visit is performed within 60 calendar days of the new complaint and the same process is used for scoring and corrective action (if indicated). In addition, quarterly enrollee complaint/grievance reports received from network facilities are reviewed by the IMCare Medical Director and QI/UM Director, and may prompt an office site visit at their discretion.

Credential File Audit

IMCare completes an annual audit of credentialing/recredentialing files, to ensure that all required elements were present at the time of the credentialing/recredentialing decision; applicable timeframes were met; and there is no evidence of discrimination during the credentialing/recredentialing process.

Provider Participation Agreements/Contracted Partners

IMCare contracts with individual practitioners and providers, including those making UM decisions, require cooperation with the IMCare QI Program. IMCare providers must cooperate with QI Program activities, maintain confidentiality of enrollee information and records, and allow IMCare to use provider performance data. IMCare provider participation agreements also require compliance with applicable Federal and State regulations, statutes, rules and laws, including reporting requirements.

Affirmative Statement

IMCare reviews the Affirmative Statement at least annually and disseminates to all providers, enrollees and IMCare staff. IMCare includes the Affirmative Statement with updated provider contracts. Additionally, IMCare updates the policy and procedure related to the affirmative statement annually and includes this in the IMCare Provider Manual.

Healthcare Directive

IMCare distributes health care directive information at least annually to enrollees, providers and IMCare staff. Healthcare directive information is included in provider contracts. The policy and procedure for health care directives is included in the IMCare Provider Manual. IMCare will continue to provide provider and enrollee education related to advanced directives.

Accessibility of Services

As required by NCQA and IMCare contracts with DHS, IMCare ensures enrollee access to primary care providers (PCP), specialty care providers (SCP), behavioral health care providers and certain ancillary providers, by analyzing data to identify gaps in network accessibility, and

comparing network performance against accessibility standards. IMCare strives to maintain current accessibility standards and identify further opportunities for improvement.

Practitioner Availability and Network Adequacy

IMCare ensures the availability of practitioners and services by identifying gaps in network adequacy through data analysis, as required by NCQA and IMCare contracts with DHS. IMCare maintains and monitors a network of practitioners, supported by written agreements, and provides adequate availability to covered services to meet the needs of the population served in accordance with MN Statute 62D.124 and MN Statute 62K.10, as well as MN DHS and CMS contracts. IMCare will continue to assess network adequacy and look for opportunities to expand specialty provider access.

Provider Satisfaction Survey

Annually, IMCare surveys network providers to assess their level of satisfaction with, and knowledge of, IMCare services. Survey questions cover topics such as authorizations, pharmacy management and overall satisfaction. Provider Satisfaction Survey responses provide valuable information that is used by IMCare to make program changes, contributing to the ultimate goal of offering optimal service to both enrollees and providers. IMCare will continue to evaluate provider satisfaction and evaluate ways to improve upon noted areas of dissatisfaction.

Medical Records

IMCare regularly audits enrollee medical records to determine if providers are documenting important aspects of enrollee medical and behavioral health needs, and to ensure that health care records are maintained with timely, legible and accurate documentation of patient information (per IMCare health record policy). Using a structured audit tool (based on DHS contracts, current MN Statutes, and NCQA standards), IMCare conducts these audits to ensure regulatory requirements and standards are met.

IMCare utilizes Ciox Health Information as a medical record retrieval system. It is used to request medical records from participating providers and ensure that records are received timely through a secure system. Non-participating providers can use facsimile to deliver medical records to IMCare. When medical records are received, IMCare staff links them into the care management system CTD.

2021 Program Improvement Planned Activities

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a tool used to measure performance on important dimensions of care and service. IMCare uses software called CareAnalyzer from DST Health Solutions to produce the required HEDIS measures. IMCare annually creates a plan to set performance goals, analyze results, identify opportunities for improvement, implement interventions and evaluate the effectiveness of the interventions, consistent with the HEDIS audit cycle and following the HEDIS audit technical specifications outlined by NCQA, to ensure that methods remain constant from year to year. HEDIS is a valid methodology that provides quantitative results. Reports include quantitative and qualitative analysis.

In 2021 IMCare plans to focus on improving preventative care measures, including but not limited to:

- Breast cancer screening (PMAP/MNCare/ MSHO)
- Chlamydia screening (PMAP/MNCare)
- Colorectal cancer screening (PMAP/MNCare/MSHO)
- Childhood immunization rates (PMAP/MNCare)
- Adolescent well care visits (PMAP/MNCare)
- Diabetic eye examinations (PMAP/MNCare/MSHO/MSC+)
- Diabetes nephropathy testing (PMAP/MNCare/MSHO)
- Potentially harmful drug-disease interactions (MSHO)
- High-risk medications (MSHO)
- Advanced care planning for older adults (MSHO/MSC+)

Performance Improvement Projects (PIPs)

IMCare conducts Performance Improvement Projects (PIPs) designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical and non-clinical care areas, that are expected to have a favorable effect on health outcomes and enrollee satisfaction. IMCare uses its Medicare Quality Improvement Project (QIP) to meet the Medicaid PIP requirements for the MSHO and MSC+ populations.

2021-2023 PIP: Increasing Human Papilloma Virus (HPV) Vaccination Rates Among Adolescents

IMCare selected the 2021-2023 PIP topic with the overall goal of improving HPV vaccination rates among male and female adolescents in IMCare PMAP and MNCare populations by an absolute two percentage points above baseline, as evidenced through hybrid data gathered for the HEDIS Effectiveness of Care (IMA) HPV measure. The goal of the project will be achieved through a collaborative approach that includes targeted enrollee/parent education, providing information to health care providers and educating the public about the topic.

2021-2023 QIP: Reducing the Incidence of Poor HbA1c Control (>9.0%) Among IMCare MSHO Enrollees

IMCare selected the 2021-2023 QIP topic with the overall goal of decreasing the percentage of MSHO enrollees with poor diabetes control (HbA1c > 9%) by an absolute two percentage points by the end of 2022, and sustaining the improvement through 2023. Interventions were designed to reduce the percentage of enrollees identified as having poor glycemic control, as defined by HEDIS technical specifications. The goal of the QIP will be achieved through a collaborative approach, including targeted enrollee interventions, implementation of diabetes management best practice recommendations, and enrollee/provider engagement.

Focus Studies

IMCare conducts focus studies to gather information relative to enrollee quality of care. The focus studies are directed at areas with potential opportunities for improvement.

Emergency Department Utilization Focus Study

The IMCare Emergency Department Utilization Focus Study (ED FS) was implemented in January of 2011 with the goals of:

- Identification of enrollees with high ED utilization, in order to provide timely and appropriate enrollee education and CM.
- Timely referral of enrollees (e.g., from an ED provider/nurse/social worker to an IMCare MCN or Senior Care Coordinator) who were seen in an IMCare network ED and who may benefit from education/CM.
- Identification of enrollees with high ED utilization, in order to identify and intervene in cases of fraud/abuse (as defined by Minnesota Administrative Rules, part 9505.2165).

In 2021, IMCare would like to continue to see a decrease in rates of ED utilization for all populations. IMCare will continue to use the current ED FS methodology, in an effort to identify and intervene early in cases of potential overutilization or fraud/abuse. Activities of care coordination, CM and evaluation for the RRP will continue on a case-by-case basis.

Controlled Substance Focus Study

The IMCare Controlled Substance (CS) Focus Study (FS) was implemented in January of 2011, with the goals of:

- Identification of enrollees with a high number of controlled substance prescription fills, in order to provide timely and appropriate CM.
- Timely referral of enrollees who may benefit from CM due to controlled substances (e.g., assistance with chemical dependency treatment enrollment).
- Identification of enrollees who use multiple providers and/or pharmacies to obtain controlled substance prescriptions, in order to intervene in cases of fraud and/or abuse (as defined by Minnesota Administrative Rules, part 9505.2165).
- Timely investigation of enrollees who a provider suspects may be committing fraud and/or abuse.

The value that this FS brings to IMCare and the community is important in the community-wide effort to reduce substance abuse in Itasca County. In 2021, IMCare will continue to identify, and attempt to reduce, inappropriate CS utilization through enrollee, provider and pharmacy interventions. Additionally, activities of care coordination, CM and evaluation for the RRP will continue a case-by-case basis.

***A Healthy Pregnancy* Prenatal Initiative Focus Study**

A Healthy Pregnancy program was developed in 2007, in collaboration with Itasca County Public Health's Maternal-Child Health Division. This program is for at-risk IMCare pregnant enrollees. Low socioeconomic status is a risk factor for preterm birth; therefore, IMCare's pregnant enrollees are considered at-risk for preterm delivery.

IMCare pregnant enrollees are offered enhanced services through *A Healthy Pregnancy* program. The program includes prenatal education and support, and is free. A pregnancy congratulatory letter is sent to each pregnant enrollee. The letter encourages the enrollee to seek early prenatal care, and informs her about the program and who she can contact for additional information. An IMCare MCN also contacts newly pregnant enrollees by telephone to explain the program and offer a referral to Itasca County Public Health. After accepting a referral, each pregnant enrollee is matched to a Maternal Child Public Health Nurse (MCH) in the *Prenatal and Healthy Beginnings* program. The education provided through the program follows MHCP Provider

Manual guidelines for enhanced services. Topics include information about normal body changes in pregnancy, fetal development, self-care, pregnancy danger warning signs, preventing preterm labor, review of signs and symptoms of preterm labor, lifestyle and parenting support, breastfeeding, and labor and delivery education. Postpartum education is also included in *A Healthy Pregnancy* program, providing education and support to new mothers.

In some cases, enrollees first seek medical services after the first trimester of pregnancy and/or enroll in IMCare in the last trimester of pregnancy. Itasca County Public Health is often the first source of services for pregnant women who may be eligible for IMCare. In addition to early Public Health intervention, IMCare will continue to emphasize early access into the medical system for prenatal education and support, and stress the importance of a postpartum visit, by enrollee phone contact, written education by newsletter, and individual educational mailings to pregnant enrollees. IMCare will continue to aim for reduction of adverse events in pregnancy and delivery through this referral program, incentives for first-time participants, and education for all pregnant enrollees. IMCare will attempt to incentivize enrollees who have not previously participated in the program by offering Target gift cards for prenatal and postpartum care visits with a Maternal Child Health Nurse and their provider.

Special Health Care Needs

IMCare has implemented mechanisms to identify enrollees with special health care needs and to assess the quality and appropriateness of care furnished to these enrollees. IMCare uses analysis of claims data diagnoses and under or over utilization patterns to identify enrollees (age 18 years and older) with special health care needs. In addition to claims data, IMCare may use other methods to identify enrollees, such as requests for service authorizations and enrollee assessments or surveys.

Medicaid Special Health Care Needs

IMCare identifies Medicaid (PMAP and MNCare) enrollees with special health care needs through regular analysis of claims, hospital admissions and UM information. If indicated, enrollees are referred to CM for screening. IMCare will continue to ensure appropriate utilization and access to care for this population through timely data analysis, and CM referral and interventions.

Seniors Special Health Care Needs

IMCare care coordinators complete a comprehensive assessment or screening for all willing senior (MSHO and MSC+) enrollees, to identify ongoing special conditions, which may require treatment or regular monitoring. A comprehensive care plan is developed and implemented, and enrollees are allowed direct access to specialists (as appropriate for identified conditions and needs). IMCare will continue to identify special health care needs for seniors through activities of care coordination, as all senior enrollees are enrolled in care coordination through their benefit.

Enrollee Experience

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

CAHPS is a nationally-recognized and comprehensive survey instrument designed to capture the experiences of consumers and enrollees with a range of health care products and services, such as customer service, shared decision making, access to care, and claims possessing. By providing consumers with standardized data, and presenting it in a way that is easy to understand and use, CAHPS is intended to help people make decisions that support better health care and better health. IMCare will continue to evaluate gaps in satisfaction, most notably Health Plan Satisfaction, and identify opportunities for improvement through enrollee, provider and staff education.

Senior Care Coordination Satisfaction Survey

IMCare surveys senior (MSHO and MSC+) enrollees annually, to assess their level of satisfaction with care coordination, as well as their knowledge of IMCare services. The intent of the survey is to receive feedback from a larger number of enrollees, not just those who contact IMCare to share feedback. IMCare divides survey results by the population served (i.e., Elderly Waiver (EW), community well (CW), and skilled nursing facility (SNF)) to further understand where gaps in satisfaction exist. In 2021, survey questions will be tailored to specific populations, to better reflect service satisfaction. Overall, IMCare senior enrollees are satisfied with care coordination services. IMCare will evaluate the 2021 survey to identify more clear and objective ways to assess enrollee satisfaction.

Enrollee Education Sessions

Outside of the COVID-19 pandemic, IMCare provides in-person monthly enrollee education. The purpose of the education is for enrollees to learn how to use their IMCare medical card, review the Member Handbook, and learn how to obtain medical care. IMCare currently measures enrollee education through attendance numbers at the monthly education sessions and contact logs with topics correlating to those addressed in enrollee education sessions. In 2021, IMCare will explore opportunities to make education more readily available to enrollees through an online delivery method.

Customer Service Call Center Performance

IMCare must ensure that enrollees and providers are able to reach IMCare Customer Service Representatives (CSRs), according to regulatory and accreditation standards. IMCare must maintain low abandonment rates for customer services lines. CMS requires a rate of 5% or less for disconnection (abandonment). IMCare will continue to work to maintain low abandonment rates during business hours, and collaborate with the afterhours agency to improve abandonment rates.

Complex Case Management

The IMCare Complex Case Management (CCM) program identifies enrollees with complex healthcare needs, based upon their chronic condition/s, potential disability, health care activity, and/or any other identified need for CM. The goals of CCM are to assist enrollees in regaining optimum health and/or improved functional capacity; educate enrollees regarding their condition; educate enrollees about self-management and preventative care; reinforce provider-prescribed

treatment plans; and provide information on resources that are available to enrollees. IMCare assists enrollees with multiple or complex conditions with obtaining access to care and services and coordinating their care.

CCM conditions include, but are not limited to, the following:

- Cancer
- Substance Use Disorder
- Hepatitis C
- Behavioral health
- Pain
- Restricted Recipient
- Serious medical condition
- State Medical Review Team (SMRT) allowable conditions

IMCare utilizes two distinct processes to identify enrollees for enrollment in CCM that include both administrative/electronic data and/or referral sources. Administrative data reports are reviewed at least monthly and referrals sources are reviewed as received.

The CCM program involves a comprehensive initial assessment of the enrollee's condition, determination of available benefits and resources, development and implementation of a care plan, and coordination of services. After an enrollee has been identified for CCM, an MCN contacts the enrollee to perform an initial assessment and develop a plan of care. The MCN works closely with the enrollee, the enrollee's legal representative, the enrollee's PCP, and other providers identified by the enrollee's treatment team, to coordinate care and access needed services. The CCM program is provided at no cost to the enrollee. Enrollees meeting criteria can voluntarily enroll with verbal and/or written consent. The program is most successful with participation of the enrollee's family, caregivers and other natural support systems, as identified by the enrollee.

Care Coordination

Care coordination is required for MSHO enrollees, but is offered to all senior enrollees, including MSC+ enrollees. Care coordination ensures access to and coordination of the delivery of all Medicare and Medicaid preventive, primary, acute, post-acute, rehabilitation, and long-term care services, including State Plan Home Care services and EW services. Care coordination ensures communication and coordination of an enrollee's care across Medicare and Medicaid network provider types and settings, to ensure smooth transitions for enrollees who move among various settings in which care may be provided over time, to strive to facilitate and maximize the level of enrollee self-determination and enrollee choice of services, providers and living arrangements. It also promotes and assures service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally-appropriate care and fiscal and professional accountability. Each enrollee is provided a primary contact person, who assists them in simplifying access to services and information. IMCare will continue to evaluate for opportunities to further enhance enrollee care coordination services to reduce barriers and promote access to care.

Population Health Management (PHM)

The IMCare Population Health Management (PHM) program was implemented on January 1, 2020. PHM is a discipline within the healthcare industry that studies and facilitates care delivery across the general population or a group of individuals. The primary areas of focus for the PHM program are keeping enrollees healthy, managing enrollees with emerging risk, enrollee safety or outcomes across settings, and managing multiple chronic illnesses.

Specific goals developed for the PHM program include the following:

1. Goal: Annual increase of enrollees in the target population receiving influenza vaccine.
   Target population: All enrollees enrolled in the plan who exceeded 6 months of age in the measurement year with or without risk factors.
2. Goal: Increase in annual age appropriate wellness exams for enrollees as captured in the following HEDIS measures: Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the 3rd-6th years of life (W34); and Adolescent Well-Care Visits (AWC).
   Target population: All enrollees enrolled in the plan who met age requirements within the measurement year.
3. Goal: Increase in annual age appropriate wellness exams for enrollees as captured in the following HEDIS measures: Breast Cancer Screening (BCS); Colorectal Cancer Screening (COL); Cervical Cancer Screening (CCS); and Chlamydia Screening in Women (CHL).
   Target population: All enrolled adults that meet age requirements in measurement year.
4. Goal: Improve statin therapy for enrollees with diabetes by two percentage points.
   Target population: Enrollees aged 40-75 with diabetes.
5. Goal: Increase follow up after ED visits for mental illness or substance use disorder (SUD) as identified by the following HEDIS measures: Follow-Up After ED Visit for Mental Illness (FUM) and Follow-Up after ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA).
   Target population: Enrolled individuals 13 years of age and older in the measurement year.
6. Goal: Annual reduction in inpatient readmissions in target population.
   Target population: Enrollees 18 years of age and older in the measurement year with two or more chronic illnesses.

IMCare plans to achieve the above goals through enrollee and provider engagement via newsletters, online resources, and individual outreach as indicated. Annual evaluation of program effectiveness will occur once the HEDIS data from the initial year of the program is available.

Practice Guidelines

The adoption, dissemination and application of clinical practice guidelines are required by IMCare 2021 Families and Children and Seniors contracts with DHS and 42 CFR §438.236. Per Article 7.1.6 of the 2021 Seniors contract, “The MCO shall adopt preventive and chronic disease

practice guidelines appropriate for Enrollees age sixty-five (65) and older, consistent with accepted geriatric practices." Both contracts require that the practice guidelines:

- are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field;
- consider the needs of the MCO Enrollees;
- are adopted in consultation with contracting Health Care Professionals; and
- are reviewed and updated periodically as appropriate.

Continuity and Coordination of Care

IMCare must ensure continuity of care for enrollees when the need exists. In these cases, an enrollee's services will continue, according to the existing treatment plan. IMCare manages care transitions for enrollees, including identification of problems that could cause transitions and, where possible, prevent unplanned transitions. Care coordinators/case managers work with enrollees to manage and identify planned and unplanned transitions, support enrollees through transitions, and partner with enrollees to work towards reducing transitions through education and coordination of services. The purpose of monitoring and managing care transitions is to decrease, reduce and eliminate unsafe and fragmented care, which may occur with poorly coordinated transitions of care. By taking steps to coordinate all aspects of transitions, potential adverse outcomes may be avoided. IMCare strives to minimize unplanned transitions and works to maintain enrollees in the least restrictive setting possible. IMCare will continue to educate and remind enrollees, the enrollee's responsible party, EW service providers, and medical providers on the importance of IMCare and provider notification of all transitions.

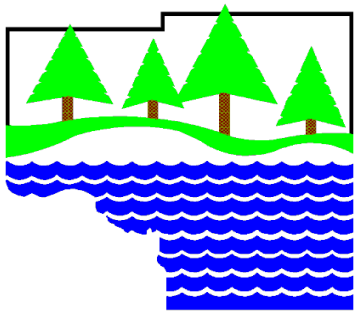
Work Plan

IMCare prepares and maintains an annual written work plan. The IMCare QI/UM Work Plan is developed by including required and identified quality program improvement activities. The External QI/UM Committee identified goals are incorporated into the work plan. The QI/UM Work Plan outlines goals and outcomes, which are specific, measurable, achievable, relevant, and timely. This allows IMCare to clearly determine whether goals and outcomes have been met and identify areas of improvement for the subsequent year. The work plan is updated frequently and monitored at least quarterly by the various committees. The work plan is filed with the commissioner as required and requested. The work plan is approved by the Itasca County BOC and meets the following requirements:

- Detailed description of the proposed quality evaluation activities that will be conducted.
- Quality evaluation activities are conducted, as indicated, in the quality plan.

Contact Information

If you have questions or comments about any information contained in this report, please contact IMCare QI/UM Director, Alexis Martire, at (218)327-6199, (800)843-9536 ext. 2199, or by email to alexis.martire@co.itasca.mn.us.



ITASCA MEDICAL CARE

2021 Annual Quality and Utilization Management Work Plan

Final Approval by:

IMCare QI/UM Committee: 3/17/2021
Itasca County Board of Commissioners:

Minnesota Department of Human Services Contract

Section 7.1.7 Annual Quality Assurance Work Plan

On or before May 1st of the Contract Year, the MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, Part 4685.1130, subpart 2, and current NCQA "Standards and Guidelines for the Accreditation of Health Plans." If the MCO chooses to substantively amend, modify or update its work plan at any time during the year, it shall provide the STATE with material amendments, modifications or updates in a timely manner.

Minnesota Rules: 4685.1130 FILED WRITTEN PLAN AND WORK PLAN.

Subpart 1. Written plan.

The health maintenance organization shall file its written quality assurance plan, as described in part 4685.1110, subpart 1, with the commissioner, before being granted a certificate of authority.

Subpart 2. Annual Work Plan.

The health maintenance organization shall annually prepare a written work plan. The health maintenance organization shall file the work plan with the commissioner, as requested. The work plan must be approved by the governing body and meet the requirements of items A and B.

A. The work plan must give a detailed description of the proposed quality evaluation activities that will be conducted in the following year and a timetable for completion. The quality evaluation activities must address the components of the health care delivery system defined in part 4685.1115, subpart 2. The quality evaluation activities must be conducted according to the steps in part 4685.1120.

In determining the level of quality evaluation activities necessary to address each of the components of the health maintenance organization, the commissioner shall consider the number of enrollees, the number of providers, the age of the health maintenance organization, and the level of quality evaluation activities conducted by health care organizations that perform similar functions.

B. The work plan must describe the proposed focused studies to be conducted in the following year. The focused studies must be conducted according to the steps in part 4685.1125. Each proposed study must include the following elements:

1) *Topic to be studied;*
2) *Rationale for choosing topic for study according to part 4685.1125, subpart 1;*
3) *Benefits expected to be gained by conducting the study;*
4) *Study methodology;*
5) *Sample size and sampling methodology;*
6) *Criteria to be used for evaluation; and*
7) *Approval by the health maintenance organization's medical director or qualified director of health designated services designated by the governing body.*

Each health maintenance organization shall annually complete a minimum of three focused studies. The focused study sample must be representative of all health maintenance organization enrollees who exhibit characteristics of the issue being studied.

Subpart 3. Amendments to plan. *The health maintenance organization may change its written quality assurance plan by filing notice with the commissioner 30 days before modifying its quality assurance program or activities. If the commissioner does not disapprove of the modifications within 30 days of submission, the modifications are considered approved.*

Subpart 4. Plan review. *Upon receipt of the filing, the commissioner shall review the health maintenance organization's annual proposed work plan to determine if it meets the criteria established in parts 4685.1105 to 4685.1130.*

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN									
Program Structure									
Source of Standard: 438 CFR Subpart E; Minnesota Rules 4685.1110 to 4685.1130; DHS Contract Sections 7.1 -7.1.8, 7.2, 7.6; NCQA QI 1-5, & UM 1-13									
Goals	**Objectives**	**Tasks**	**Outcome Measures**	**Data / Information Source**	**Responsible Staff**	**Timeline Expected**	**Status**	**Progress/Results**	**Date Completed**
Quality Program Description is filed with MDH by 5/1	To improve the quality and safety of clinical care and services provided to IMCare enrollees.	Revise Quality Program Description as necessary	Quality Program Description is revised & includes the following: • QI Program Structure • Behavioral Healthcare (BH) aspects of the IMCare QI program & involvement of a BH practitioner • Involvement of a designated physician (Medical Director) in the IMCare QI Program • Oversight of QI functions of IMCare by the IMCare QI/UM Committee • How IMCare addresses enrollee safety • IMCare's objectives for serving a culturally and linguistically diverse enrollees • IMCare's objectives for serving enrollees with complex health needs Quality Program Description is: • Approved by QI/UM Committee • Filed with the State	2020 QI/UM Program Evaluation to identify areas needing improvement 2021 QI Program Description	QI/UM Director	Q1 2021	Complete	Reviewed/ approved by QI/UM Committee	3/17/2021
Quality & Utilization Management Evaluation is filed with the State by 5/1 and URL in which enrollees can review is provided	The Quality and Utilization Management Programs are evaluated for ongoing effectiveness and to ensure compliance with state and federal regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans"	Review and evaluate all aspects of IMCare's Quality and Utilization Management Programs	Quality Improvement & Utilization Management Program Evaluation includes assessment of the following elements: • The QI and UM Program Structures • Ongoing QI activities that address quality and safety of clinical care and quality of service; and trending measures associated with those activities • The overall effectiveness of QI Program • The UM Processes and information used to make determinations • The level of involvement of a physician and BH practitioner in the UM program QI/UM Program Evaluation is: Approved by the IMCare QI/UM Committee Filed with the State Made available on the IMCare website for enrollee review	2020 Quality Reports 2020 UM Reports	QI/UM Director	Q1 2021	Complete	Reviewed/ approved by QI/UM Committee	3/17/2021

2018 Utilization Management Program Description is filed with the State by 5/1	To ensure IMCare makes utilization decisions affecting health care of enrollees in a fair, impartial and consistent manner	Revise Utilization Management Program Description as necessary	Utilization Management Program Description includes the following elements: UM Program Structure • Behavioral Healthcare (BH) aspects of the IMCare UM program & involvement of a BH practitioner • Involvement of a designated physician (Medical Director) in the IMCare UM Program • Oversight of UM functions of IMCare by the IMCare QI/UM Committee • The UM Program scope, process and information sources used to determine benefit coverage and medical necessity UM Program Description is: • Approved by QI/UM Committee • Filed with the State	2019 QI/UM Program Evaluation to identify areas needing revision 2020 UM Program Description	QI/UM Director	Q1 2020	Complete	Reviewed/ approved by QI/UM Committed	3/18/2020
Quarterly report of QI/UM activities to the QI/UM Committee	IMCare's QI/UM Committee and practitioners develop, implement and oversee the QI/UM program	Present the following to QI/UM Committee: • Quarterly DTR / Grievance/ Appeals Report • Quality of Care Grievance Review • QI/UM Documents/ R	• Ensures practitioner participation in the QI/ UM program through planning, design, implementation or review • Analyzes and evaluates the results of the QI/UM activities • Review and approve quality improvement and utilization management documents • UR data and analysis to QI/UM committee at least quarterly • Quarterly DTR/Appeal/Grievance/Quality of Care Grievance Review	IMCare QI/UM Committee agendas and minutes; Annual QI Program Evaluation, Annual QI Program Description	Director Medical Director QI/UM Director	Q1 2021 Q2 2021 Q3 2021 Q4 2021	In progress	Q1 Complete	3/17/2021
Quarterly reports of UR, UM and QI activities to the QI/UM Committee	Itasca County Board of Commissioners (BOC) will provide ongoing oversight of the QI/UM program.	Present quarterly updates to BOC	• Review and approve quality improvement and utilization management documents • UR data and analysis to BOC at least quarterly	BOC agenda & minutes	Director QI/UM Director	Q1 2021 Q2 2021 Q3 2021 Q4 2021	In progress	Q1 Complete	

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Credentialing QI Activities

Source of Standard: NCQA CR1- CR8; MED 3; MDH Monitoring Guide - Credentialing Process

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Annual review of credentialing policy and procedure (P&P)	To ensure alignment with NCQA credentialing standards	Review and update P&Ps pertaining to credentialing to reflect current NCQA Guidelines	IMCare will have updated P&Ps to utilize	Credentialing P&Ps	Credentialing staff (MSS) with oversight from Medical Director as needed	Q2 2021	In progress		
Annual Credentialing File Audit	To ensure a consistent, thorough credentialing process	Review 10 credentialing files against standards	IMCare will have a consistent and thorough credentialing process that meets community standards and current contractual and legal requirements	Credentialing File Audit Report	QI/UM Director	Q4 2021	In progress		
Annual Credentialing File Audit Report for previous year	To ensure a consistent, thorough credentialing process	Compose Annual Credentialing File Audit Report	IMCare will annually evaluate the credentialing process and implement quality improvement measures as indicated	Credentialing File Audit Report	Credentialing staff (MSS) KR	Q1 2021	Complete	Presented to PAC and approved on 02/10/2021	2/10/2021
Quarterly Reporting of credentialing activities to the Credentialing Committee (PAC)	To ensure committee oversight	Report quarterly on credentialing activities or concerns	IMCare will have a consistent and thorough credentialing process that meets community standards and current contractual and legal requirements	PAC Agenda/ Minutes	Medical Director	Q1 2021 Q2 2021 Q3 2021 Q4 2021	Complete	Presented to PAC and approved on 02/10/2021	2/10/2021
Individual Practitioner Credentialing Report	To ensure that all initial credentialing and credentialing applications are reviewed and completed within the required timeframes	Evaluate credentialing files completed and compose report	IMCare meets all requirements for individual credentialing	Quarterly Timeliness Report Annual Timeliness report	Credentialing Staff (MSS) KR	Q1 2021	Complete	Presented to PAC and approved on 02/10/2021	2/10/2021
Organizational Provider Credentialing Report	To ensure a consistent, thorough credentialing process	Evaluate organizational credentialing files completed and compose report	IMCare will have a consistent and thorough credentialing process that meets community standards and current contractual and legal requirements	Organizational Provider Credentialing Report	Credentialing Staff (MSS) KR	Q1 2021	Complete	Presented to PAC and approved on 02/10/2021	2/10/2021
Review of Site Visit Audit Tool	To ensure alignment with NCQA Standards CR7 & MED 3	Review current audit tool and modify to align with NCQA Standards	IMCare will have an updated site visit audit tool to IMCare will have network provider sites that meet office site standards	Site Visit Audit Tool	Managed Care Nurse Final review by Medical Director	Q3 2021			

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Annual Technical Report (ATR)

Source of Standard: 438 CFR Subpart E; Minnesota Rules 4685.1110 to 4685.1130; DHS Contract Sections 7.1 -7.1.8, 7.2, 7.6; NCQA QI 1-5, & UM 1-13

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
ATR Response Population: PMAP, MNCare, MSHO, MSC+	Evaluate the data sources reviewed by MPRO as the EQRO to determine the progress IMCare has made in meeting the goals set forth in the DHS/MCO contract. To provide a detailed account of all review activities undertaken during the past year to reach the above determination.	Review areas needing improvement and implement recommendations as indicated. See HEDIS tab for specific HEDIS interventions	ATR Response submitted to IPRO by 11/15/2021	ATR Response Document	QI/UM Director	Q4 2021	In progress		

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Practitioner Availability and Network Adequacy

Source of Standard: Minnesota Statutes §62D.124, §62K.10, Minnesota Rules, part 4865.1010, and 42 C.F.R. § 438.68 (DHS Contact section 6.13) and Medicare & Medicaid Services (CMS) contracts; NCQA NET 1-6

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	TimelineExpected	Status	Progress/Results	Date Completed
Cultural, ethnic, racial and linguistic needs assessments of all enrollees at enrollment	To ensure practitioner availability for minority and special needs populations	Mail out initial enrollee screening survey to newly enrolled individuals & evaluate results upon return	Enrollees have access to culturally competent providers	Health Risk Assessment Results/ CTD	OSS/MCN	Ongoing, monthly	In progress		01/08/2021 02/08/2021 03/05/2021 04/06/2021
Provider survey for cultural competency training, interpreter availability and handicap accessibility	To ensure practitioner availability for minority and special needs populations	Compile results from Q3 provider survey for Provider Directory	Enrollees have access to providers that can meet their needs	Provider Directory indicates which providers notated these in the survey	OSS/MSS/ Health Plan Compliance Coordinator	At least annually in Q4 2021 and as new information becomes available.	Ongoing		
Review of clinic grievance reports	To identify barriers to care for enrollees	Provider reminders two weeks prior to due date of submission Present to PAC/ QI/UM committee for input as indicated	Enrollees have access to quality healthcare within the IMCare network	Clinic Grievances Submitted by providers PAC/ QI/UM Agenda/ Minutes	Medical Director QI/UM Director QI/UM Committee	Q1 2021 Q2 2021 Q3 2021 Q4 2021	In progress	Q1 reviewed by QI/UM Director & Medical Director no referrals to PAC or QI/UM committee.	2/5/2021
Provider education regarding Network Adequacy	To ensure contractual and regulatory standards are met	Write article for provider newsletter	Network providers are knowledgeable of network adequacy standards	Information regarding network adequacy will appear in provider newsletter	MCN	Q2 2021	In progress		
Assess practitioner availability and network adequacy Population: PMAP, MNCare, MSHO, MSC+	To reduce gaps in network adequacy and practitioner availability	Write annual report Present to Provider Advisory Committee (PAC) Present to QI/UM Committee	Practitioner Availability and Network Adequacy Report will be completed	CTD Provider Roster Enrollment files GIS Mapping	MCN	Q4 2021	In progress		

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Accessibility of Services

Source of Standard: 438 CFR Subpart E; Minnesota Rules 4685.1110 to 4685.1130; DHS Contract Sections 6.13; NCQA NET 1-6

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Cultural, ethnic, racial and linguistic needs assessments of all enrollees at enrollment	To ensure practitioner availability for minority and special needs populations	Mail out health screening survey to newly enrolled individuals & evaluate results upon return	Enrollees have access to culturally competent providers	Health Risk Assessment Results/ CTD	OSS/ MCN	Ongoing, monthly	In progress		01/08/2021 02/08/2021 03/05/2021 04/06/2021
Assess accessibility of network providers	To ensure compliance with NCQA, contractual and regulatory requirements for accessibility	Calls to network providers and compile the data of those results	Services are accessible to enrollees within the NCQA, contractual and regulatory requirements	Provider call spreadsheet Provider Roster Data from provider survey results	MSS-BB, MCN-JF	Q2 2021	In progress		
Annually evaluate accessibility of network providers	To ensure compliance with NCQA, contractual and regulatory requirements for accessibility	Analyze data from calls, CAHPS, Credentialing Audit report and write Accessibility of Services Report Present to PAC & QI/UM Committee	IMCare enrollees have accessibility to services within the network area	CAHPS Data Provider Call Spreadsheet Site Visits Results	MCN-JF QI/UM Director-AM	Q4 2021	In progress		
Support network recruitment	To promote a robust network of providers and enrollee accessibility of services	Aide with credentialing process Reduce unnecessary authorization requirements	IMCare has an adequate network with access to services that enrollees need	Credentialing files Authorization List Provider Manual	MSS-credentialing UR Workgroup	Ongoing	In progress		
Ensure IMCare Network Adequacey Population: PMAP, MNCare, MSHO, MSC+	To reduce gaps in network adequacy and practitioner availability	Send follow-up questionare if access standards are not met by providers.	Providers will identify opportunities to meet access standards.	Follow up letters& response from providers.	MCN-JF & QI/UM Director - AM	Q4 2021	In progress		

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Provider Satisfaction

Source of Standard: 42 CFR 438 Subpart C; Minnesota Rules 4685.1110 to 4685.1130; DHS Contract Sections 7.1.4, NCQA UM 1-13

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Annual Provider Satisfaction Survey	To gather information regarding provider satisfaction with IMCare and its processes and UR procedures and plan	Mail Survey/ compile results	Survey results are compiled and ready for analysis	Provider Survey	OSS	Q1 2021	Complete	Survey mailed and compliled in Jan of 2021.	1/22/2021
Annual Evaluation of the Provider Satisfaction Surveys	To assess network provider's satisfaction with IMCare processes and authorization requirements	Analyze data and write Provider Satisfaction report Present to PAC & QI/UM Committee	IMCare staff and network providers are aware of overall provider satisfaction and make recommendations/ modifications accordingly	Provider Satisfaction Report	Director	Q2 2021	In progress		
Review of the IMCare Authorization List	To ensure appropriate utilization of resources and promote provider satisfaction	Review each section of the authorization list considering utilization patterns, cost and medical necessity	IMCare will have an updated authorization list and provider manual	IMCare authorization list IMCare Provider Manual	UR Workgroup	Ongoing Biweekly	In progress		02/11/2021 03/11/2021 03/25/2021 04/08/2021
Review of the IMCare Medicaid Formularies Population: PMAP, MNCare, MSHO, MSC+	To ensure appropriate utilization of resources and promote provider satisfaction	Review Medicaid formulary and modify as appropriate based on cost and utilization patterns	IMCare will have an updated Medicaid Formulary that is in compliance with the DHS Preferred Drug List	IMCare Medicaid Formulary	Drug Utilization Review Committee	Q2 2021 Q3 2021 Q4 2021	In progress		

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Record Audits

Source of Standard: 438 CFR Subpart E; Minnesota Rules 4685.1110 to 4685.1130; DHS Contract Sections 7.1 -7.1.8, 7.2, 7.6; NCQA 2020 MED 5

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Medical Record Audit	To ensure that medical records are maintained with timely, legible and accurate documentation of patient information, treatment and appropriate follow-up	Compile a list of network facilities based on claims inquired and coordinate audit Compile data results for analysis	Audit is conducted and results are compiled on a spreadsheet	SSRS Reports Medical Record Audit tool/ result spreadsheet	Data Project Coordinator MSS QI/UM Director	Q2 2021	In progress		
Review of Medical Record Audit Tool	To ensure that the audit tool reflects contractual and regulatory requirements	Review each section of the audit tool for appropriateness and validity	The IMCare Medical Record Audit Tool is updated and meets regulatory and NCQA requirements	Medical Record Audit Tool	QI/UM Director	Q2 2021	In progress		
Provider notification	To promote provider awareness of the medical record requirements and audit components	Compose letter with intent to audit and provide audit tool to each network facility audited	Providers are aware of medical record audit components	Letter of intent	QI/UM Director	Q2 2021	In progress		
Provider Newsletter	To promote provider awareness of standards that have been historically low within the medical record audit	Complete newsletter entry on health care directives and importance of addressing maltreatment/abuse at primary care visits	Providers are aware of standards around identified areas	Provider Newsletter	QI/UM Director	Q2 2021	In progress		
Auditor Training	To promote understanding of medical record requirements and components of the audit tool	Provide training to medical record auditors	Auditors fully understand the audit tool and medical record requirements	Medical Record Audit Training Sign-in sheet	QI/UM Director	Q2 2021	In progress		
Behavioral Health Audit	To ensure that behavioral are maintained with timely, legible and accurate documentation of patient information, treatment and appropriate follow-up	Compile a list of high volume network providers based on claims inquired and coordinate audit Compile data results for analysis	Audit is conducted and results are compiled on a spreadsheet	Crystal Reports Behavioral Health Record Audit tool/ result spreadsheet	Data Project Coordinator MSS QI/UM Director	Q2 2021	In progress		

Review of Behavioral Health Record Audit Tool	To ensure that the audit tool reflects contractual and regulatory requirements	Review each section of the audit tool for appropriateness and validity; consult with behavioral health consultant as needed	The IMCare Behavioral Health Record Audit Tool is updated and meets regulatory and NCQA requirements	Behavioral Health Record Audit	QI/UM Director	Q2 2021	In progress
Provider notification	To promote provider awareness of standards that have been historically low within the behavioral health record audit	Compose letter with intent to audit and provide audit tool to each network providers audited	Providers are aware of behavioral health record audit components	Letter of intent	QI/UM Director	Q2 2021	In progress
Auditor Training	To promote understanding of behavioral health record requirements and components of the audit tool	Provide training to behavioral health record auditors	Auditors fully understand the audit tool and behavioral health record requirements	Behavioral Health Record Audit Training Sign-in sheet	QI/UM Director	Q2 2021	In progress
Population: PMAP, MNCare, MSHO, MSC+							

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HEDIS

Source of Standard: 438 CFR Subpart E; Minnesota Rules 4685.1110 to 4685.1130; DHS Contract Sections 7.1 -7.1.8, 7.2, 7.6; NCQA 2020 QI 1-5, & UM 1-13

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Medicaid HEDIS Report	To analyze HEDIS outcomes and identify opportunities to improvement performance.	Analyze HEDIS data, compose report and implement interventions as indicated	IMCare is able to identify areas needing improvement and strategize to implement	HEDIS 2020	Managed Care Nurse	Q4 2020	In progress		
Collaborate with Itasca County Public Health	To increase childhood immunization rates	Coordinate designate IMCare immunization nights	Enrollees will have increased access to childhood immunizations	HEDIS 2020	Managed Care Nurse	Q2 2020 Q4 2020	In progress		
Preventative Screening	To increase preventative screening rates	Compose information for enrollee newsletter and IMCare Website	Enrollees will develop an increased understanding of recommended age-specific preventative screening guidelines	HEDIS 2020 Enrollee newsletter IMCare Website	Managed Care Nurse	Q2 2020 Q4 2020	In progress		
Medicare HEDIS Report Population: PMAP, MNCare, MSHO, MSC+	To analyze HEDIS outcomes and identify opportunities to improvement performance.	Analyze HEDIS data, compose report and implement interventions as indicated	IMCare is able to identify areas needing improvement and strategize to implement	HEDIS 2020	Senior Care Coordinator	Q4 2020	In progress		

2020 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

2018-2020 Opioid Performance Improvement Project (OPIP)

Source of Standard: DHS Contract Section 7.2.2

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Cotninue utilizing Pharmacy Opioid Point of Sale (POS)	To decrease DHS calculated New Chronic User (NCU) rate by promoting education between the pharmacist, provider and enrollee	Coding programed into pharmacy claims system as follows: • Initial opioid fill limited to seven days for individuals who have not filled an opioid in the last 90 days • Opioid fills are limited to 90 MME/day based on 30-day supply • Step Therapy requirement for the use of extended-release opioids; must use immediate release first	DHS New Chronic User rate decreases from baseline	DHS NCU Rate	Caremark staff under the direction of Pharmacy Director	Q1 2020	Ongoing	Edits are in place and appear to be working correctly	1/2/2021
Final Report	Evaluate effectiveness OPIOID Performance Improvement Project	Evaluate NCUser rate provided by DHS for 2020, outcome measures and compose report.	Report is submitted to DHS by 09/01/2021	PIP Report	QI/UM Diretor	Q3 2021			

Population:PMAP, MNCare

2021 IMCARE

2021-2023 Performance Improvement Project (PIP)

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Source of Standard: DHS Contract Section 7.2.2

Activities	Objectives/ Goals	Tasks
Biannual enrollee/provider education	To increase HPV vaccination rates amoung male and female adolescents	Compose article for biannual enrollee/ provider newsletters
Targeted outreach at community events as able	To increase HPV vaccination rates amoung male and female adolescents	Participate in Community Connect, Children's Fair and other community health gatherings to promote HPV Vaccine

Population:PMAP, MNCare

QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

uman Papilloma Virus (HPV) Vaccination Rates Among Adolescents

Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected
Increase HEDIS measure by 2 percentage points above baseline	Newsletters	QI/UM Director	Q2 2021 Q4 2021
Increase HEDIS measure by 2 percentage points above baseline	HPV Handouts	QI/UM Staff	As able

Increasing

Status	Progress/Results	Date Completed
In progress		

2020 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

2018-2020 Opioid Quality Improvement Project (OQIP)

Source of Standard: DHS Seniors Contract Section 7.2

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Pharmacy Opioid Point of Sale (POS) Soft edit per CMS guidance	To decrease DHS calculated New Chronic User (NCU) rate by promoting education between the pharmacist, provider and enrollee	Coding programed into pharmacy claims system as follows: • Initial opioid fill limited to seven days for individuals who have not filled an opioid in the last 90 days • Opioid fills are limited to 90 MME/day based on 30-day supply •Duplicate therapy rejct for long-acting	DHS New Chronic User rate decreases from baseline	DHS NCU Rate	Caremark staff under the direction of Pharmacy Director	Q1 2021	Completed	Edits are in place and continue to be working correctly	1/2/2021
Final Report	Evaluate effectiveness OPIOID Quality Improvement Project	Evaluate NCUser rate provided by DHS for 2020, outcome measures and compose report.	Report is submitted to DHS by 09/01/2021	PIP Report	QI/UM Diretor	Q3 2021			

Population: MSHO, MSC+

2021 IMCAR

2021-2023 Quality Improvement Project

Incidence of Poor HbA1c (

Source of Standard: DHS Seniors Contract Section 7.2

Activities	Objectives/ Goals	Tasks
Biannual enrollee/ pharmacy/ provider education regarding QIP	To reduce percentage of poor HbA1C control among senior enrollees	Compose article for biannual enrollee/ provider newsletters
Care Coordinator/ Case Manager Education	To increase aware of project and implementation plan of interventions	Develop Diabetes Handouts, configure CTD to track interventions and develop presentation for staff
Provide enrollees with educational resources	To promote awareness of QIP and role of care coordinator in implementing interventions	Develop information and education resource to be provided to enrollee by interal and elderly waiver case managers
Population: MSHO, MSC+		

E QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Control (>9.0%) (CDC) among the IMCare Minnesota Senior Health Option (MSHO) Enroll

Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected
Decrease HEDIS measure of senior enrollees within IMCare with poor HbA1c control (>9%) by 2 percentage points	Newsletters	QI/UM Director	Q2 2021 Q4 2021
Increase staff awareness of Diabetes QIP	Educational Materials Sign in sheet	QI/UM Director	Q2 2021
Care coordinators/ case managers will be knowledgeable of members with Diagnoses of diabetes and pre-diabetes and participate in interventions to promote a decrease in poor HbA1c	Interventions documented in CTD	QI/UM Director	Q4 2021

Reducing the lees.

Status	Progress/Results	Date Completed
In Progress		
In Progress		
In Progress		

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Mental Health Utilization in Seniors CCIP

Source of Standard: 438 CFR Subpart E; Minnesota Rules 4685.1110 to 4685.1130; DHS Contract Sections 7.1 -7.1.8, 7.2, 7.6; NCQA 2020 QI 1-5, & UM 1-13

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Enrollee Education & Enrollee/Caregiver Engagement	To increase knowledge, access and appropriate utilization of mental health services by 10%. An additional goal of ensuring follow-up after ED visits will be implemented as well with the goal of a 25% increase. IMCare will contact enrollees following an ED visit to verify that they have a follow-up appointment scheduled and the means to get there.	Newsletter article reagarding coverage of Mental Health Services and when appropriate to access. Importance of follow up.	HEDIS(MPT) & (FUM)measures improves for MSHO/ MSC+ population	Enrollee newsletter case note	Senior Care Coordinator	Q2 2021	In progress		
Provider Outreach	To increase knowledge, access and appropriate utilization of mental health services by 10%. An additional goal of ensuring follow-up after ED visits will be implemented as well with the goal of a 25% increase. IMCare will contact enrollees following an ED visit to verify that they have a follow-up appointment scheduled and the means to get there.	Newsletter article about CCIP and goals to increase OP access and follow up after ER visits for MH.	HEDIS(MPT) & (FUM)measures improves for MSHO/ MSC+ population	Provider Newsletter	Senior Care Coordinator	Q2 2021	In progress		
Population: PMAP, MNCare, MSHO, MSC+									

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Prenatal Initiative Focus Study
Emergency Department Utilization Focus Study
Controlled Substance Focus Study

Source of Standard: Minnesota Rules, part 4685.1158; DHS Contract Sections 7.1 -7.1.8, 7.2, 7.6

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Prenatal Focus Study Population: PMAP/ MNCare									
Monthly review and refer pregnant enrollees to the maternal child health (MCH) program	To promote healthy pregnancy individuals by identifying high risk pregnancies	Review monthly pregnancy file to identify participants of the prenatal focus study, send congratulatory letters and refer to PH Educate new	IMCare will have a reduced rate of preterm births or adverse events in pregnancy	DHS Monthly Pregnancy File	MSS	Monthly throughout 2021	In progress		
Monthly calls to pregnant enrollees to educate on maternal child health (MCH) program	To promote healthy pregnancy individuals by identifying high	Call pregnant enrollees							
Education regarding prenatal care, PHN visit and postpartum care	To reduce adverse events during pregnancy and preterm birth rates	Review referrals, provide educational mailings and contact enrollees to set up PHN	IMCare will have a reduced rate of preterm births or adverse events in pregnancy	Claims/ MCH records	Itasca County PHN	Ongoing	In progress		
Education regarding the prenatal focus study	To promote awareness of the program to increase referrals and participation	Compose articles for the enrollee and provider newsletters	IMCare enrollees and providers will have increased awareness of the Healthy Pregnancy Program/ prenatal focus study	Enrollee & provider newsletters	Managed Care Nurse RK	Q2 2021 Q4 2021	In progress		
Annual evaluation of Prenatal Focus Study	To evaluate the outcomes and effectiveness the prenatal focus study	Review data from previous year for prenatal focus study, compose report and evaluate opportunities for	IMCare will have a successful prenatal focus study that a reduces rates of preterm births or adverse events in pregnancy	Annual Prenatal Focus Study Report	Managed Care Nurse RK	Q1 2021	In progress		
Emergency Department (ED) Utilization Focus Study Population: PMAP. MNCare.									
Review of the monthly ED Utilization Report for PMAP/ MNCare Enrollees	To provide timely and appropriate enrollee education and case management (CM) & identify and intervene in cases of fraud/abuse	Review ED Utilization Report and associated medical records to determine if visit meet definition of an emergency, analyze for patterns of abuse and initiate	IMCare will have reduced rates of inappropriate ED utilization	ED Focus Study Case Notes Monthly Reports	Managed Care Nurse	Ongoing monthly	In progress		
Review of the monthly ED Utilization Report for MSHO/ MSC+ Enrollees	Timely referral of enrollees who may benefit from higher intensity case management/ care coordination	Review ED Utilization Report and associated medical records as indicated to determine if additional intervention is	IMCare will have reduced rates of inappropriate ED utilization	Case Notes Monthly Reports	Care Coordinators/ Case Managers	Ongoing monthly	In progress		
Care Coordinator/ Case Manager Education	To promote education regarding the ED Utilization Focus Study and increase CC/CM	Develop training for CC/CM regarding senior ER focus study	IMCare care coordinators and Itasca County Public Health case Managers will have an increased understanding on ED Utilization Focus Study and will implement additional interventions as indicated	Case Notes Monthly Reports	QI/UM Director- AM	Q3 2021			
Annual evaluation of Emergency Department Focus Study	To evaluate and report effectiveness of the focus study	Evaluate ED Utilization Reports, interventions and referral sent for the previous year	IMCare will evaluate focus study and identify opportunities for improvement	Annual ED FS Report	Managed Care Nurse	Q1 2021	Complete	Report was presented and approved at PAC on 2/10/2021 Presented and approved by OI/UM	02/10/2021 03/17/2021
Controlled Substance (CS) Focus Study Population: PMAP & MNCare									
Review of the monthly CS Utilization Report for	Identification of enrollees with a high number of controlled substance prescription fills, in order to provide timely case management or fraud referrals	Review CS monthly report and associated pharmacy claims, MN PMP and analyze for patterns of abuse and initiate appropriate interventions or	IMCare will have reduced rates of inappropriate or unsafe CS utilization	CS Focus Study Case Notes Monthly Reports	Managed Care Nurse	Ongoing Monthly	In progress		01/10/2021 02/08/2021 03/08/2021 04/02/2021
Annual evaluation of Controlled Substance Focus Study	To evaluate and report effectiveness of the focus study	Evaluate CS Reports, interventions and referral sent for the previous year	IMCare will evaluate focus study and identify opportunities for improvement	Annual CS FS Report	Managed Care Nurse	Q1 2021	Complete	Report was presented and approved at PAC on 2/10/2021 Presented and approved by OI/UM	02/10/2021 03/17/2021
Enrollee education on appropriate use and disposal or controlled substance medications	To reduce inappropriate use of CS	Compose article for enrollee newsletter	Enrollees will have increased understanding of appropriate use and disposal of CS, in turn resulting in decrease rates of use	Monthly & annual reports	QI/UM Staff	Q2 2021			
Quarterly review of Safety Monitoring Solutions (SMS) and Enhanced Safety Monitoring Solutions (ESMS)	To reduce inappropriate use of CS	Review of the SMS & ESMS reports generated by Caremark and implement interventions as indicated	IMCare will have reduced rates of inappropriate or unsafe CS utilization	Quarterly reports	Pharmacy Director	Q1 2021 Q2 2021 Q3 2021 Q4 2021	In progress		

Source of Standard: DHS Contracts Sections 7.1.4

Activities	Objectives/ Goals	Tasks
Special Health Care Needs PMAP & MNCare		
Identification of enrollees with special health care needs	To assess quality and appropriateness of care furnished to enrollees identified	Periodically review claims data to identify enrollees who have one of the following: • at least one inpatient stay with the primary diagnosis of asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), dehydration, hypertension, bacterial pneumonia or urinary tract infection (UTI); •four or more Emergency Department visits during the measurement year • at least one hospital readmission within five days for same or similar diagnosis; • enrollment in complex case management or the IMCare disease management program; • use of home care services; and/or • total claims exceeded $100,000.

Information in the enrollee and provider newsletters regarding Population Health Management (PHM) and Complex Case Management (CCM) Programs	Increase awareness of Population Health Management (PHM) & CCM programs to promote referrals and further identification of enrollees with Special Health Care Needs	Compose articles for the enrollee newsletter regarding PHM and CCM Programs
Inpatient Admission Review	Further identification for enrollees with Special Health Care Needs	Review daily admission reports from network facilities and determine if further intervention is required
Quarterly review of SMRT & Stop loss reports	Further identification for enrollees with Special Health Care Needs	Review SMRT and Stop loss reports quarterly and determine if further intervention is required
Annual evaluation of Medicaid Special Health Care Needs	To evaluate the outcomes and effectiveness of the activities of identification and interventions for enrollees with Special Health Care Needs	Review data from previous year for Special Health Care Needs, compose report and evaluate opportunities for improvement

Special Health Care Needs
Population:
MSHO & MSC+

Identification of enrollees with special health care needs	To assess quality and appropriateness of care furnished to enrollees identified	Review the following data sources for identification of enrollees with Special Health Care Needs to determine if advanced care coordination is indicated:
Care Coordination for enrollees with Special Health Care Needs	To assess quality and appropriateness of care furnished to enrollees identified	Ensure that enrollees with Special Health Care Needs have the following: • complete a comprehensive assessment or screening for all senior enrollees; • identify ongoing special conditions which may require treatment or regular monitoring; • develop and implement a care plan; and • allow enrollees to directly access specialists, as appropriate, for identified conditions and needs.
Annual evaluation of Senior Special Health Care Needs Population: PMAP, MNCare, MSHO, MSC+	To evaluate the outcomes and effectiveness of the activities of identification and interventions for senior enrollees with Special Health Care Needs	Review data from previous year for Special Health Care Needs, compose report and evaluate opportunities for improvement

QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Special Health Care Needs

Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected
To ensure quality and appropriate care for enrollees identified	Claims Data Complex Case Management Work flow Case Notes	QI/UM Director	Ongoing

Providers and enrollees will have increased knowledge regarding the programs that IMCare offers to enrollees	Enrollee and Provider Newsletters	QI/UM Director Managed Care Nurse	Q2 2021 Q4 2021
IMCare will ensure that individuals with Special Health Care Need receive quality and appropriate care	Claims Data Complex Case Management Work flow Case Notes	Managed Care Nurse	Ongoing
IMCare will ensure that individuals with Special Health Care Need receive quality and appropriate care	Claims Data Complex Case Management Work flow Case Notes	Managed Care Nurse	Q1 2021 Q2 2021 Q3 2021 Q4 2021
IMCare will ensure that individuals with Special Health Care Need receive quality and appropriate care	Annual Medicaid Special Health Care Needs Report	MCN	Q1 2021

• daily inpatient admission reports from network facilities • quarterly Senior SMRT Report • quarterly Senior Stop loss Report • quarterly inpatient readmission report for seniors • monthly ED utilization reports for seniors	Pertinent reports	Senior Care Coordinators PH Case Managers	Timelines outlined in tasks
IMCare will ensure that individuals with Special Health Care Need receive quality and appropriate care	Focus Case Management work flow Case Notes	Senior Care Coordinators	Ongoing
IMCare will ensure that individuals with Special Health Care Need receive quality and appropriate care	Annual Medicaid special Health Care Needs Report	Senior Care Coordinator	Q1 2021

Status	Progress/Results	Date Completed

In progress		
In progress		
Complete	Presented to External QI/UM	3/17/2021

In progress		
In progress		
Complete	Presented to External QI/UM	3/17/2021

2021 IMCARE		
DHS Contracts Sections F&C 7.4 and Seniors contract 7.4		
Activities	**Objectives/ Goals**	**Tasks**
Consumer Assessment of Healthcare Providers and Systems Population: PMAP, MNCare, MSC+ & MSHO		
Provide information in provider and enrollee newsletter regarding CAHPS Survey	Promote awareness of the survey and previous year results	Compose articles for both the provider and enrollee newsletter
Request to participate in Medicare CAHPS Survey	Ensure that IMCare is able to collect Medicare CAHPS Data	Email CMS to request participattion
Review of CAHPS Results	To identify opportunities for improvement	Compose annual report evaluating previous years results and report to PAC, QI, SAC and internal QI workgroup
Enrollee Education Sessions Population: PMAP, MNCare, MSC+ & MSHO		
Information regarding enrollee education in the provider and enrollee newsletters	To promote awareness of the monthly education sessions	Compose articles for the provider and enrollee newsletters
Inform enrollees of ways to access benefits information and education sessions upon enrollment	To promote awareness of the monthly education sessions	Mail information regarding enrollee education with monthly membership

Modify enrollee education sessions	To increase enrollee's knowledge of benefits available through IMCare by increasing interest/ participation in education sessions	Consider presenting health or utilization information at each sessions Consider offering a skype or online educational session
Evaluation of enrollee education sessions	To review participation rates and identify opportunities for improvement	Review participation data and contact logs from previous year and compose report
Customer Call Performance Population: PMAP, MNCare, MSC+ & MSHO		
Review Prairie Fyre reports to determine the call abandonment rate	To identify any issues and promote early intervention and problem resolution	Review the automatic call distribution reports in Prairie fyre, identify patterns and implement interventions as indicated
Evaluate calls performance annually	To assess compliance and identify opportunities for improvement	Analyze Prairie Fyre Data and CMS Data and compose report of previous years call performance
Senior Enrollee Satisfaction with Care Coordination Population: MSHO/ MSC+		
Distribute Enrollee Satisfaction with Care Coordination Survey	To collect data on senior satisfaction with care coordination	Use updated survey and mail to both MSHO & MSC+ enrollees and collect survey results and compile into a table

Evaluation of Senior Enrollee Satisfaction with Care Coordination

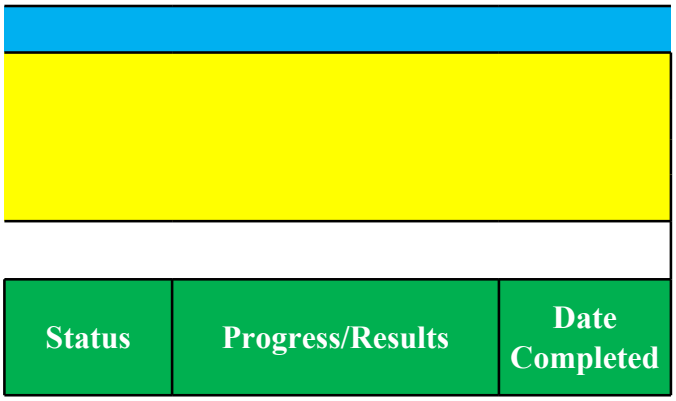
E QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Consumer Assessment of Healthcare Providers and Systems
Enrollee Education Sessions
Customer Call Performance
Senior Enrollee Satisfaction with Care Coordination

Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected
IMCare enrollees and providers will have an increased understanding of CAHPS survey	2021 CAHPS results	QI/UM Director	Q4 2021
IMCare will have CAHPS data available to analyze in 2022	2022 CAHPS Results	QI/UM Director	Q4 2021
IMCare will identify opportunities for improvement and implement interventions as indicated	2021 CAHPS Report	QI/UM Director	Q4 2021
IMCare will have increased participation in the monthly	Enrollee and provider newsletters	QI/UM Staff	Q2 2021 Q4 2021
IMCare will have increased participation in the monthly education sessions	Membership letters enrollee education attendance	OSS	Monthly

IMCare will have increased participation in the monthly education sessions, resulting in increased enrollee understanding of the IMCare benefits and plan network	Enrollee education attendance sheets	QI/ UM Department	Q2 2021 Q3 2021 Q4 2021
IMCare will annually identify opportunities for improvement and implement changes to the enrollee education sessions as indicated	Enrollee Education Report	QI/UM Director-AM	Q1 2021
IMCare will have a decrease in the call abandonment rate	Prairie Fyre reports	QI/UM Director-AM	Q1 2021 Q2 2021 Q3 2021 Q4 2021
IMCare will be compliant with call abandonment rates and have a reduction in those rates	Customer Call Performance Report	QI/UM Director-AM Compliance Officer	Q1 2021
IMCare will utilize a larger sample size with more accurate data to identify opportunities for improvement and implement interventions as indicated	Data table from returned surveys	OSS	Q2 2021

IMCare will identify opportunities for improvement and implement interventions as indicated	Senior Enrollee Satisfaction with Care Coordination Report	Senior Care Coordinator	Q3 2021



Status	Progress/Results	Date Completed

In progress

In progress

In progress		
Complete		
In progress		
Complete	Completed and reviewed at QI/UM Committee Meeting	3/17/2021
In progress		

In progress

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Case Management (CM) (PMAP & MNCare)

Source of Standard: DHS Contract Section 6.1.5; NCQA PHM 5

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Review CM policies/ procedures & flow charts	To ensure alignment with DHS contract, NCQA requirements and current workflow	Review existing policies, procedures and CM flow sheets update and implement process changes	IMCare will have updated CM policy/ procedures and flow charts	Updated CM P&P Updated CM Flow charts	CM Workgroup QI/UM Director	Q2 2021	In progress		
Enrollee Identification	Identify enrollees who would benefit from complex case management	Identify enrollees appropriate for CM using various methods including: • PHM •Provider/ staff referral • SMRT report • Stop Loss report • Inpatient Readmission Report • ED Utilization Report • CS FS Report •Initial Enrollee • Authorizations • Enrollee request	IMCare enrollees have access to plan benefits and needed care	Case Management Work Flows	Managed Care Nurses	Ongoing	In progress		
Initial Enrollee Screening	Identify enrollees who may benefit from CM or have other unique needs	Mail out Initial Enrollee Screening upon enrollment and refer to appropriate nurse upon return of survey	To ensure that enrollees have access to plan benefits and needed care	Complete Enrollee Initial Health Screening	OSS	Ongoing	In progress		
Case Management of enrollees	To ensure enrollees with complex health needs are able to access plan benefits	Complete CM assessment within 30 days of opting into CM and complete a person-centered care plan within 30 days of the assessment Set intensity level and follow up accordingly	IMCare enrollees opted into case management will have access to appropriate, quality, care	CM workflows	Managed Care Nurses	Ongoing	In progress		

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Elderly Waiver (EW)Case Management/ non-EW Care Coordination (CC) (MSHO & MSC+)

Source of Standard: DHS Senior Contract Sections 3.5, 6.1.4-6.1.6, 7.8, 9.3.7, Model of Care 1-4

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Review CC policies/ procedures	To ensure alignment with DHS contract, regulatory requirements and current workflow	Review current P&Ps against contract and regulatory requirements, make suggested edits and bring to care coordination meeting for input	IMCare will have updated CC policy/ procedures	Update P&Ps	Senior Care Coordinator	Q3 2021	In progress		
Model of Care (MOC) Training	To increase knowledge of IMCare staff, delegates and providers regarding processes involving enrollment, care management and utilization management in seniors	Develop an electronic training, upload to the IMCare website and notify staff, delegates and providers or training and collect attestation for training	IMCare staff, delegates and providers will have increased knowledge regarding processes involving enrollment, care management and utilization management in seniors	MOC Training on Websites and attestation page	QI/UM Director SM	Q3 2021	In progress		
Assessment	To ensure that enrollees have access to plan benefits and needed care	Health risk assessment (HRA) will be completed within 10 business days for the EW population, and 30 business days for the community well and nursing home populations; annually thereafter for all populations.	IMCare senior enrollees have timely access to plan benefits and needed care	Enrollment Date and Date on HRA	Senior Care Coordinator Elderly Waiver Case Managers	Ongoing	In progress		
Comprehensive Care Plan (CCP)	To ensure enrollees have access to a person-centered plan of care and meet contract and regulatory requirements	Complete CCP within 30 days of completing the HRA Provide enrollee and provider with a copy of care plan and obtain signature from pertinent parties	IMCare enrollees have access to care plan and there is shared decision making regarding that plan	Care plan date	Senior Care Coordinator Elderly Waiver Case Managers	Ongoing	In progress		

Transitions of care	To ensure enrollees have a seamless transition from one care setting to the next	Complete all transitions of care within one business day of notification, notify provider or transition and send receiving setting a summary of the care plan, contact enrollee upon return to usual setting	IMCare have seamless transition from one care setting to the next	Transition Log	Senior Care Coordinator Elderly Waiver Case Managers	Ongoing	In progress
Annual Transitions of Care Review	To ensure enrollees consistently have effective management of transitions	Review transitions data from the previous calendar year, and implement interventions when indicated	IMCare will have improvement in the transitions of care process	MSHO/ MSC+ Transitions Report	Senior Care Coordinator	Q4 2021	.
EW Case Management Delegate Review	To ensure that activities of care coordination meet contract and regulatory requirements	Review 30 EW HRA/ Care plans auditing for the items outlined on the collaborate EW protocol, if the first 8 have no not met elements the audit is complete	IMCare meets delegate oversight requirements and CCPs contain required elements	Completed Audit Tools	Senior Care Coordinators	Q2 2021	In progress
Care Coordinator Delegate Review of non-EW enrollees	To ensure that activities of care coordination meet contract and regulatory requirements	Review 30 non-EW HRA/ Care plans auditing for the items outlined on the collaborate non-EW protocol, if the first 8 have no not met elements the audit is complete- note auditors may not review their own charts, peer review	IMCare meets delegate oversight requirements and CCPs contain required elements	Completed Audit Tools	Senior Care Coordinators	Q2 2021	In progress
Care Coordination Delegate Report	To meet contract requirements for care coordination and delegate oversight	Analyze data from the delegate review, implement any necessary interventions and compose report using DHS template, submit to DHS on 9/1	IMCare meets delegate oversight requirements and care coordination program meets required elements	Care Coordination Delegate Report	Senior Care Coordinator	Q3 2021	In progress

Transitions of Care Audit	To ensure timiliness, completeness, and proper documentation of all transitions	Develop audit template to address timliness, completeness, and proper documentation of transitions	IMCare will demonstrate compliance with transition requirements internally and with delegate Public Health EW staff	Completed Audit Tools	Senior Care Coordinator/s	Q2 2021	In progress

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Population Health Management (PHM) (PMAP, MNCare, MSC+ and MSHO)

Source of Standard: 438 CFR Subpart E; Minnesota Rules 4685.1110 to 4685.1130; DHS Contract Sections 7.1 -7.1.8, 7.2,7.3, 7.6; NCQA 2021 PHM 1-7

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Annual Population Assessment	To identify unique health, social and psychosocial factors of the IMCare enrollee population	Evaluate updated census data, claims data, risk-analysis, disease prevelance, CCM assessment,	IMCare is able to identify and implement interventions to address needs of IMCare enrollees	Impact Analysis report report submitted to DHS 7/31	QI/UM Director	Q2 2021	In progress		
Population Health Management (PHM) Program description	IMCare ensures a cohesive plan of action for addressing enrollee needs across the continuum of care.	Annually review and update the PHM Program Description	PHM Program is implemented and working effetively based on guidance of the PD	PHM Program Description, Agenda External QI/UM Committee at which it was reviewed	QI/UM Director	Q1 2021	Complete	Presented to QI/UM Committee 03/17/2021	3/17/2021
PHM Standard 6	IMCare will evaluate the effectiveness of it's PHM strategy	Review quantative results: clinical measures, cost/utilization measures, member	IMCare will utilize results from the PHM impact analysis to identify opportunities for improvement, and provide interventions to improve outcomes	Impact Analysis report report submitted to DHS 7/31	QI/UM Director	Q2 2021	In progress		
Notification of PHM Program to providers/enrollees at a minimum biannually	To promote health and wellness among IMCare enrollees by encouraging participation in PHM	Compose article for biannaul enrollee/newsletters newsletter, Facebook, Materials for website	IMCare enrollees are aware of what the PHM program is and how it might benefit them.	Biannual enrollee newsletter, Facebook articles, website	QI/UM Director	Q2 2021	In progress		
Make Health Appraisal available for IMCare enrollees	To promote health and wellness among IMCare enrollees by encouraging participation in PHM and offering response and interventions as indicated.	Develop letter that references the Health Appraisal to be sent to new enrollees and with other documents, include in newsletters, website, facebook.	Increased rate of health appraisals and enrollee engagement into PHM	Biannual enrollee newsletter, Facebook articles, website	QI/UM Director	Q2 2021	In progress		
Annually review PHM self-management tools and update as indicated	Providing IMCare enrollees up-to-date tools to manage their health	Review current self-management tools and ensure they have been updated within the last two years and ensure documents on the website are updated to reflect the most current tools.	Improved health outcomes for overall IMCare population due to enrollee engagement	Self-management tools updated on IMCare website for following categories • Healthy weight (BMI) maintenance • Smoking and tobacco use cessation • Encourging physical activity • Healthy eating • Managing stress • Avoiding at-risk drinking • Identifying depressive symptoms	MCN	Q2 2021	In progress		

Staff education on PHM	Increase staff participation to increase enrollee engagement	Create PPT or short presentation to outline PHM and areas of focus for 2021, present at team meeting	All staff will have increased understanding of PHM goals and intiatives	Powerpoint and sign-in sheet	QI/UM Director	Q2 2021	In progress
Evaluate enrollee experience with PHM	Meet NCQA requirements and measure effectiveness of PHM program	Create Survey, mail to enrolles, compile and analyze survey results	IMCare will utilize results from the PHM impact analysis to identify opportunities for improvement, and provide interventions to improve outcomes	Survey and data	QI/UM Director	Q2 2021	

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Practice Guidelines

Source of Standard: NCQA 2020-MED 2; DHS Contract - Article 7.1.6

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Adoption of Practice Guidelines	To adopt, disseminate and apply practice guidelines	Evaluate previous year plan and determine if there any needed areas of improvement and compose plan Include in provider/ enrollee newsletter and present to PAC & Ext QI	IMCare will adopt, disseminate and apply practice guidelines, as required by 42 CFR 438.236. Per Article 7.1.6 of the 2020 Seniors contracts, and Article 7.1.6 of the 2020 Families and Childrens contract "The MCO shall adopt preventive and chronic disease practice guidelines appropriate for Enrollees age sixty-five (65) and older, consistent with accepted geriatric practices: The MCO shall adopt guidelines that: 1) are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 2) consider the needs of the MCO Enrollees; 3) are adopted in consultation with contracting Health Care Professionals; and 4) are reviewed and updated periodically asappropriate. The guidelines must also be disseminated to all affected providers and, upon request, to enrollees and potential enrollees. In addition, IMCare must ensure that the practice guidelines are applied to utilization management decisions, coverage of service decisions, enrollee education, and any other applicable areas. **IMCARE 2020 CLINICAL PRACTICE GUIDELINES** (UpToDate – www.uptodate.com)**:** • *Overview of General Medical Care in Nonpregnant Adults with Diabetes Mellitus* • *Overview of Preventive Care in Adults* • *Geriatric Health Maintenance* • *Screening Tests in Children and Adolescents* • *Guidelines for Adolescent Preventive Services* • *Prenatal Care: Initial Assessment* • *Prenatal Care: Second and Third Trimesters*	Practice Guideline Plan	QI/UM Director	Q1 2021	Complete	Report was presented and approved at PAC on 2/10/2021 and External QI/UM Committee 3/17/21	2/10/2021

2021 IMC

Source of Standard: DHS Contract Sections 6.10, 7.1.4 -7.1.8; N

Activities	Objectives/ Goals	Tasks
Criteria for UM Decisions	To ensure consistency among UM decisions	Evaluate UM criteria used and determine if it is still updated and clinically significant
Annual review of Inter-rater reliability	To ensure that there is consistent application of UM criteria and timely decisions across UM staff and identify any opportunities for improvement	Analyze quarterly spreadsheet of inter-rater reviews and identify
Inter-rater Audit Protocal Review	To ensure that there is a clear and consistent way to evaluate the application of UM criteria and timely decisions.	Review Inter-rater Audit Tool and revise questions.
Utilization Management Drug Auth Flow Chart review	To ensure alignment with DHS contract, NCQA, regulatory requirements and current workflow	Review existing policies, procedures and UM flow sheets update and implement process changes
Utilization Management Policy/ Procedure Review	To ensure alignment with DHS contract, NCQA, regulatory requirements and current workflow	Review existing policies, procedures and UM flow sheets update and implement process changes

Utilization Management Service Auth Flow Chart review	To ensure alignment with DHS contract, NCQA, regulatory requirements and current workflow	Review existing policies, procedures and UM flow sheets update and implement process changes
UM Training	To ensure UM staff are knowledgeable and consistent in their UM decisions	Update drug authorization slides ongoing, provide training periodically at UM Ops
Timeliness of UM Decisions	To ensure that enrollees receive UM decisions timely in accordance with contract and regulatory requirements	Periodically evaluate timeliness of UM Decisions and report any unmet timelines to Compliance Officer
Inter-rater Review	To ensure that there is consistent application of UM criteria and timely decisions across UM staff	Quarterly evaluate 10 UM Decisions for each UM Staff, if there are fewer than 10, then all decisions are reviewed; evaluate reviews and implement any needed training or improvement

ARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Utilization Management (UM) PMAP, MNCare, MSHO, MSC+

NCQA UM 1-13

Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected
IMCare will have consistent criteria across UM decisions	UM Criteria for Medical-Necessity	QI/UM Director - AM oversight from Medical Director as indicated	Q1 2021
IMCare will identify way to improve consistency as indicated	Inter-rater Reliability Report	QI/UM Director - AM	Q1 2021
IMCare will have consistent application of the audit tool across staff.	Updated tool, annual report outcomes.	QI/UM Director-AM with oversight from Medical Director as indicated	Q2 2021
IMCare will have updated UM P&P and flow charts to ensure consistency across staff	Updated P&P	UM Ops Workgroup QI/UM Director-AM	Q1 2021
IMCare will have updated UM P&P and flow charts to ensure consistency across staff	Updated Drug Auth Flow Chart	UM Ops Workgroup QI/UM Director-AM	Q2 2021

IMCare will have updated UM P&P and flow charts to ensure consistency across staff	Updated Service Auth Flow Chart	UM Ops Workgroup QI/UM Director-AM	Q2 2021
IMCare will have consistency across all UM decisions	Drug authorization training slides UM Ops meeting minutes	QI/UM Director-AM with oversight from Medical Director as indicated	Monthly
IMCare will meet all timelines for UM decisions	Timeliness report	QI/UM Director-AM	Q1 2021 Q2 2021 Q3 2021 Q4 2021
IMCare will have consistency and timeliness across all UM decisions	Quarterly Inter-rater reviews & spreadsheet	MCN Medical Director QI/UM Director-AM	Q1 2021 Q2 2021 Q3 2021 Q4 2021

Status	Progress/Results	Date Completed
Complete	Report was presented and approved at PAC on 2/12/2020 and QI/UM Committee on 03/18/2020	2/10/2021 03/17/2021
Complete	Report was presented and approved at PAC on 2/10/2021 and QI/UM Committee on 03/17/2021	2/10/2021 03/17/2021
In Progress		
Complete	Completed 03/31/21	3/31/2021
In progress		

In progress		
In progress		
In progress	Reviewed for Q1	4/8/2021
	04/08/2021	
In progress	Q1 pulled in April	

2021 IMCARE Q

Source of Standard: 438 CFR Subpart E; Minnesota Rules 4685.1110 t

Activities	Objectives/ Goals	Tasks
CVS Caremark Delegation Agreement	To set forth the duties and responsibilities of both parties.	Evaluate CVSCaremark's performance against the delegation agreement with IMCare and compose report distributing to CVS
Care Coordinator Delegate Review of non-EW enrollees	To ensure that activities of care coordination meet contract and regulatory requirements	Review 30 non-EW HRA/ Care plans auditing for the items outlined on the collaborate non-EW protocol, if the first 8 have no not met elements the audit is complete- note auditors may not review their own charts, peer review

QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Utilization Management Delegation

to 4685.1130; DHS Contract Sections 7.1 -7.1.8, 7.2, 7.6; NCQA QI 1-5, & UM 1-13

Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status
IMCare delegates the following services to CVS Caremark: • Establishing a Pharmacy Network, • Retail network auditing, • Providing a Pharmacy Help Desk • Maintaining member eligibility • Maintaining point-of-sale claims processing • Formulary Management • Patient Safety Quality management • Specialty Pharmacy	CVS Caremark Delegation Oversight Report	Pharmacy Director	Q1 2021	Complete
IMCare meets delegate oversight requirements and CCPs contain required elements	Completed Audit Tools	Senior Care Coordinators	Q2 2021	In progress

Progress/Results	Date Completed
Reviewed at QI/UM Committee	3/17/2021

2021 IMC

Source of Standard: 438 CFR Subpart E; Minnesota Rules 4685

Activities	Objectives/ Goals	Tasks
DTR, Appeals and Grievance Policy/ Procedure Review	To ensure compliance with contract and regulatory requirements	Review P&Ps against regulatory and contract requirements and modify as indicated
Quarterly Grievance Report	To ensure compliance with contract and regulatory requirements	Run report of all grievances received by IMCare and prepare report for PAC and external QI
Annual evaluation of grievances	To review grievances to determine whether there are any trends and/or opportunities for improvement.	Compile all quarterly grievance reports from the previous year and write analysis, noting any trends
Quarterly DTR Report	To ensure compliance with contract and regulatory requirements	Run report of all DTR received by IMCare and prepare report for PAC and external QI
Annual evaluation of DTRs	To review DTRs to determine whether there are any trends and/or opportunities for improvement.	Compile all quarterly DTR reports from the previous year and write analysis, noting any trends
Quarterly Quality of Care (QOC) Grievances	To ensure compliance with contract and regulatory requirements	Run report of all Quality of Care Grievances received by IMCare and prepare report for PAC and external QI

Annual evaluation of QOC grievances	To review QOC grievances to determine whether there are any trends and/or opportunities for improvement.	Compile all quarterly QOC grievance reports from the previous year and write analysis, noting any trends
Quarterly Appeals	To ensure compliance with contract and regulatory requirements	Run report of all appeals received by IMCare and prepare report for PAC and external QI
Annual evaluation of Appeals	To review appeals to determine whether there are any trends and/or opportunities for improvement.	Compile all quarterly appeal reports from the previous year and write analysis, noting any trends
Grievances and appeals Work Group	To review contact logs or any ongoing greivances for further classification or needed follow up.	Meet monthly to review assigned agenda, including previous weeks contact logs.

ARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Denial, Terminations, Reduction (DTR), Appeals and Grievances

5.1110 to 4685.1130; DHS Contract - Article 8, NCQA UM 7-12

Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected
IMCare will have updated P&Ps that are in compliance with contract and regulatory requirements	Updated P&Ps	Health Plan Compliance Coordinator	Q2 2021
IMCare will report all grievances to PAC and External QI to obtain suggestions for improvement or further intervention	Quarterly Reports/ Meeting Minutes/ Agenda	Health Plan Compliance Coordinator	Q1 2021 Q2 2021 Q3 2021 Q4 2021
IMCare will present to PAC and external QI to identify opportunities for improvement	Annual Grievance Report / Meeting Minutes	Health Plan Compliance Coordinator	Q1 2021
IMCare will report all DTRs to PAC and External QI to obtain suggestions for improvement or further intervention	Quarterly Reports/ Meeting Minutes/ Agenda	Health Plan Compliance Coordinator	Q1 2021 Q2 2021 Q3 2021 Q4 2021
IMCare will present to PAC and external QI to identify opportunities for improvement	Annual DTR Report / Meeting Minutes	Health Plan Compliance Coordinator	Q1 2021
IMCare will report all QOC grievances to PAC and External QI to obtain suggestions for improvement or further intervention	Quarterly Reports/ Meeting Minutes/ Agenda	Health Plan Compliance Coordinator	Q1 2021 Q2 2021 Q3 2021 Q4 2021

IMCare will present to PAC and external QI to identify opportunities for improvement	Annual QOC Grievance Report / Meeting Minutes	Health Plan Compliance Coordinator	Q1 2021
IMCare will report all appeals and the outcome to PAC and External QI to obtain suggestions for improvement or further intervention	Quarterly Reports/ Meeting Minutes/ Agenda	Health Plan Compliance Coordinator	Q1 2021 Q2 2021 Q3 2021 Q4 2021
IMCare will present to PAC and external QI to identify opportunities for improvement	Annual Appeals Report / Meeting Minutes	Health Plan Compliance Coordinator	Q1 2021
IMCare will be in compliance with reporting grievances and appeals appropriately.	Meeting Minutes Appeals/ Grievances Quarterly reports	Health Plan Compliance Coordinator Compliance Officer Director UM Director	Monthly

Status	Progress/Results	Date Completed
In progress		
In progress	Presented to PAC on 2/10/2021 and QI/UM Committee on 03/17/2021	
Complete	Presented to PAC on 2/10/2021 and QI/UM Committee on 03/17/2021	
In progress	Presented to PAC on 2/10/2021 and QI/UM Committee on 03/17/2021	
Complete	Presented to PAC on 2/10/2021 and QI/UM Committee on 03/17/2021	
In progress	Presented to PAC on 2/10/2021 and QI/UM Committee on 03/17/2021	

Complete	Presented to PAC on 2/10/2021 and QI/UM Committee on 03/17/2021
In progress	Presented to PAC on 2/10/2021 and QI/UM Committee on 03/17/2021
Complete	Presented to PAC on 2/10/2021 and QI/UM Committee on 03/17/2021
Ongoing	

Source of Standard: DHS Contract Sections 7.1 -7.1.4; NCQA

Activities	Objectives/ Goals	Tasks
Periodic Post-Utilization Review	To ensure that enrollees are receiving necessary and appropriate care.	Run utilization report and present to UR Workgroup, evaluate appropriateness of care and modify authorization requirements as indicated
Medicare Under and Over Utilization Report	To identify patterns of over and under utilization in Seniors and intervene as necessary	Review HEDIS Use of Services measures and compose report with analysis, identifying opportunities for improvement
Medicaid Under and Over Utilization Report	To identify patterns of over and under utilization in Medicaid population and intervene as necessary	Review HEDIS Use of Services measures and compose report with analysis, identifying opportunities for improvement

ARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Under and Over Utilization

UM 1-13

Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected
IMCare enrollees have access to appropriate, cost-effective care	UR Workgroup Meeting Minutes	UR Workgroup	Periodically
IMCare enrollees have access to appropriate, cost-effective care	Medicare Under and Over Utilization Report	QI/UM Director-AM	Q4 2021
IMCare enrollees have access to appropriate, cost-effective care	Medicaid Under and Over Utilization Report	MCN-RK	Q4 2021

Status	Progress/Results	Date Completed
Ongoing		
In progress		
In progress		

2021 IMC

Source of Standard: DHS Contract Sections 7.1 -7.1.8

Activities	Objectives/ Goals	Tasks
Annual review of process for IP readmission review	To ensure that enrollees receives safe and cost-effective care	Outline process and timeline for IP readmission report and review
Quarterly review of IP Readmissions	To ensure that enrollees receives safe and cost-effective care	Review quarterly report and associated medical records of IP Stays with readmission with 15 days of discharge, determine if care at discharge was appropriate, transition to Medical Director if not

ARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Inpatient (IP) Readmission Review

Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected
To ensure that there is consistent application of review across all UM staff	IP Readmission Review Process	QI/UM Director	Q1 2021
To ensure that IMCare enrollees have access to safe, quality and cost-effective care	Case note	MCN Medical Director as needed	Q1 2021 Q2 2021 Q3 2021 Q4 2021

Status	Progress/Results	Date Completed
Complete	Complete	3/5/2021

In progress

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1519

DEPARTMENT: Health & Human Services **TIME REQUESTED:** 10 Minutes
PRESENTER: Kelly Chandler

AGENDA ITEM:
Updated Tobacco Ordinance

BOARD ACTION REQUESTED:
Approve updated tobacco ordinance.

BACKGROUND:
The MN Legislature approved Tobacco 21 in 2020. We are not able to have an ordinance that is less restrictive locally. The ordinance language attached aligns our ordinance with the MN ordinance with updated penalties for sales to minors and language on compliance checks including age of persons utilized for the compliance checks. If we did not update the compliance check language, it would create a very limited ability to carry out this required task due to limiting age groups we can utilize.

COUNTY ATTORNEY REVIEW: No

SUPPORTING DOCUMENTATION:
1. Itasca Tobacco Ordinance Updated 2021
2. MN-Tobacco-21-FAQ FINAL

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

Ordinance #065

An ordinance relating to the sale of commercial tobacco, tobacco-related devices, electronic delivery devices, and nicotine or lobelia delivery products in the county and to reduce the illegal sale of such items to persons under the age of 21.

The county Board of the county of Itasca Ordains:

Section 100. Purpose and Findings. Because the county recognizes that the sale of commercial tobacco, tobacco-related devices, electronic delivery devices, and nicotine or lobelia delivery products to persons under the age of 21, violates, both state and federal laws: and because studies which county accepts and adopts, have shown that youth use of any commercial tobacco products has increased to 27.6% in Minnesota; and because nearly 90% of people who smoke begin smoking before they have reached the age of 18 years, and that almost no one starts smoking after age 25; and because marketing analysis, public health research, and commercial tobacco industry documents reveal that tobacco companies have used menthol, mint, fruit, candy and alcohol flavors as a way to target youth and young adults and that the presence of such flavors can make it more difficult to quit; and because studies show that youth and young adults are especially susceptible to commercial tobacco product availability, advertising and price promotions at tobacco retail environments; and because commercial tobacco use has been shown to be the cause of many serious health problems which subsequently place a financial burden on all levels of government, this ordinance is intended to regulate the sale of commercial tobacco, tobacco-related devices, electronic delivery devices, and nicotine or lobelia delivery products for the purpose of enforcing and furthering existing laws, to protect youth and young adults against the serious health effects associated with use and initiation, and to further the official public policy of the state to prevent young people from starting to smoke as stated in Minn. Stat. § 144.391, as it may be amended from time to time.

In making these findings, the County Board accepts the conclusions and recommendations of: the U.S. Surgeon General reports, E-cigarette Use Among Youth and Young Adults (2016), The Health Consequences of Smoking — 50 Years of Progress (2014) and Preventing Tobacco Use Among Youth and Young Adults (2012); the Centers for Disease Control and Prevention in their studies, Tobacco Use Among Middle and High School Students — United States, 2011– 2015 (2016), and Selected Cigarette Smoking Initiation and Quitting Behaviors Among High School Students, United States, 1997 (1998); and of the following scholars in these scientific journals: Chen, J., & Millar, W. J. (1998). Age of smoking initiation: implications for quitting. Health Reports, 9(4), 39-46; D'Avanzo, B., La Vecchia, C., & Negri, E. (1994). Age at starting smoking and number of cigarettes smoked. Annals of Epidemiology, 4(6), 455–459; Everett, S. A., Warren, C. W., Sharp, D., Kann, L., Husten, C. G., & Crossett, L. S. (1999). Initiation of cigarette smoking and subsequent smoking behavior among U.S. high school students. Preventive Medicine, 29(5), 327–333; Giovino, G. A. (2002). Epidemiology of tobacco use in the United States. Oncogene, 21(48), 7326–7340; Khuder, S. A., Dayal, H. H., & Mutgi, A. B. (1999). Age at smoking onset and its effect on smoking cessation. Addictive Behaviors, 24(5), 673–677; Minnesota Department of Health. (2018). Data Highlights from the 2019 Minnesota Youth Tobacco Survey. Saint Paul, MN; Xu, X., Bishop, E. E., Kennedy, S. M., Simpson, S. A., & Pechacek, T. F. (2015) Annual healthcare spending attributable to cigarette smoking: an update. American Journal of Preventive Medicine, 48(3), 326–333, copies of which are adopted by reference.

This Ordinance must be liberally construed to carry out the following remedies/purposes:

to enforce the law,
to promote public health and reduce youth access to tobacco products,
to reduce the economic incentive to engage in illegal conduct; and,
to increase the pecuniary loss resulting from the detection of illegal activity.

Section 200. Definitions and Interpretations. Except as may otherwise be provided or clearly implied by context, all terms shall be given their commonly accepted definitions. The singular shall include the plural and the plural shall include the singular. The masculine shall include the feminine and neuter and vice-versa. The term "shall" means mandatory and the term "may" means permissive. The following terms shall have the definitions given to them:

Subd. 1 Child-Resistant Packaging. “Child resistant packaging” means packaging that meets the definition set forth in Code of Federal Regulations, title 16, section 1700.15(b), as in effect on January 1, 2015, and was tested in accordance with the method described in Code of Federal Regulations, title 16, section 1700.20, as in effect on January 1, 2015.

Subd. 2 Cigar. “Cigar” means any roll of tobacco that is wrapped in tobacco leaf or in any other substance containing tobacco, with or without a tip or mouthpiece, which is not a cigarette as defined in Minn. Stat. § 297F.01, subd. 3, as may be amended from time to time.

Subd. 3 Compliance Checks. "Compliance Checks" mean the system the County uses to investigate and ensure that those authorized to sell licensed products are following and complying with the requirements of this ordinance. “Compliance Checks” involve the use of persons under the age of 21 who purchase or attempt to purchase licensed products. “Compliance Checks” may also be conducted by the county or other units of government for educational, research and training purposes or for investigating or enforcing appropriate Federal, State, or local laws and regulations relating to licensed products.

Subd. 4 Delivery Sale. "Delivery Sale” means the sale of any licensed product to any person for personal consumption and not for resale when the sale is conducted by any means other than an in-person, over-the- counter sales transaction in a licensed retail establishment. “Delivery Sale” includes but is not limited to the sale of any licensed product when the sale is conducted by telephone, other voice transmission, mail, the internet, or app-based service. “Delivery Sale” includes delivery by licensees or third parties by any means, including curbside pick-up.

Subd. 5 Electronic Delivery Device. “Electronic Delivery Device” means any product containing or delivering nicotine, lobelia, or any other substance, whether natural or synthetic, intended for human consumption through the inhalation of aerosol or vapor from the product. “Electronic Delivery Device” includes, but is not limited to, devices manufactured, marketed, or sold as e-cigarettes, e-cigars, e-pipes, vape pens, mods, tank systems, or under any other product name or descriptor. Electronic delivery device includes any component part of a product, whether or not marketed or sold separately. “Electronic Delivery Device” does not include any nicotine cessation product that has been authorized by the U.S. Food and Drug Administration to be marketed and for sale as ”drugs,” “devices,” or “combination products,” as defined in the Federal Food, Drug, and Cosmetic Act.

Subd. 6 Flavored Product. "Flavored Product" means any licensed product that contains a taste or smell, other than the taste or smell of tobacco, that is distinguishable by an ordinary consumer either prior to or during the consumption of the product, including, but not limited to, any taste or smell relating to chocolate, cocoa, menthol, mint, wintergreen, vanilla, honey, fruit, or any candy, dessert, alcoholic beverage, herb, or spice. A public statement or claim, whether express or implied, made or disseminated by the manufacturer of a licensed product, or by any person authorized or permitted by the manufacturer to make or disseminate public statements concerning such products, that a product has or produces a taste or smell other than a taste or smell of tobacco will constitute presumptive evidence that the product is a flavored product.

Subd. 7 Imitation Tobacco Product. "Imitation Tobacco Product" means any edible non-tobacco product designed to resemble a tobacco product, or any non-edible tobacco product designed to resemble a tobacco product and intended to be used by children as a toy. "Imitation Tobacco Product" includes, but is not limited to, candy or chocolate cigarettes, bubble gum cigars, shredded bubble gum resembling chewing tobacco, and shredded beef jerky in containers resembling tobacco snuff tins. "Imitation Tobacco Product" does not include electronic delivery devices or nicotine or lobelia delivery products.

Subd. 8 Indoor Area. "Indoor area" means all space between a floor and a ceiling that is bounded by walls, doorways, or windows, whether open or closed, covering more than 50 percent of the combined surface area of the vertical planes constituting the perimeter of the area. A wall includes any retractable divider, garage door, or other physical barrier, whether temporary or permanent.

Subd. 9 Licensed Products. "Licensed Products" shall mean any tobacco, tobacco-related device, electronic delivery device, or nicotine or lobelia delivery product.

Subd. 10 Loosies. "Loosies" shall mean single cigarettes, cigars, and any other licensed products that have been removed from their original retail packaging and offered for sale. "Loosies" does not include premium cigars that are hand-constructed, have a wrapper made entirely from whole tobacco leaf, and have a filler and binder made entirely of tobacco, except for adhesives or other materials used to maintain size, texture, or flavor.

Subd. 11 Moveable Place of Business. "Moveable Place of Business" shall refer to any form of business operated out of a kiosk, truck, van, automobile or other type of vehicle or transportable shelter and that is not a fixed address or other permanent type of structure licensed for over-the-counter sales transactions.

Subd. 12 Nicotine or Lobelia Delivery Product. "Nicotine or Lobelia Delivery Product" means any product containing or delivering nicotine or lobelia intended for human consumption, or any part of such a product, that is not tobacco or an electronic delivery device as defined in this section. "Nicotine or Lobelia Delivery Product" does not include any nicotine cessation product that has been authorized by the U.S. Food and Drug Administration to be marketed and for sale as "drugs," "devices," or "combination products," as defined in the Federal Food, Drug, and Cosmetic Act.

Subd. 13 Pharmacy. "Pharmacy" means a place of business at which prescription drugs are prepared, compounded, or dispensed by or under the supervision of a pharmacist and from which related clinical pharmacy services are delivered.

Subd. 14 Retail Establishment. "Retail Establishment" shall mean any place of business where licensed products are available for sale to the general public. “Retail Establishment” shall include, but not be limited to, grocery stores, tobacco product shops, convenience stores, liquor stores, gasoline service stations, bars, and restaurants.

Subd. 15 Sale. A "Sale" shall mean any transfer of goods for money, trade, barter, or other consideration.

Subd. 16 Self-Service Display. “Self-Service Display” means the open display of licensed products in a retail establishment in any manner where any person has access to the licensed products without the assistance or intervention of the licensee or the licensee’s employee and where a physical exchange of the licensed product from the licensee or the licensee’s employee to the customer is not required in order to access the licensed products.

Subd. 17 Smoking. “Smoking” means inhaling, exhaling, burning, or carrying any lighted or heated cigar, cigarette, or pipe, or any other lighted or heated product containing, made, or derived from nicotine, tobacco, marijuana, or other plant, whether natural or synthetic, that is intended for inhalation. “Smoke” also includes carrying or using an activated electronic delivery device.

Subd. 18 Tobacco. "Tobacco" means any product containing, made, or derived from tobacco that is intended for human consumption, whether chewed, smoked, absorbed, dissolved, inhaled, snorted, sniffed , or ingested by any other means, or any component, part, or accessory of a tobacco product including but not limited to cigarettes; cigars; cheroots; stogies; perique; granulated, plug cut, crimp cut, ready rubbed, and other smoking tobacco; snuff; snuff flour; cavendish; plug and twist tobacco; fine cut and other chewing tobaccos; shorts; refuse scraps, clippings, cuttings and sweepings of tobacco; and other kinds and forms of tobacco. "Tobacco" does not include any nicotine cessation product that has been authorized by the U.S. Food and Drug Administration to be marketed and for sale as "drugs,” "devices," or "combination products," as defined in the Federal Food, Drug, and Cosmetic Act.

Subd. 19 Tobacco-Related Device. “Tobacco-Related Device” means any rolling papers, wraps, pipes, or other device intentionally designed or intended to be used with tobacco products. “Tobacco-Related Device” includes components of tobacco-related devices or tobacco products, which may be marketed or sold separately. “Tobacco-Related Devices” may or may not contain tobacco.

Subd. 20 Vending Machine. "Vending Machine" shall mean any mechanical, electric or electronic, or other type of device which dispenses licensed products upon the insertion of money, tokens, or other form of payment into the machine by the person seeking to purchase the licensed product.

Subd. 21 Youth-Oriented Facility. "Youth-Oriented Facility" means any facility with residents, customers, visitors, or inhabitants of which 25 percent or more are regularly under the age of 21 or that primarily sells, rents, or offers services or products that are consumed or used primarily by persons under the age of 21. “Youth-Oriented Facility” includes, but is not limited to, schools, playgrounds, recreation centers, and parks.

Section 300 License. No person shall sell or offer to sell any licensed product without first having obtained a license to do so from the County.

Subd. 1 Application. An application for a license to sell licensed products shall be made on a form provided by the County. The application shall contain the full name of the applicant, the applicant's residential and business addresses and telephone numbers, the name of the business for which the license is sought and any additional information the County deems necessary. If the Auditor/Treasurer shall determine that an application is incomplete, he or she shall return the application to the applicant with notice of the information necessary to make the application complete.

Subd. 2 Action. The Board may either approve or deny the license, or it may delay action for such reasonable period of time as necessary to complete any investigation of the application or applicant it deems necessary. If the Board shall approve the license application, the Auditor/Treasurer shall issue the license to the applicant. If the Board denies the license, notice of the denial shall be given to the applicant along with notice of the applicant's right to appeal the Board's decision.

Subd. 3 Term. All licenses issued under this ordinance shall expire on December 31st of the year for which they were issued.

Subd. 4 Revocation or Suspension. Any license issued under this ordinance may be revoked or suspended as provided in Sections 1200 and 1300 of this ordinance.

Subd. 5 Transfers. All licenses issued under this ordinance shall be valid only on the premises for which the license was issued and only for the person to whom the license was issued. The transfer of any license to another location or person is prohibited.

Subd. 6 Display. All licenses shall always be posted and displayed in plain view of the general public on the licensed premises.

Subd. 7 Renewals. The renewal of a license issued under this section shall be handled in the same manner as the original application. The request for renewal shall be made at least sixty (60) days but no more than ninety (90) days before the expiration of the current license.

Subd. 8 Issuance as a Privilege not a Right. The issuance of a license issued under this ordinance shall be considered a privilege and not an absolute right of the applicant and shall not entitle the holder to an automatic renewal of the license.

Subd. 9 Samples prohibited. No person shall distribute samples of any licensed product free of charge or at a nominal cost.

Subd. 10 Instructional programs. Licensees must ensure that all employees complete a training program on the legal requirements related to the sale of licensed products and the possible consequences of license violations. Licensees must maintain documentation demonstrating their compliance and must provide this documentation to the county at the time of renewal, and whenever requested to do so during the license term.

Section 400. Fees. No license shall be issued under this ordinance until the appropriate license fee shall be paid in full. The fee for a license under this ordinance shall be $100.00. The County Board may, by resolution, set this fee on an annual basis.

Section 500. Basis for Denial of License. The following shall be grounds for denying the issuance or renewal of a license under this ordinance; however, except as may otherwise be provided by law, the existence of any particular ground for denial does not mean that the County must deny the license. If a license is mistakenly issued or renewed to a person, it may be revoked upon the discovery that the person was ineligible for the license under this Section:

A. The applicant has been convicted within the past five (5) years of any violation of a Federal, State, or local law, ordinance provision, or other regulation relating to licensed products.

B. The applicant has had a license to sell licensed products suspended or revoked within the preceding twelve (12) months of the date of application.

C. The applicant fails to provide any information required on the licensing application or provides false or misleading information.

D. The applicant is prohibited by Federal, State, or other local law, ordinance or other regulation from holding such a license.

E. The business for which the license is requested is a moveable place of business. Only fixed-location retail establishments are eligible to be licensed.

F. The applicant is under 21 years of age.

Section 600. Prohibited Sales.

Subd. 1 It shall be a violation of this ordinance for any person to sell or offer to sell any licensed product:

A. By means of any type of vending machine.

B. By means of loosies as defined in Section 200 of this ordinance.

C. Containing opium, morphine, jimson weed, bella donna, strychnos, cocaine, marijuana, or other deleterious, hallucinogenic, toxic or controlled substances except nicotine and other substances found naturally in tobacco or added as part of an otherwise lawful manufacturing process. It is not the intention of this provision to ban the sale of lawfully manufactured cigarettes or other products subject to this ordinance.

D. By means of self-service display. All licensed products must be stored behind the sales counter, in a locked case, in a storage unit, or in another area not freely accessible to the general public. Any retailer selling licensed products at the time this ordinance is adopted must comply with this section within 90 days of the effective date of this ordinance.

E. By means of delivery sales. All sales of licensed products must be conducted in person, in a licensed retail establishment, in over-the-counter sales transactions.

F. By any other means, to any other person, or in any other manner or form prohibited by federal, state, or other local law, ordinance provision, or other regulation.

Subd. 2 Legal age. No person shall sell any licensed product to any person under the age of 21.

A. Age verification. Licensees must verify by means of government-issued photographic identification containing the bearer's date of birth that the purchaser is at least 21 years of age. Verification is not required for a person over the age of 30. That the person appeared to be 30 years of age or older does not constitute a defense to a violation of this subdivision.

B. Signage. Notice of the legal sales age, age verification requirement, and possible penalties for underage sales must be posted prominently and in plain view at all times at each location where licensed products are offered for sale. The required signage, which will be provided to the licensee by the county, must be posted in a manner that is clearly visible to anyone who is or is considering making a purchase.

Subd. 3 Liquid Packaging. No person shall sell or offer to sell any liquid, whether or not such liquid contains nicotine, which is intended for human consumption and use in an electronic delivery device, in packaging that is not child-resistant. Upon request by the county, a licensee must provide a copy of the certificate of compliance or full laboratory testing report for the packaging used.

Section 900. Responsibility. All licensees under this ordinance shall be responsible for the actions of their employees in regard to the sale, offer to sell, and furnishing of licensed products on the licensed premises. The sale, offer to sell, or furnishing of any licensed product by an employee shall be considered an act of the licensee. Nothing in this section shall be construed as prohibiting the County from also subjecting the clerk to any civil penalties that the county deems to be appropriate under this ordinance, state or federal law or other applicable law or regulation.

Section 1000. Compliance Checks and Inspections. All licensed premises shall be open to inspection by the County law enforcement or other authorized County official during regular business hours. From time to time, but at least once per year, the County shall conduct compliance checks. In accordance with state law, the county shall conduct a compliance check that involves the participation of a person at least 17 years of age, but less than 21, to enter the licensed premises to attempt to purchase licensed products. Prior written consent from a parent or guardian is required for any person under the age of 18 to participate in a compliance check. Persons used for the purpose of compliance checks shall be supervised by County-designated law enforcement officers or other designated County personnel. No person used in compliance checks shall attempt to use a false identification misrepresenting the person's age and all persons lawfully engaged in compliance checks shall answer all questions about their age asked by the licensee or his or her employee and shall produce any identification, if any exists, for which he or she is asked. Nothing in this section shall prohibit compliance checks authorized by State or Federal laws for educational, research or training purposes or required for the enforcement of a particular State or Federal law.

Section 1100. Prohibited Furnishing or Procurement. It shall be a violation of this ordinance for any person 21 years of age or older to purchase or otherwise obtain any licensed product on behalf of a

person under the age of 21. It shall further be a violation for any person 21 years of age or older to coerce or attempt to coerce a person under the age of 21 to purchase or attempt to purchase any licensed product.

Section 1200. Violations.

Subd. 1 Notice. A person violating this ordinance may be issued, either personally or by mail, a citation from the county that sets forth the alleged violation and that informs the alleged violator of his or her right to a hearing on the matter and how and where a hearing may be requested, including a contact address and phone number.

Subd. 2 Hearings.

A. Upon issuance of a citation, a person accused of violating this ordinance may request in writing a hearing on the matter. Hearing requests must be made within 10 business days of the issuance of the citation and delivered to the County Auditor or other designated county officer. Failure to properly request a hearing within 10 business days of the issuance of the citation will terminate the person's right to a hearing.

B. The County Auditor or other designated county officer will set the time and place for the hearing. Written notice of the hearing time and place will be mailed or delivered to the accused violator at least 10 business days prior to the hearing.

Subd. 3 Hearing Officer. The County Board shall serve as the hearing officer. The County Board may by resolution delegate this responsibility to such person or persons as it deems appropriate. The hearing officer will be an impartial employee of the county or an impartial person retained by the county to conduct the hearing.

Subd. 4 Decision. A decision will be issued by the hearing officer within 10 business days of the hearing. If the hearing officer determines that a violation of this ordinance did occur, that decision, along with the hearing officer's reasons for finding a violation and the penalty to be imposed, will be recorded in writing, a copy of which will be provided to the county and the accused violator by in-person delivery or mail as soon as practicable. If the hearing officer finds that no violation occurred or finds grounds for not imposing any penalty, those findings will be recorded and a copy will be provided to the county and the acquitted accused violator by in-person delivery or mail as soon as practicable. The decision of the hearing officer is final, subject to an appeal as described in subdivision (5) of this section.

Subd. 5 Appeals. Appeals of any decision made by the hearing officer shall be filed in the Itasca County district court within 10 business days of the date of the decision.

Subd. 6 Continued Violation. Each violation, and every day in which a violation occurs or continues, shall constitute a separate offense.

Section 1300. Penalties.

Subd. 1 Licensees. Any licensee found to have violated this ordinance, or whose employee violated this ordinance, will be charged an administrative fine of [$300] for a first violation; [$600] for a second offense at the same licensed premises within 36 months of the first violation; and [$1,000] for a third or subsequent offense at the same location within 36 months of the first violation. Upon the third violation, the license will be suspended for a period of not less than [30] consecutive days. And the licensee will be required to submit a written plan to the county board explaining any changes made to the establishment's technology, physical environment, training and/or procedure to avoid the sale of licensed products to persons less than 21 years of age. Upon a fourth violation within 60 months of the first violation, the license will be revoked.

Subd. 2 Employees of licensees and other Individuals. Individuals, other than persons under the age of 21 regulated by subdivision 3 of this section, found to be in violation of this ordinance may be charged an administrative fine of $50.00.

Subd. 3 Persons under the Age of 21. Persons under the age of 21 who violate this ordinance may only be subject to noncriminal, non-monetary civil penalties or remedies such as tobacco-related education classes, diversion programs, community services, or another non-monetary civil penalty that the county determines to be appropriate. The County Board will consult with court personnel, educators, parents, guardians, persons under the age of 21, public health officials, and other interested parties to determine an appropriate remedy for persons under the age of 21 in the county in the best interest of the underage person. The remedies may be established by ordinance and amended from time to time.

Subd. 4 Misdemeanor. Nothing in this section shall prohibit the County from seeking prosecution as a misdemeanor for any an alleged second violation of this ordinance by persons 21 years or older within five years of a previous conviction under the ordinance.

Section 1400. Exceptions and Defenses. Nothing in this ordinance shall prevent the provision of tobacco or tobacco related devices to any person as part of an indigenous practice or a lawfully recognized religious, spiritual, or cultural ceremony or practice. It shall be an affirmative defense to the violation of this ordinance for a person to have reasonably relied on proof of age as described by State law.

Section 1500. Severability and Savings Clause. If any section or portion of this ordinance shall be found unconstitutional or otherwise invalid or unenforceable by a court of competent jurisdiction, that finding shall not serve as an invalidation or affect the validity and enforceability of any other section or provision of this ordinance.

Section 1600. Effective Date. This ordinance shall take effect on June 1, 2021.

PUBLIC HEALTH LAW CENTER
at Mitchell Hamline School of Law

MINNESOTA COMMERCIAL TOBACCO

June 2020

TOBACCO 21 AND OTHER STATUTORY CHANGES

Frequently Asked Questions

On May 16, 2020, Governor Tim Walz signed Minnesota's Tobacco 21 bill, HF 331, Minnesota Session Laws, Regular Session, Ch. 88 – HF 331 (2020), raising the minimum legal sales age (MLSA) from 18 to 21.

This legislation also includes important updates and reforms to Minnesota's commercial tobacco retailer licensing laws and youth access laws that will improve state and local regulation and enforcement. The new law reflects years of effort by communities, local public health professionals, and advocates to advance public health. This FAQ document is designed to help communities understand these changes.

Q: How does this legislation change regulation of commercial tobacco in Minnesota?

A: Effective August 1, 2020, the legislation:

- Raises the minimum legal sales age for commercial tobacco products to 21;
- Increases retailer penalties for furnishing or selling to persons under 21;
- Eliminates criminal penalties for underage possession, use, or purchase (PUP) violations, allowing only non-monetary, civil penalties for underage use of false identification to purchase or attempt to purchase;
- Updates compliance check protocols to require decoys to be between 17 and 20 years of age;
- Narrows the adult-only store exceptions for self-service and sampling, allowing these activities only in stores that prohibit entry by anyone under the age of 21, have an entrance directly to the outside, and derive at least 90 percent of gross revenue from licensed products;[1]
- Requires retailers to check photo identification to verify the age of anyone under 30;
- Requires MLSA signage at every licensed retail location; and
- Updates the definition of electronic delivery devices, providing broader coverage than federal law.

Q: What are the key changes that every local community should know about?

A: The main points to understand are that, effective August 1, 2020:

- All local licensing authorities must enforce the Minnesota MLSA and other changes to state laws.
- State law no longer criminally penalizes PUP by underage persons. Civil, non-monetary penalties are allowed for underage use of false identification for purchases or attempted purchases. Federal law has never penalized underage PUP. Therefore, any local prosecution of an underage person for these activities no longer aligns with state or federal law.
- Compliance check decoys must now be 17 to 20 years old, instead of 15 to 17.

- The definition of electronic delivery devices will now include natural or synthetic nicotine and non-nicotine e-liquids.
- Retailer penalties for sales to underage persons and other violations will increase to a minimum of $300 for a 1st violation, $600 for a 2nd violation within 36 months, and $1,000 for a 3rd or subsequent violation within 36 months. Upon the 3rd or subsequent violation within 36 months of the first violation, a suspension of the retailer's license of at least seven days will be required and the retailer's license may be revoked.
- Self-service and sampling are allowed only in tobacco product shops that prohibit any person under the age of 21 to enter or be present, have an entrance directly to the outside, and derive at least 90 percent of gross revenue from sales of licensed products.1

Q: What commercial tobacco products are covered by the new law?

A: No one in Minnesota can sell tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery devices to anyone under the age of 21. The definition of electronic delivery devices has been updated to include natural and synthetic formulations of nicotine or other substances.

Q: If my community passed a Tobacco 21 law before the passage of the state law, are any changes needed?

A: Every community must, at a minimum, abide by the new state law requirements. We strongly recommend that all communities review their current licensing ordinances and regulatory practices, consider updating policy provisions that are inconsistent with state law, and take steps to ensure that all licensing and enforcement practices will conform with the state law by August 1, 2020.

Q: What should my community do if it has not yet passed a Tobacco 21 law? Do we have to change our local ordinance by August 1, 2020?

A: No. Although local licensing authorities must comply with and enforce the new Tobacco 21 MLSA by this date, state law does not require them to amend their current ordinances to do so. If a jurisdiction's current ordinance is less restrictive than the new changes to state law, it must

enforce the state provisions. State licensing and underage access laws allow local authorities to adopt more stringent regulations to further protect public health. An existing ordinance may create confusion if it conflicts with state law. An updated local law will help ensure retailer compliance and provide clarity for enforcement. A community may also want to adopt additional commercial tobacco policies to align with public health best practices and further protect community health.

Q: What about penalties for those under the age of 21?

A: In alignment with best practices and promotion of equity, PUP penalties have been removed from state law; however, a person under 21 who uses false identification to purchase or attempt to purchase commercial tobacco products may face court-ordered civil, non-monetary alternative penalties such as community service.[2]

Q: Who is responsible for conducting compliance checks under the state law?

A: State law continues to require a local licensing authority to conduct at least one unannounced compliance check per calendar year at each licensed location.

Q: Does the Minnesota Tobacco 21 law apply to Tribal lands?

A: Because Tribal reservations are sovereign territories, they are not subject to most state laws, including this one. Tribal reservations are required to comply with the federal Tobacco 21 law, however. As a result, retailers on Tribal lands may only sell commercial tobacco products to persons aged 21 or older.

Q: How does the Minnesota Tobacco 21 law intersect with the federal law enacted in 2019?

A: Since December 20, 2019, the federal MLSA has been age 21 in all U.S. states and territories, and in all Tribal jurisdictions. The Food and Drug Administration (FDA) is responsible for enforcing the federal law and conducts compliance checks for that purpose. In Minnesota, FDA compliance checks are conducted under a contract with DHS.[3]

Q: Will new retailer signs, window clings, and other resources be made available?

A: The Minnesota Department of Health (MDH) will work with its tobacco technical assistance providers, like the Association for Nonsmokers-Minnesota, to provide signs and window clings. MDH will also post a PDF online for retailers and public health workers to print and distribute.[4]

Q: Is help available if our community wants to review or update its ordinance?

A: Please contact your local public health department or the Public Health Law Center for assistance. The Public Health Law Center provides free legal technical assistance to help communities amend or adopt commercial tobacco control ordinances.

This publication was prepared by the Public Health Law Center at Mitchell Hamline School of Law, St. Paul, Minnesota, and made possible with funding from the Minnesota Department of Health. The Center provides information and legal technical assistance on issues related to public health and does not provide legal representation or advice. This document should not be considered legal advice.

Endnotes

1 Communities that have clean indoor air and/or flavored products ordinances should review language to ensure compliance with the new state MLSA.

2 Please see discussion of PUP penalties in the Public Health Law Center's model policies for MN cities and counties.

3 Click here for information on the federal Tobacco 21 law and what it means for Tribal, state, and local governments.

4 The FDA's *This is Our Watch* webpage also provides resources for retails, including age calculator clocks.

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1508

DEPARTMENT: Transportation
TIME REQUESTED: 5 Minutes
PRESENTER: Kory Johnson

AGENDA ITEM:
Change in Allocation Sign Tech/Highway Maintenance Worker Position

BOARD ACTION REQUESTED:
Approve the change in allocation of (1) Sign Tech/Highway Maintenance Worker position to Highway Maintenance Worker position.

BACKGROUND:
The Transportation Department has historically had a position of Sign Tech/Highway Maintenance worker that handles the installation of road signs throughout the County and completed snow plowing operations in the winter months. This position was posted internally January 19-26 and was not filled due to lack of interest. We would like to change this position to a full time Highway Maintenance Worker and move the sign technician work to the Traffic/GIS Technician position. Highway Maintenance Workers do still support the signing operations if there is a large replacement project, and by removing old posts.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1500

DEPARTMENT: Transportation
TIME REQUESTED: 5 Minutes
PRESENTER: Kory Johnson, Ryan Sutherland

AGENDA ITEM:
2021 Chloride Contract

BOARD ACTION REQUESTED:
Award County Project 2021-10 for 2021 Calcium Chloride to the lowest responsible bidder, Knife River Corporation and Magnesium Chloride to the lowest responsible bidder, Trimark Industrial and authorize the necessary signatures to execute the contract documents.

BACKGROUND:
Bids Opened April 6, 2021

CALCIUM CHLORIDE

Trimark Industrial - No Bid
Knife River Corporation - $241,758.00
Envirotech Services Inc - $266,400.00

MAGNESIUM CHLORIDE

Trimark Industrial - $223,992.00
Knife River Corporation - No Bid
Envirotech Services Inc - No Bid

COUNTY ATTORNEY REVIEW: Yes and/or Pending; This will use a standard service contract that has been previously approved by the County Attorney's Office.

SUPPORTING DOCUMENTATION: None

04/20/2021

RESULT:	**RECOMMENDED FOR CONSENT**	**NEXT: 04/27/2021 2:30 PM**

ITASCA COUNTY
BOARD OF COMMISSIONERS
Itasca County Courthouse
123 NE 4th Street
Grand Rapids, MN 55744

Tuesday, April 20, 2021

REQUEST FOR BOARD ACTION: RBA-2021-1533

DEPARTMENT: Administrative Services
TIME REQUESTED: 5 Minutes
PRESENTER: Ben DeNucci

AGENDA ITEM:
CDBG Program Discussion

BOARD ACTION REQUESTED:

BACKGROUND:

COUNTY ATTORNEY REVIEW:

SUPPORTING DOCUMENTATION: None

It was the consensus of the County Board to direct staff to communicate program information with Itasca County cities and townships.

RESULT:	**INFORMATIONAL - NO ACTION TAKEN**