



ITASCA COUNTY BOARD OF COMMISSIONERS

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

Tuesday, April 26, 2022

2:30 PM

Itasca County Boardroom

FINAL

REGULAR SESSION MINUTES

I. CALL TO ORDER

Chair Snyder 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: Add Item #6.9 (Recognition of County Employees) and approved the agenda, as amended.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

IV. MINUTES APPROVAL

Motion To: Approve the minutes of the Tuesday, April 19, 2022 County Board Work Session.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Burl Ives
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

V. CONSENT AGENDA

Motion To: Approve the Consent Agenda.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

1. Approve the IMCare Quality Program documents.

2. Approve the 2022/2023 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 the Attachment "A" to Agreements as needed and upon mutual agreement with the Township or City.
3. Approve the 2022 Lease Agreement between Itasca County and the Northern Minnesota Swap Meet and Car Show, and authorize necessary signatures.
4. Approve the 2022 Fairgrounds Race Track Agreement between Itasca County and Grand Rapids Speedway Inc. and authorize necessary signatures.
5. Authorize the notice of intermediate and regular oral bid auction of timber to be given by publication in the official newspaper of the County as provided by law, and that Land Commissioner offers such tracts of timber in order in which they appear in said notice of sale, and that sale shall commence at 10:00 AM on Wednesday June 8, 2022 at Cohasset Community Center.
6. Approve 2022 Firewise grant application, accept the grant and authorize necessary signatures if awarded.
7. Initiate 2018 and 2019 Secure Rural Schools Act (SRS) Title III county funds and obligate 100% of the funds for the purposes to: (1) carry out activities under the Firewise Communities program and/or (2) develop/carry out the Itasca County Community Wildfire Protection Plan. The funds can be used for these allowable Title III purposes after a 45 day public comment period and after submission of said proposal to the Itasca County SRS Resource Advisory Committee (RAC). 2018 SRS Title III funds total \$27,506.49 and 2019 SRS Title III funds total \$24,192.99.
8. Upon successfully being awarded the 2022 Itasca County Firewise grant, approve 2022 Itasca County Firewise Coordinator service contract to Moore Outdoor Services, LLC for \$31,360.00 and authorize necessary signatures.

VI. REGULAR AGENDA

1. Citizen Input
No citizen input provided.
3. Commissioner Warrants

Motion To: Approve Commissioner Warrants with a check date of April 29, 2022, in the amount of \$3,014,721.38.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Burl Ives
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

4. ICHHS Warrants

Motion To: Approve the Itasca County Health and Human Services (ICHHS) Department Warrants for April 2022, in the amount of \$2,153,083.61.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

5. 2022-2024 AEA Labor Agreement

Motion To: Approve and authorize necessary signatures for the 2022-2024 Labor Agreement for Itasca County Attorney Employees Association (AEA).

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

6. 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

7. PILT Resolution

Motion To: Adopt the Resolution Re: Support for Increase in Payment in Lieu of Taxes (PILT) Payments to Itasca County.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Burl Ives
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

8. County Government Appreciation Day

Motion To: Adopt the Resolution Re: County Government Appreciation Day.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

9. Recognition of County Employees

The following employees were recognized:

Welcome new employee, Nevada Childs, Corrections Agent, Probation Department effective April 18, 2022.

Farewell to Ryan Dowell whose last day as a Highway Maintenance Worker will be April 28, 2022 after 4 months of service.

Congratulations to Walker Maasch in taking a new job assignment from an Assessment Technician to Assessor/Appraiser I, Assessor Department effective May 1, 2022.

Welcome new employee, Matthew Grossell, Deputy Sheriff/Road Deputy, Sheriff's Department effective April 25, 2022.

Farewell to Tanya Elich whose last day as an Assessment Technician, Assessor's Office, will be April 29, 2022 after 4 years of service.

RESULT:	INFORMATIONAL - NO ACTION TAKEN

RECESS

Motion To: Go into Recess at 2:49 PM.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

RECOVENE

Chair Snyder reconvened the meeting at 3:10 PM, with all members present, except Tinquist and Trunt absent.

2. **Legislative Conference Call**

A Legislative Conference Call was provided by Representative Matt Bliss and Itasca County Lobbyist Loren Solberg.

RESULT:	INFORMATIONAL - NO ACTION TAKEN

VII. COMMISSIONER COMMENTS

County Attorney Matti Adam provided comment regarding the upcoming Itasca County Traffic Safety Summit hosted by the Itasca County Toward Zero Deaths (TZD) Safe Roads Coalition.

Commissioner Ives provided comment regarding the many calls he has received regarding valuations as well as upcoming meetings regarding Short Term Rental properties.

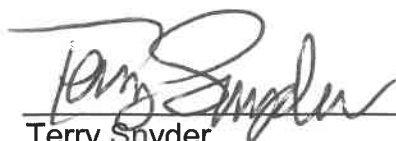
Commissioners DeNucci and Snyder provided comment regarding the obligation of the State of Minnesota to reimburse Probation Officer salary costs per M.S. 244.19.

Commissioner Snyder provided comment regarding a presentation he provided, along with County Administrator Brett Skyles, at a recent ItasCAP meeting regarding the Itasca County Justice Center and Referendum.

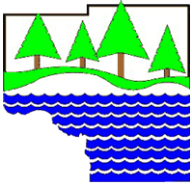
VIII. CLOSED SESSIONS**IX. ADJOURN**

Chair Snyder adjourned the meeting at 3:54 PM.

ATTEST


Terry Snyder
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 26, 2022

RESOLUTION 2022-27

RE: SUPPORT FOR INCREASE IN PAYMENT IN LIEU OF TAXES (PILT) PAYMENTS TO ITASCA COUNTY

WHEREAS, the Payment in Lieu of Taxes (PILT) Program passed into Minnesota law in 1979 with the statutory purpose “to address the disproportionate impact of state land ownership on local units of government with a large proportion of state land;” and

WHEREAS, 95% of all PILT acreage is located in the northern-half of Minnesota; and

WHEREAS, since 1995, nearly all PILT payment increases have gone to southern Minnesota and metro area counties; and

WHEREAS, , in 1979 when PILT payments began, the biggest disparity between the highest PILT compensated county to the lowest compensated county was 8:1 or, 8 times higher, yet today that disparity has grown to a whopping 170:1 or, 170 times higher; and

WHEREAS, the principal cause PILT payments are so inequitable across MN, is because in 1995, the Acquired Acres category of PILT Payments switched from a flat rate to instead, a land value basis, yet all other major PILT Payment categories remained at a flat rate; and

WHEREAS, the Northern Counties Land Use Coordinating Board (NCLUCB) recently completed a Comprehensive Study re: State PILT and Payments to Counties which verifies all of the above-mentioned inequities; and

WHEREAS, SF 2793 (Bakk) & HF 3073 (Ecklund) have been introduced to help rectify these huge inequities in PILT Payments by substantially increasing PILT payments to Northern MN counties, including a 56% increase in Itasca County.

NOW THEREFORE BE IT RESOLVED, that Itasca County hereby urges the 2022 Legislature to pass the respective Bakk-Ecklund PILT Bills through the necessary committees and include them in their final Omnibus Tax Bill.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Burl Ives
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

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 26th day of April A.D. 2022 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 26th day of April A.D. 2022.



Administrator



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

RESOLUTION 2022-28

RE: COUNTY GOVERNMENT APPRECIATION DAY

WHEREAS, Minnesota's 87 counties employ over 36,000 people to provide essential services to create healthy, safe and vibrant communities; and

WHEREAS, the work of county employees is fundamental, whether it's a newborn well-check by a public health nurse, a passport renewal at a license center, or voter registration and ballot processing; and

WHEREAS, through their commitment to public service, county employees dedicate their time, skills, and expertise for the benefit of their neighbors, and at times, risk their personal safety by coordinating emergency management and managing justice and public safety systems; and

WHEREAS, the vital work of counties promotes healthy communities, fosters conditions for economic growth, strengthens infrastructure, and improves residents' quality of life.

NOW THEREFORE BE IT RESOLVED, the Itasca County Board of Commissioners recognizes the commitment and dedication to public service excellence of county staff and officials and proclaims April 26, 2022 County Government Appreciation Day.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

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 26th day of April A.D. 2022 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 26th day of April A.D. 2022.

Administrator



April 26, 2022

Chair:

PULL: None

ADDITIONS:

1. Item #6.9 – Recognition of County Employees

CHANGES: None

INFORMATIONAL:

1. Item #6.6 – Additional Information

Amanda



ITASCA COUNTY BOARD OF COMMISSIONERS

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

Tuesday, April 19, 2022

2:30 PM

Itasca County Boardroom

DRAFT

WORK SESSION MINUTES

I. CALL TO ORDER

Chair Snyder 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: Add Item #6.5 (Tobacco License) and approve the agenda, as amended.

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

IV. MINUTES APPROVAL

Motion To: Approve the minutes of the Tuesday, April 12, 2022 County Board Regular Session.

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

V. RECOMMENDED FOR CONSENT AGENDA

1. Approve the 2022/2023 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 the Attachment "A" to Agreements as needed and upon mutual agreement with the Township or City.

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/26/2022 2:30 PM

2. Approve the 2022 Lease Agreement between Itasca County and the Northern Minnesota Swap Meet and Car Show, and authorize necessary signatures.

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/26/2022 2:30 PM

3. Approve the 2022 Fairgrounds Race Track Agreement between Itasca County and Grand Rapids Speedway Inc. and authorize necessary signatures.

RESULT: RECOMMENDED FOR CONSENT NEXT: 04/26/2022 2:30 PM

4. Authorize the notice of intermediate and regular oral bid auction of timber to be given by publication in the official newspaper of the County as provided by law, and that Land Commissioner offers such tracts of timber in order in which they appear in said notice of sale, and that sale shall commence at 10:00 AM on Wednesday June 8, 2022 at Cohasset Community Center.

RESULT: RECOMMENDED FOR CONSENT NEXT: 04/26/2022 2:30 PM

5. Approve 2022 Firewise grant application, accept the grant and authorize necessary signatures if awarded.

RESULT: RECOMMENDED FOR CONSENT NEXT: 04/26/2022 2:30 PM

6. Initiate 2018 and 2019 Secure Rural Schools Act (SRS) Title III county funds and obligate 100% of the funds for the purposes to: (1) carry out activities under the Firewise Communities program and/or (2) develop/carry out the Itasca County Community Wildfire Protection Plan. The funds can be used for these allowable Title III purposes after a 45 day public comment period and after submission of said proposal to the Itasca County SRS Resource Advisory Committee (RAC). 2018 SRS Title III funds total \$27,506.49 and 2019 SRS Title III funds total \$24,192.99.

RESULT: RECOMMENDED FOR CONSENT NEXT: 04/26/2022 2:30 PM

7. Upon successfully being awarded the 2022 Itasca County Firewise grant, approve 2022 Itasca County Firewise Coordinator service contract to Moore Outdoor Services, LLC for \$31,360.00 and authorize necessary signatures.

RESULT: RECOMMENDED FOR CONSENT NEXT: 04/26/2022 2:30 PM

VI. DISCUSSION / INFORMATIONAL

1. Citizen Input

No citizen input provided.

2. IMCare Quality Program Document Review and Approval

QI/UM Director Amber Silliman provided information regarding the request to approve the IMCare 2022 Quality Program Description, 2022 UM Program Description, 2021 QI UM Program Evaluation, and the 2022 QI/UM Workplan.

RESULT: RECOMMENDED FOR CONSENT NEXT: 04/26/2022 2:30 PM

3. Public Hearing Re: Rezone Application Submitted by Joshua and Angela Eschenbach

Motion To: Open the Public Hearing Re: Rezone Application of Joshua and Angela Eschenbach.

RESULT: APPROVED (5 TO 0)

MOVER: Commissioner Davin Tinquist

SECONDER: Commissioner Burl Ives

AYES: Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

Motion To: Close the above public hearing.

RESULT: APPROVED (5 TO 0)

MOVER: Commissioner Leo Trunt

SECONDER: Commissioner Ben DeNucci

AYES: Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci

Motion To: Adopt the Resolution Re: Application Submitted by Joshua and Angela Eschenbach to Rezone Parcels 02-027-2300, 02-027-2200, and 02-027-3200 from Industrial to Farm Residential.

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

4. County Assessor Presentation Re: Valuations
County Assessor Amber Peratalo provided a 2022 Property Assessment Update.

RESULT:	INFORMATIONAL - NO ACTION TAKEN

5. Tobacco License

Motion To: Approve new tobacco license for KKWC, Inc. dba: Fred's Store located at 19517 County Road 560, Goodland MN 55742.

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

VII. COMMITTEE REPORTS

Commissioner Ives reported on the many calls he has received regarding property valuations.

Commissioner DeNucci reported on his attendance of the County Board's Special Session Re: American Rescue Plan (ARP) funding, as well as recent Grand Village Board, Nashwauk Joint School/Public Library Board, Arrowhead Economic Opportunity Agency (AEOA) Board, and Kootasca Finance Committee meetings.

Commissioner Tinquist reported on the many calls he has received regarding valuations and roads, as well as his attendance of the recent Extension Committee meeting.

Commissioner Trunt reported on the many calls he has received regarding valuations and roads, as well as his attendance of recent Fair Board, Northeast Waste Advisory Council (NEWAC), Itasca County Township Association (ICTA), and Western Mesabi Mine Planning Board (WMMPB) meetings.

Commissioner Snyder reported on the many calls he has received regarding valuations, as well as his attendance of various mining meetings.

VIII. ADMINISTRATOR UPDATE

County Administrator Brett Skyles provided an Administrator Update, including information regarding the Correctional Facility/Courts construction project which is currently on budget and only 3-4 days behind schedule due to weather, as well as the Solid Waste Regional Study currently underway.

IX. COMMISSIONER COMMENTS

RECESS

Chair Snyder recessed the meeting at 3:47 PM.

RECONVENE

Chair Snyder reconvened the meeting at 4:07 PM, with all members present except Trunt absent.

X. CLOSED SESSIONS

1. Closed Session Re: Timothy D. Moratzka, Trustee of the Nancy L. Mayen Residual Trust, a Trust under the laws of Minnesota vs. Aaron Britton, et al., 31-CV-19-1367

Motion To: Go into Closed Session, which may be closed pursuant to Minn. Stat. 13D.05, subd. 3(b) and 13D.05, subd. 1(d) based upon Attorney Client Privilege, Minn. Stat. 595.02, subd 1(b) to consult with it's attorney in reference to a pending action in the Matter of Timothy D. Moratzka, Trustee of the Nancy L. Mayen Residual Trust, a Trust under the laws of Minnesota vs. Aaron Britton, et al.

RESULT:	APPROVED (4 TO 0)
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Leo Trunt

Others Present: County Attorney Matti Adam, County Surveyor Guy Carlson, Land Commissioner Kory Cease, County Engineer Karin Grandia, Chief Deputy/First Assistant County Attorney Mike Haig (via telephone), Environmental Services Director Dan Swenson, County Administrator Brett Skyles, and Deputy Clerk of the County Board Amanda Schultz.

Motion To: Go into Open Session.

RESULT:	APPROVED (4 TO 0)
MOVER:	Commissioner Davin Tinquist
SECONDER:	Commissioner Ben DeNucci
AYES:	Davin Tinquist, Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Leo Trunt

RESULT:	INFORMATIONAL - NO ACTION TAKEN

XI. ADJOURN

Chair Snyder adjourned the meeting at 4:28 PM.

ATTEST

Terry Snyder
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 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2321

DEPARTMENT: Health & Human Services

TIME REQUESTED: 10 Minutes

PRESENTER: Sarah Anderson

AGENDA ITEM:

IMCare Quality Program Document Review and Approval

BOARD ACTION REQUESTED:

Approve the IMCare Quality Program documents.

BACKGROUND:

Annually IMCare is requested to evaluate its Quality Program, identify opportunities for improvement and update the QI/UM Program Description to include initiatives for the current year and create a work plan to address interventions and ongoing activities.

COUNTY ATTORNEY REVIEW: N/A

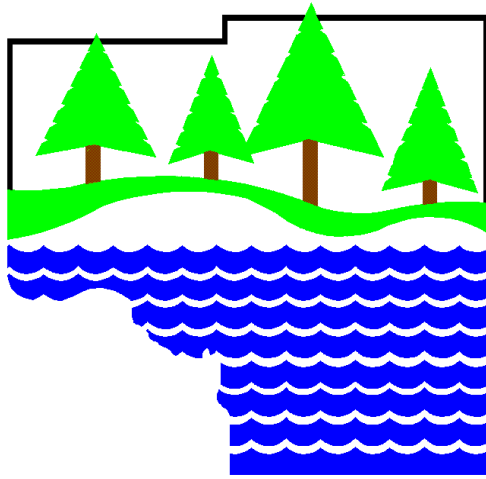
SUPPORTING DOCUMENTATION:

1. 2021 QI UM Program Evaluation
2. 2022 Quality Program Description
3. 2022 UM Program Description
4. 2022 workplan

04/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/26/2022 2:30 PM

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt



2021 ITASCA MEDICAL CARE PROGRAM EVALUATION

Approved by:

IMCare External QI/UM Committee: 03/16/2022

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.

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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 2021 QI/UM activities.

In 2021, 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, throughout 2021, IMCare continued to evaluate and improve its Population Health Management (PHM) program. Work was completed to improve the electronic platform that houses the Complex Case Management (CCM) program, enrollee and provider communication on the PHM program was relayed via newsletters, and the IMCare website was updated to offer disease and condition education and resources available for enrollees within the PHM section. IMCare also continued to review, modify, and update authorization requirements through the IMCare Utilization Review Workgroup, to improve enrollee access to appropriate care. IMCare continued ongoing improvement of grievance and appeal processes, and all staff and Itasca County Elderly Waiver Care Coordinator delegates completed annual training in early 2021. This initiative began in 2018, but efforts continue.

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 became 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 enrollee's 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 Directors 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 2021 QI/UM Work Plan activities and outcome measurements collected throughout the year are outlined below.

2021 Quality Improvement 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.

2021 HEDIS – Medicaid

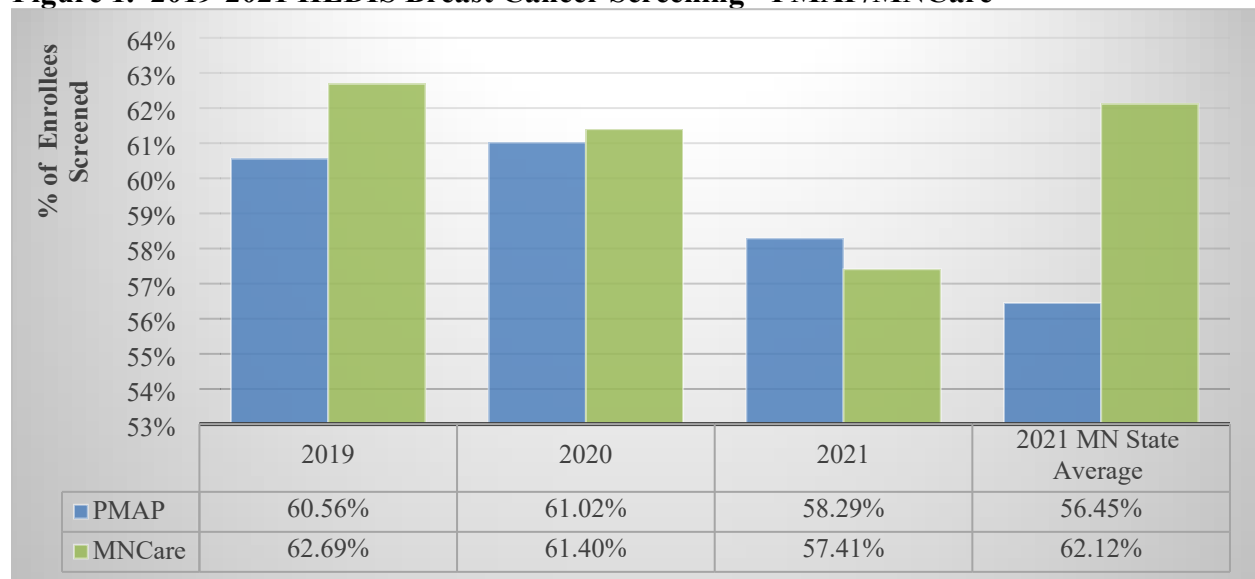
IMCare notes a negative effect for several HEDIS 2021 preventative healthcare measures including: breast cancer screening, cervical cancer screening, chlamydia testing and diabetic eye exams. Clinic policy changes (availability of preventive appointments), as well as public perception and reaction due to the COVID-19 pandemic is thought to have influenced these rates as enrollees were less likely to seek care for non-emergent issues in 2020.

Breast Cancer Screening (BCS)

Though IMCare had an expected decline in the rate of screening for breast cancer in 2021 IMCare did remain above the MN state average for the PMAP population and so met goal. IMCare did not meet goal for breast cancer screening in MNCare, which is due to both the

smaller population within this benefit group and the overall decrease in preventative services seen through 2021.

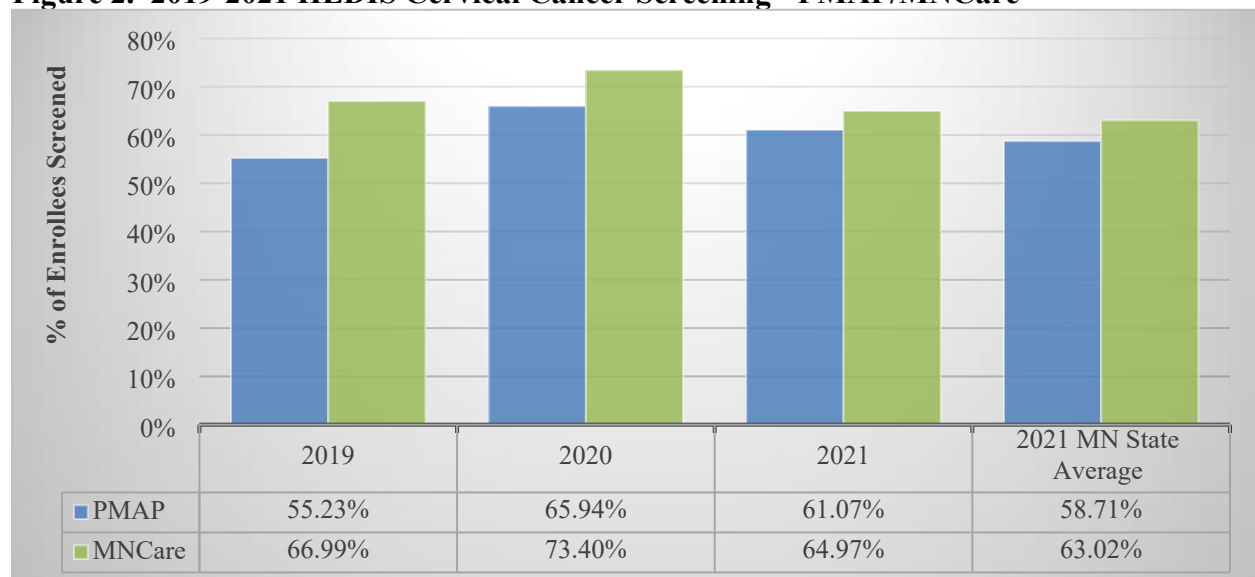
Figure 1. 2019-2021 HEDIS Breast Cancer Screening - PMAP/MNCare



Cervical Cancer Screening (CCS)

IMCare had an expected decline from 2021 for both PMAP and MNCare consistent with the overall decrease in preventative health services. Despite the decrease from 2020, IMCare continued to meet the goal of being above the MN state average.

Figure 2. 2019-2021 HEDIS Cervical Cancer Screening - PMAP/MNCare

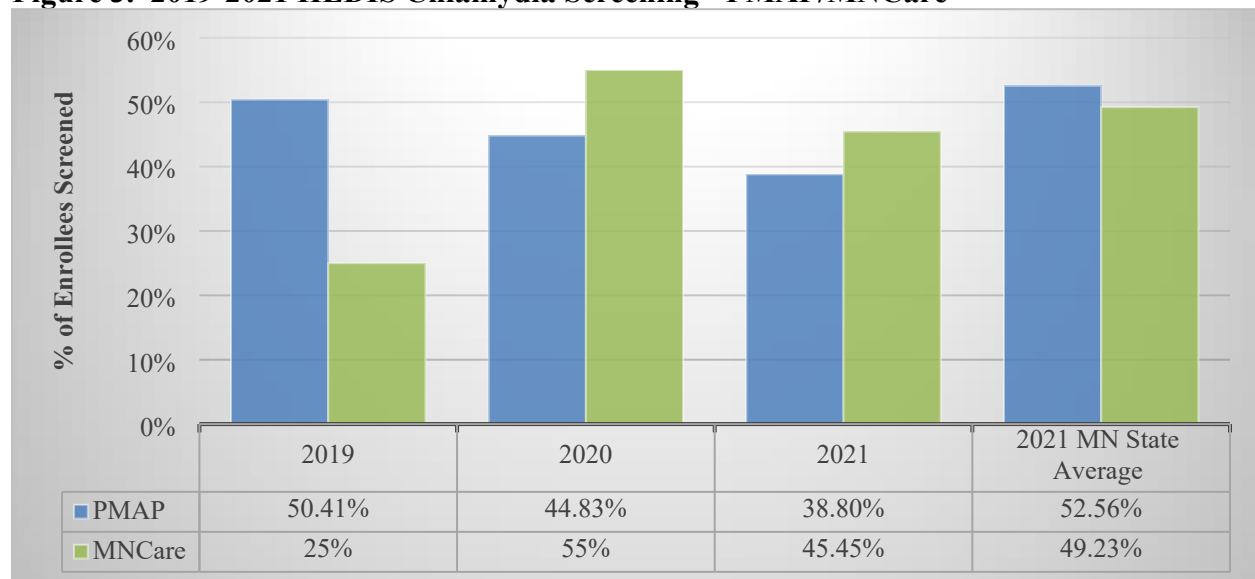


Chlamydia Screening (CHL)

Chlamydia testing shows a continued decrease from 2019 to 2021 for PMAP and has continued to remain below goal. The MNCare population also did not meet this goal, however, due to the

historically small and inconsistent denominators the results for this population are considered inconclusive.

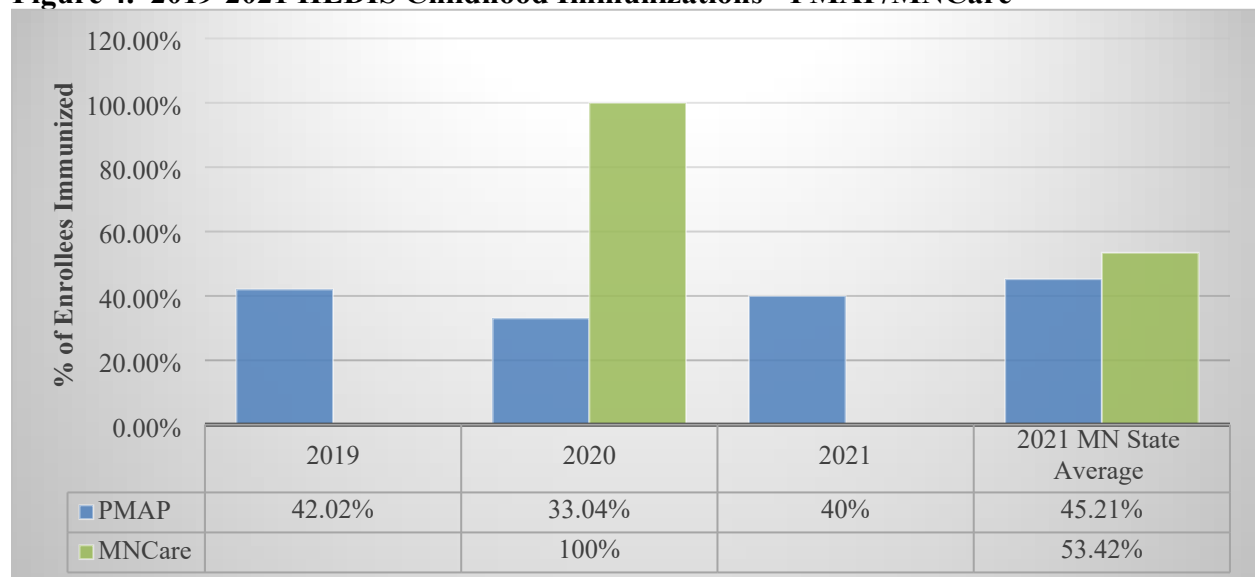
Figure 3. 2019-2021 HEDIS Chlamydia Screening - PMAP/MNCare



Childhood Immunizations (CIS)

IMCare's goal for childhood immunization combo 10 rate does not meet the goal of being above the MN State average. This rate does show an increase from 2020 to 2021, however, a similar increase of the MN state average contributes to this measure continuing to be below goal.

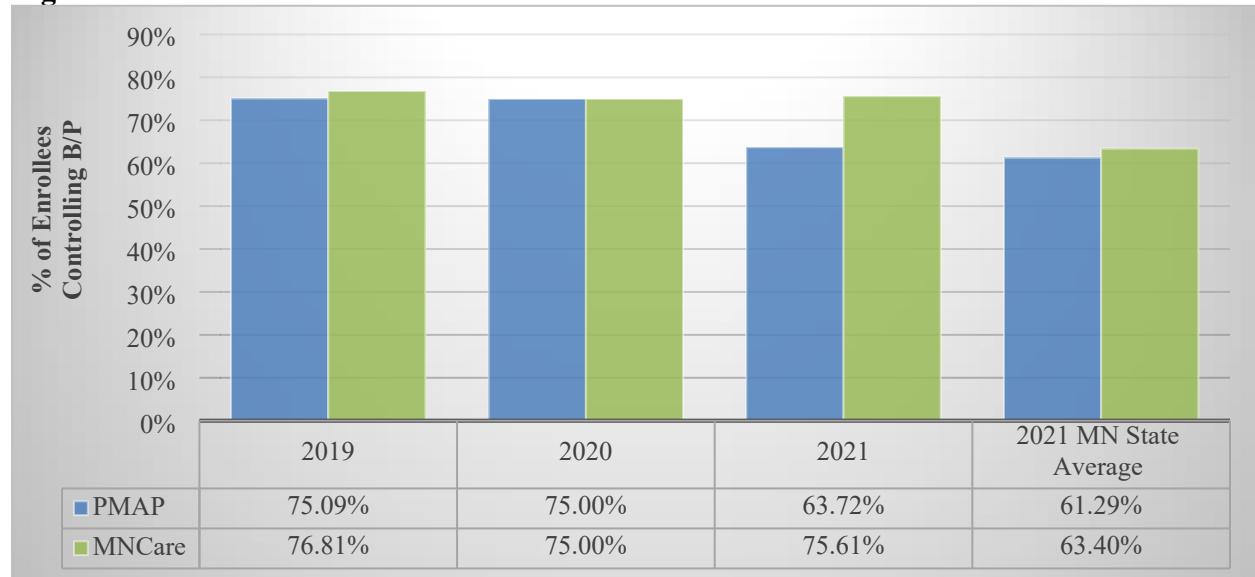
Figure 4. 2019-2021 HEDIS Childhood Immunizations - PMAP/MNCare



Blood Pressure Control (CBP):

Though IMCare did note a significant decrease in blood pressure control from the previous two years for the PMAP population, IMCare continued to meet the goal of at or above the MN state average rate.

Figure 5. 2019-2021 HEDIS Blood Pressure Control - PMAP/MNCare



Prenatal and Postpartum Care (PPC)

IMCare meets goals within prenatal and postpartum care which is likely related to the Healthy Pregnancy Program (a focus study) and working collaboratively with Itasca County Public Health to coordinate benefits and offer health education to these enrollees.

Figure 6. 2019-2021 HEDIS Prenatal Care - PMAP/MNCare

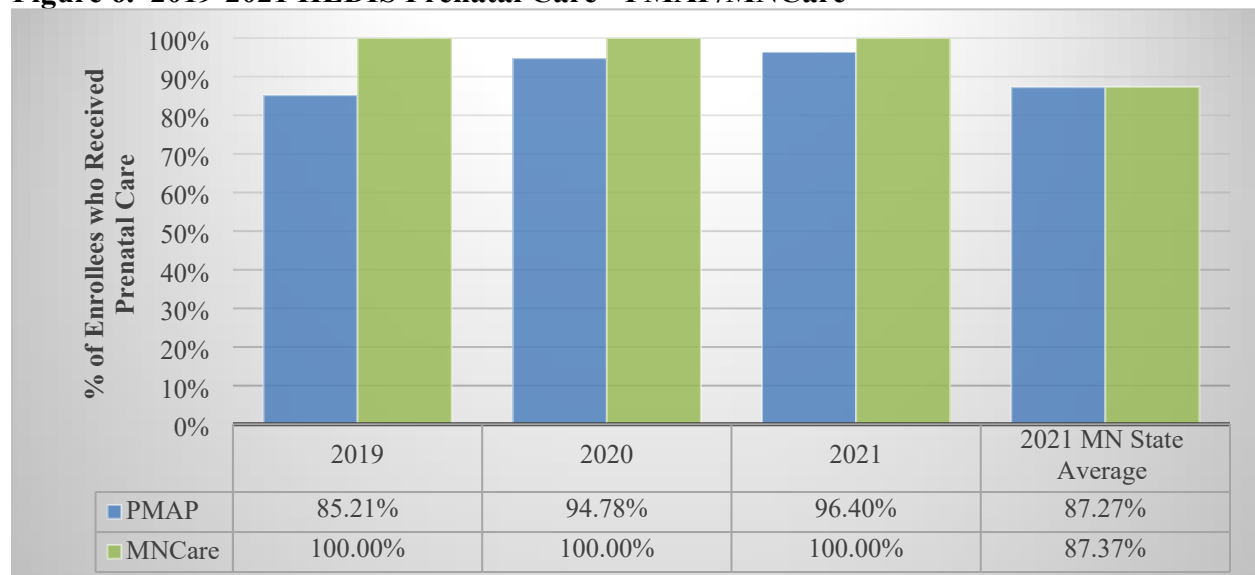
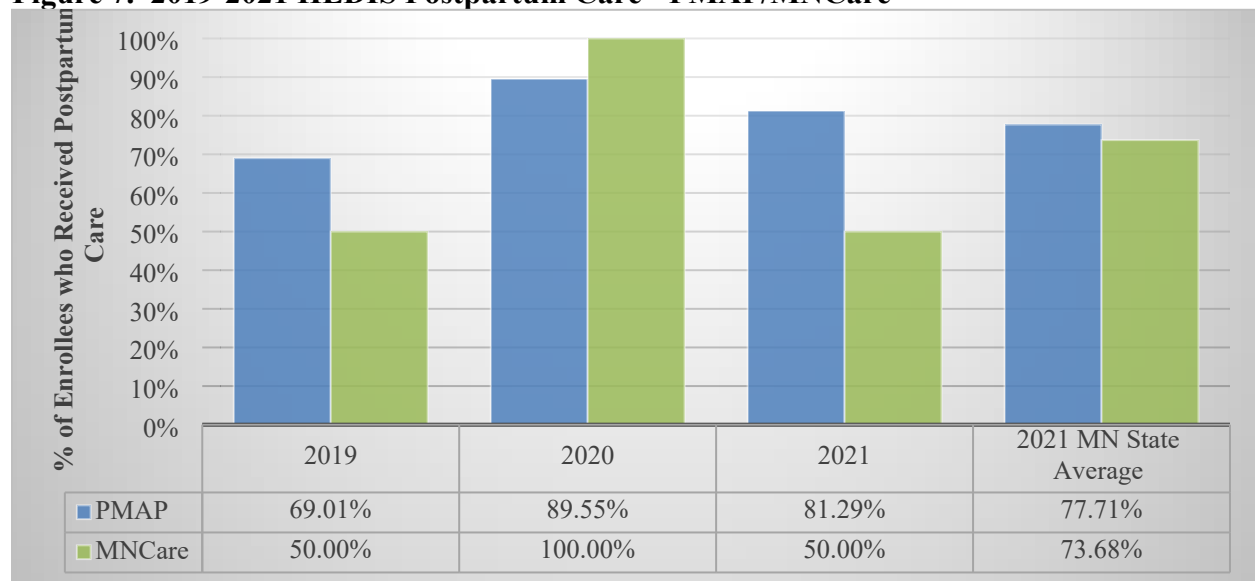


Figure 7. 2019-2021 HEDIS Postpartum Care - PMAP/MNCare



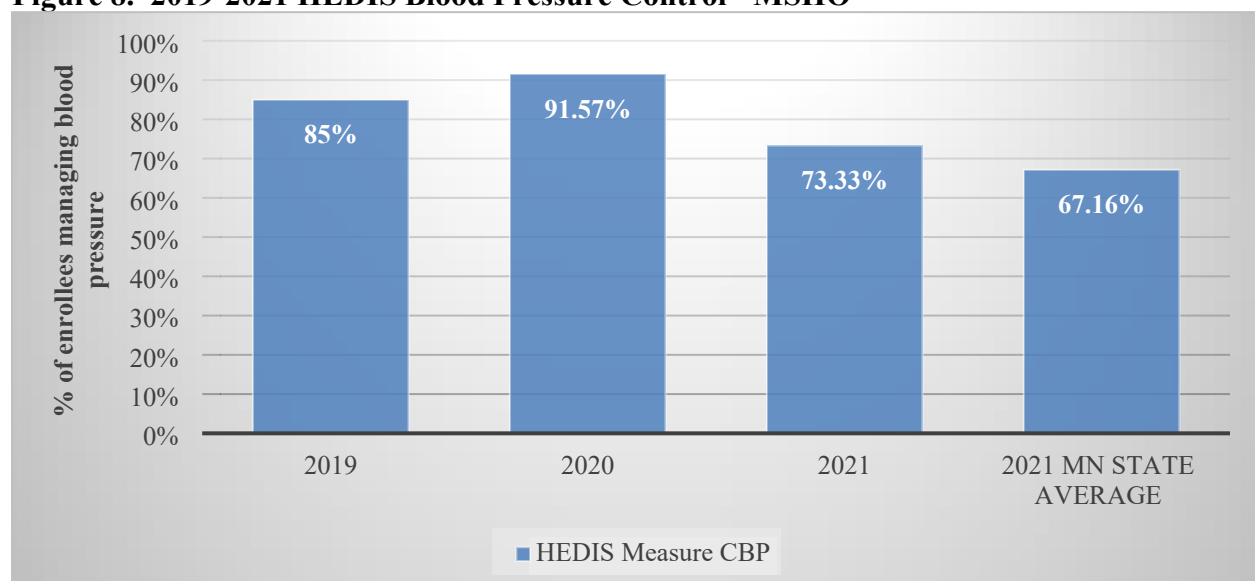
2021 HEDIS - MSHO

Overall, a majority measures met goal in 2021. IMCare noted some negative impact thought to be caused by the pause on preventative care services in 2021 due to the COVID-19 pandemic. While most measures met goal in 2021, several measures did show a negative trend from the previous year rates.

Blood Pressure Control (CBP)

IMCare experienced an expected decline in blood pressure control in the MSHO population in 2021, however met goal of being above the MN state average.

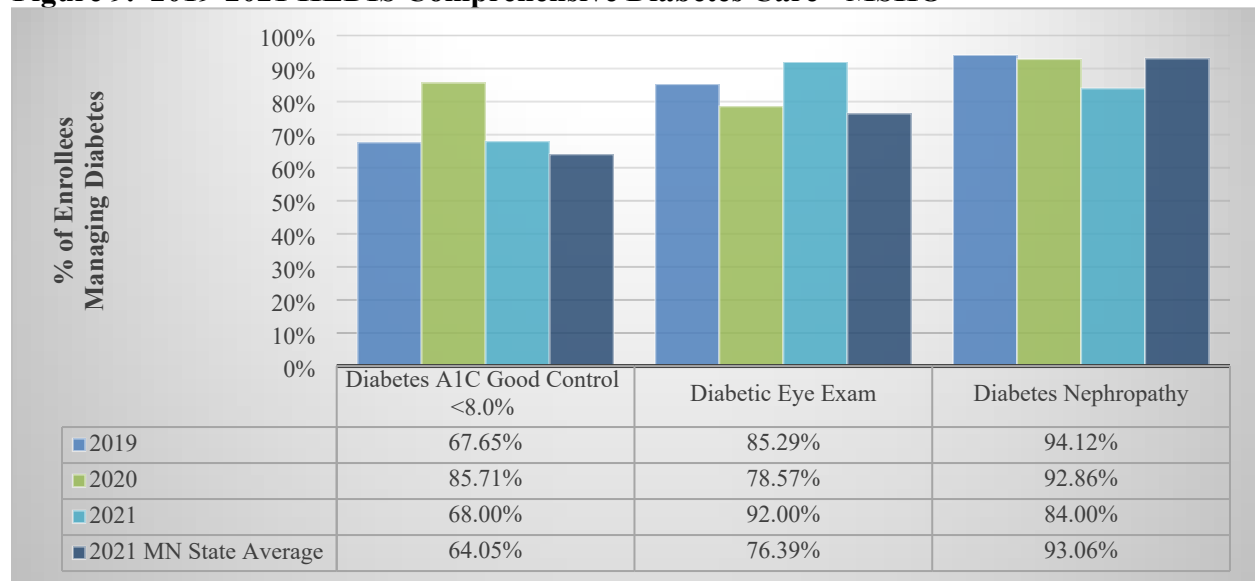
Figure 8. 2019-2021 HEDIS Blood Pressure Control - MSHO



Comprehensive Diabetes Care

IMCare noted an expected decrease in A1c control (below 8%) and nephropathy measures. Though A1c control decreased this measure continued to meet the goal of being above the MN state average. IMCare did not meet goal in nephropathy most likely related to the decrease in preventative healthcare services noted through all populations. IMCare noted an increase in diabetic eye exams.

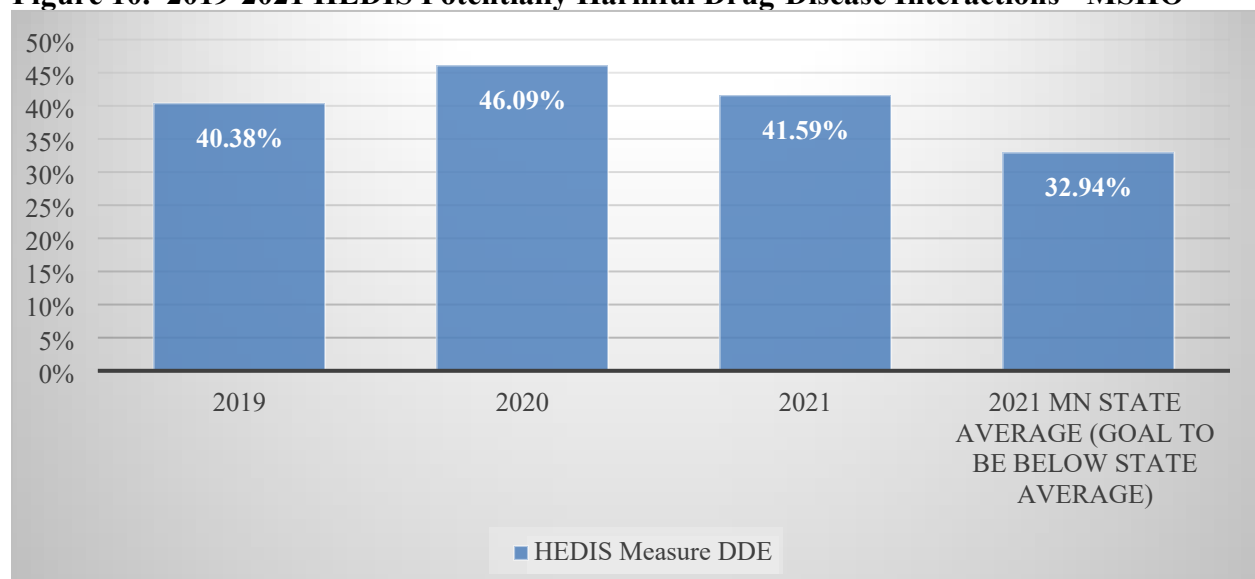
Figure 9. 2019-2021 HEDIS Comprehensive Diabetes Care - MSHO



Potentially harmful drugs (DDE)

Use of potentially harmful drug-disease interactions continues to be not unmet as it is above the MN State average, though this rate did decrease from 2020 to 2021 which shows some progress in this measure.

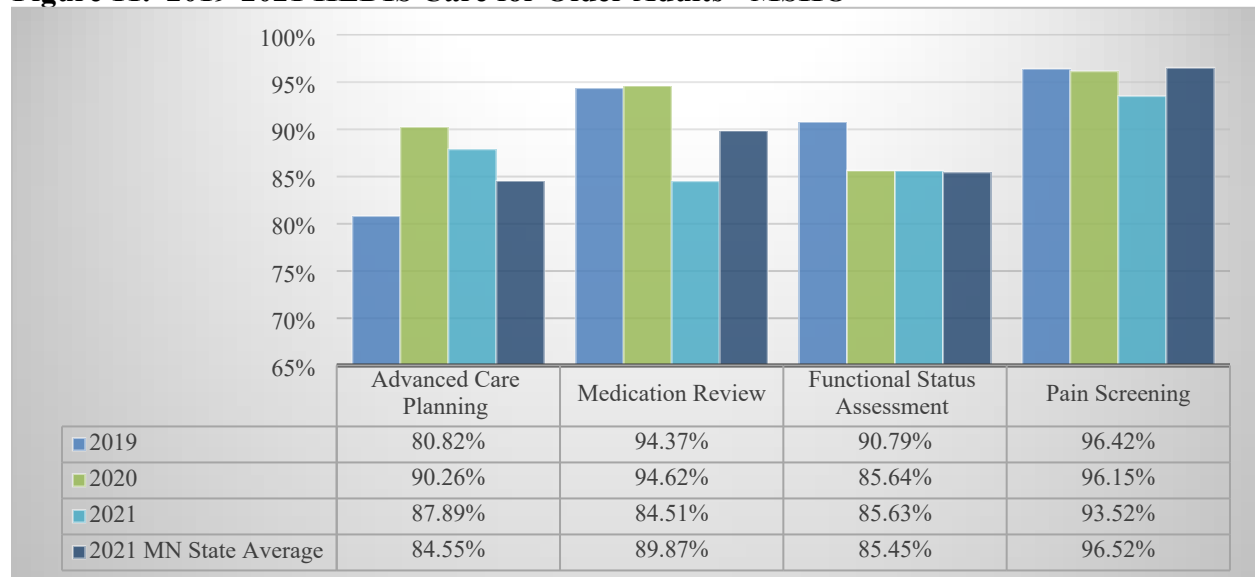
Figure 10. 2019-2021 HEDIS Potentially Harmful Drug-Disease Interactions - MSHO



Care for older adults (COA)

IMCare noted an expected decrease across all measures within the care for older adults. Despite the overall decrease through these measures IMCare did meet goal for advance care planning and functional status assessments.

Figure 11. 2019-2021 HEDIS Care for Older Adults - MSHO



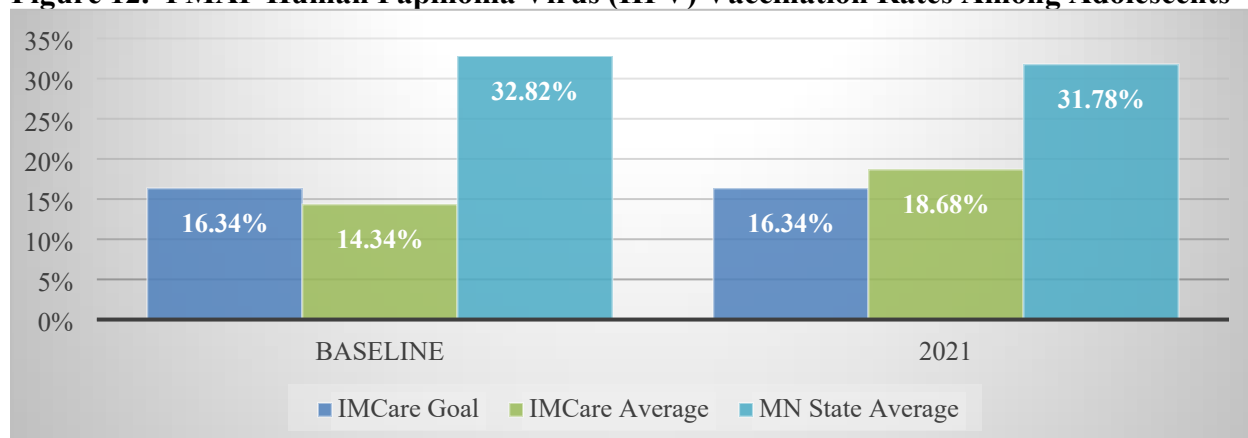
Performance Improvement Projects

2021-2023 Increasing Human Papilloma Virus (HPV) Vaccination Rates Among Adolescents Performance Improvement Project

As per the 2021 Contract for Prepaid Medical Assistance and MinnesotaCare, Section 7.2 “The Managed Care Organization (MCO) must conduct Performance Improvement Projects (PIP) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR §438.330(b)(1) and (d) and CMS protocol entitled “*CMS EXTERNAL QUALITY REVIEW (EQR) PROTOCOLS October 2019.*” The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.”

The Goal of the HPV PIP is to improve HPV vaccination rates among male and female adolescents in the PMAP and MNCare population by an absolute 2 percentage points above baseline, as evidenced through the HEDIS measure - Effectiveness of Care (IMA) HPV measure.

Figure 12. PMAP Human Papilloma Virus (HPV) Vaccination Rates Among Adolescents

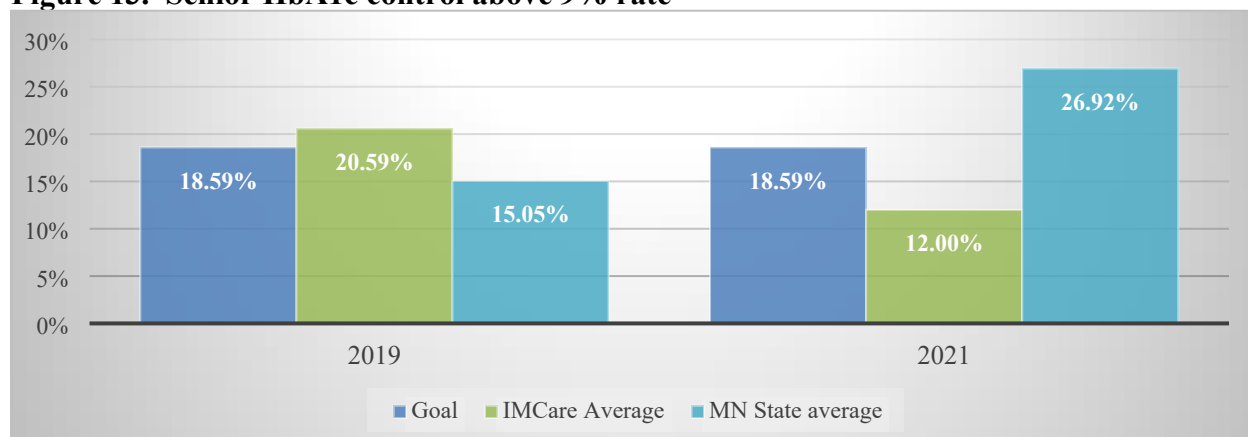


IMCare met the goal of increasing the HEDIS HPV vaccine rate in 2021 above the established goal. IMCare will continue to expand efforts to maintain or improve the rate through the end of the project.

2021-2023 Reducing the Incidence of Poor HbA1c Control (>9.0%) (CDC) among the IMCare Minnesota Senior Health Option (MSHO) Enrollees

As per the 2021 *Contract For Minnesota Senior Health Options and Minnesota Senior Care Plus Services with Itasca Medical Care*, Section 7.2, “The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Projects must comply with 42 CFR §438.330(b)(1) and (d), and with CMS protocol entitled “*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects.*”” The purpose and proposed intervention strategies will seek to reduce the percentage of Poor HbA1c control (>9%) among senior enrollees within IMCare by an absolute 2 percentage points above baseline by 2022, as evidenced through hybrid data gathered from the MY2020 HEDIS Comprehensive Diabetes Care (CDC).

Figure 13. Senior HbA1c control above 9% rate



The goal of this HbA1c QIP is to decrease the IMCare rate of poor diabetic control (9% or above) to 18.59% or lower by 2022 and sustain or continue decreasing this rate through 2023. IMCare noted success with reduction of this measure in 2021, meeting the QIP goal. HEDIS technical specifications limit this study population to enrollees below 75 years of age, however, the target population for this QIP is all senior enrollees (65 years old and older). HEDIS data indicates that only 25 enrollees within the population qualified for this measure, which may skew the measures of success for this project as IMCare identified 148 enrollees in 2021 with a diagnosis of diabetes based on claims data.

The potential for impact of this project is significant as diabetes affects 33.26% of the MSHO enrollees. Care coordination services are available to all senior enrollees and enrollees are contacted at least annually to offer services. Improved outcomes are noted for enrollees participating in care coordination. Enrollees who participate in care coordination and receive a Health Risk Assessment (HRA) are noted to have improved compliance with clinic visits and HbA1c tests. Those enrollees that do not participate are shown to have poorer outcomes.

Focus Studies

Emergency Department (ED) Utilization Focus Study (FS)

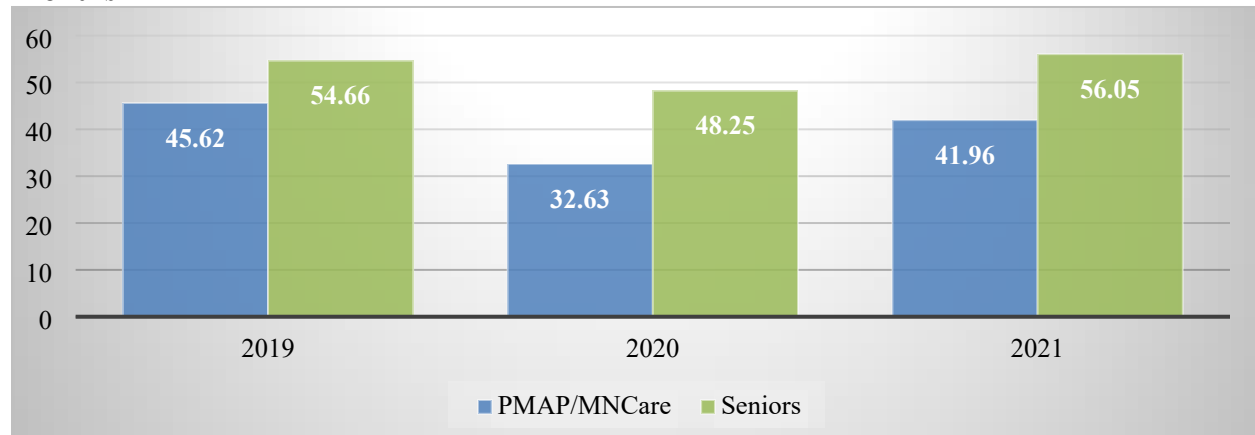
IMCare identified enrollees with high ED utilization, in order to provide timely and appropriate enrollee education and case management (CM), as well as to identify and intervene in cases of potential fraud, waste and/or abuse. Monthly ED FS reports included enrollees with four or more cumulative ED visits since the beginning of the calendar year (excluding visits for cancer, neoplasm/blood disorders, pregnancy, perinatal, and/or congenital anomalies).

In 2021, 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 2020 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. In addition, IMCare staff worked with Itasca County Public Health, local clinics, and hospitals to get information out to enrollees through local media and social media messaging on accessing the right care at the right time during the COVID-19 pandemic. Information provided narratives on the importance of preventative care, how best to safely access primary care, availability of virtual visits, when to seek emergency care, etc. Additionally, the IMCare Compliance staff attended DHS Universal Restricted Recipient Program (URRP) meetings throughout 2021.

Of the 212 Medicaid enrollees identified through the ED FS in 2021, 23 received individualized written education regarding their ED use; none received RRP warning letters; and one was enrolled in the RRP. Of the 43 senior enrollees identified through the ED FS in 2021, 100% received case management through their assigned Care Coordinator.

Overall, ED utilization relative to enrollment increased for both Medicaid and Medicare, with a correlated increase in population identified by the senior ED FS reports. Though there were increases in ED use, RRP warning letters and RRP enrollment had no significant change. IMCare first saw an increase in overall ED utilization most likely related to the COVID-19 pandemic. Decreased utilization by enrollees for preventative and routine provider visits has left the potential for an increase in exacerbation of chronic conditions, development of new conditions, and enrollees delaying and cancelling preventative visits.

Figure 14. 2019-2021 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 2021. Global provider education via newsletter included the 2020 CS FS results and a request for CS FS intervention suggestions. 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.

The CVS/Caremark Safety and Monitoring Solutions (SMS) and Enhanced Safety and Monitoring Solution (ESMS) programs were administered by CVS/Caremark for IMCare throughout 2021. 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 2021. When appropriate, enrollee Restricted Recipient Program (RRP) warning or placement occurred.

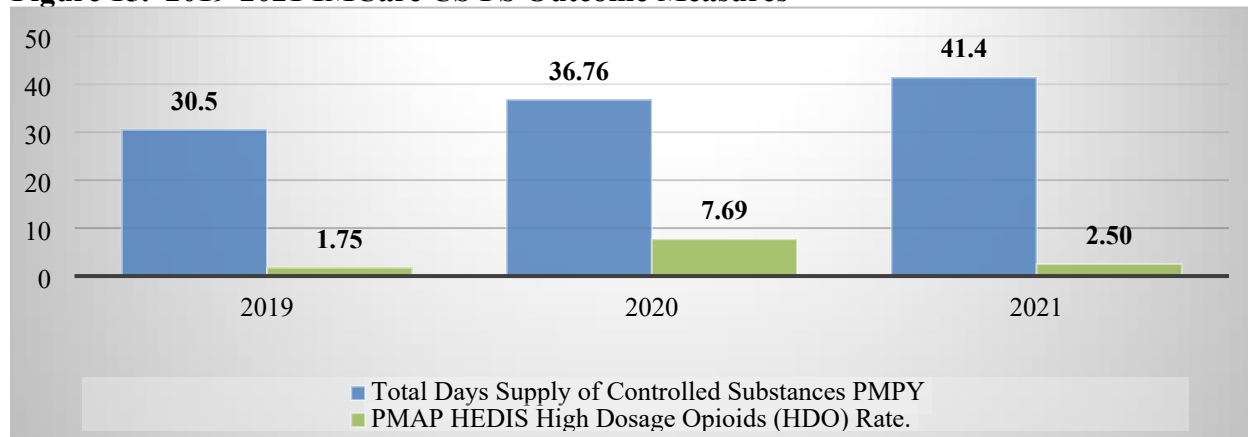
CVS Health SMS program interventions increased in 2021 compared to 2020 except for provider responses. Though provider responses are noted to have declined, outcome measures for SMS

cases closed did increase from previous years. The enrollees identified through the CS FS had no significant change from 2020.

Although the number of enrollees receiving methadone treatment for opioid use disorder has shown minimal change from 2019 to 2021, the number of enrollees utilizing buprenorphine drugs has significantly increased each year, from 71 enrollees in 2019 to 101 enrollees in 2021. While IMCare does not have an in-network methadone medication assisted treatment (MAT) provider, network providers began offering buprenorphine MAT in 2017, which likely accounts for the continued increase in this treatment option over the past three years.

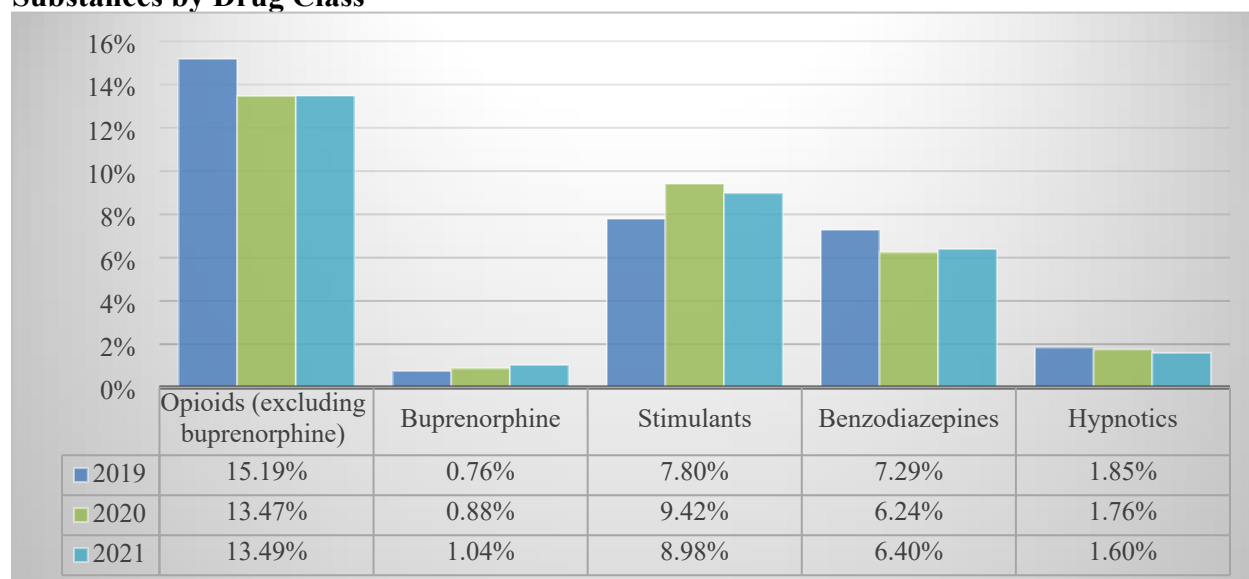
The total days-supply (TDS) of all controlled substances dispensed per Medicaid enrollee increased through the past three years. This is most likely related to an increase in stimulant prescribing with Amphetamine-Dextroamphetamine increasing from a TDS of 91,654 in 2019 to 195,186 in 2021. A positive trend is seen within these measures as the HEDIS measure for high dosage opioids (HDO) has decreased from 2020 to 2021.

Figure 15. 2019-2021 IMCare CS FS Outcome Measures



IMCare noted a decrease in the IMCare percentage of controlled substance use for opioids, stimulants, and hypnotics. An increase in benzodiazepine use is noted and may be related to increased mental health conditions through the public health emergency. An increase in the buprenorphine use is noted, which is a positive trend as it indicates an improvement in substance use disorder treatment being offered.

Figure 16. 2019-2021 Percent of the total IMCare Population Utilizing Controlled Substances by Drug Class



A Healthy Pregnancy Prenatal Initiative Focus Study (FS)

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 nurse and have a postpartum visit with their doctor within the prescribed 7-84 days postpartum timeframe.

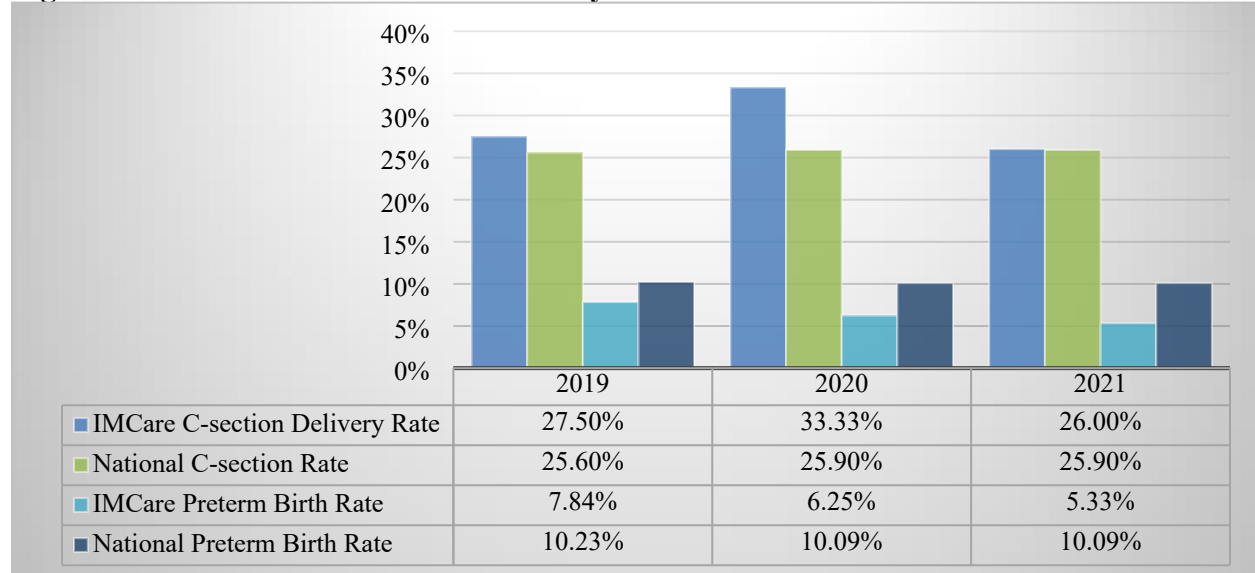
IMCare utilizes the prenatal focus study to identify potentially pregnant enrollees with a goal to provide early interventions and education in order to improve pregnancy outcomes. Monthly an IMCare data project coordinator evaluates medical claim diagnoses and identifies enrollees with a diagnosis consistent with a current pregnancy and/or delivery. Enrollees that trigger on this report for a potentially new pregnancy are compiled into a cumulative master list, and previous participation in A Healthy Pregnancy program is noted. IMCare utilizes this list to send out congratulatory letters to enrollees as appropriate. IMCare specifies one Managed Care Nurse (MCN) to conduct the prenatal focus studies. The MCN is responsible for providing outreach to enrollees for confirmation of pregnancy, assisting the enrollee in reporting their pregnancy to their financial worker, providing education for A Healthy Pregnancy program, and referring enrollees who wish to participate in the program to MCH.

The majority of the measures are noted to have had improved trends through the year. IMCare additionally compared for quality measures and identified 47 enrollees who had paid claims for delivery but had no record of receiving a congratulatory letter sent for their pregnancy. Of the 46 enrollees, 17 had been identified through the monthly focus study and phone contact was attempted by the nurse. The missed mailings may be due to a variety of contributing factors including: IMCare enrollment start date being late in pregnancy, lack of prenatal care during pregnancy, and/or delay of prenatal appointment billing. IMCare's process relies heavily on discovering new and unreported pregnancies through billing of obstetric ICD-10 diagnoses on claims. A significant delay may be present from the date of service, date of claim billing, and date of IMCare monthly data pull. Additionally, IMCare also has a local service for Native Americans to receive prenatal care that is not billed directly to IMCare, it is provided through Indian Health Services (IHS). These enrollees often deliver at network hospitals; however, as the prenatal clinic visits would not be submitted for IMCare payment this presents a barrier to offering education and screening for early intervention. In these cases, IMCare relies on the enrollee to contact their financial worker and report their pregnancy.

Of the enrollees who received a congratulatory letter it is noted that there was one duplicate enrollee that had received two congratulatory letters related to duplicate PMIs.

With the addition of an IMCare Managed Care Nurse providing active outreach to enrollees a significant increase is noted to enrollees participating in public health pre and/or postnatal visits as well as public health nurse visits and provider visits. A positive reduction is seen in both C-section delivery rate and preterm birth rate, however IMCare continued to exceed the 2020 national average rate for C-section delivery rate and did not meet this goal. Contributing factors for C-section rates may include an increase in planned inductions at network facilities to allow for COVID-19 testing prior to admission if the inductions were unsuccessful this may have contributed to the C-section rate. In contrast the continued reduction of pre-term births has decreased for the third year, this may be correlated with the continued COVID-19 pandemic, which has created a workplace shift to allow more work from home abilities. This is thought to allow pregnant enrollees more time to rest and access pregnancy resources both in-person and virtually.

Figure 17. 2019-2021 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 CCM for screening and participation. In 2021, 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 CCM program for screening or have care coordination contact log present
- use of home care services
- total claims exceeding \$100,000

IMCare has also historically utilized prior authorizations to assist in identifying enrollees with complex and special healthcare needs. IMCare annual Medicaid authorizations were included as a new measure to monitor the opportunities and changing population needs.

In 2021, IMCare noted no change or an overall increase of the majority of the measures. Several factors may be influencing this increase including the COVID-19 federal public health emergency, which does not allow for changes in coverage that may negatively affect an enrollee. Due to this IMCare has an increased membership compared to previous years which may add to all the above numbers.

There is a significant increase in authorizations for each authorization type, this may be affected somewhat by increased membership, enrollees moving out of the IMCare network area and seeking out of network care. Mental health and substance use disorder (SUD) measures have increased significantly, this suggests that enrollees are not utilizing preventative services and checkups and instead when they are presenting for care, they are in a more critical condition.

Enrollees with increased and repeated ED visits also increased, and enrollees filling a high level of controlled substances decreased. This may further support the possibility that the COVID-19 pandemic has discouraged the population from seeking out provider care, has impacted urgent care needs significantly and had an inverse relationship on the ability to obtain controlled substances.

There was a significant decrease from 2019 to 2020 for enrollees identified by (CCM) program. Previously enrollees enrolled in the Disease Management program were included in this measure, however the program was discontinued in 2019. The program was replaced by Population Health Managements' CCM program, which was implemented on 01/01/2020 and focuses on a preventative healthcare model. The implementation of this new program and process improvements through 2020 all contribute to the low number of enrollees referred for CCM.

Medical and pharmacy claims have all increased through the three-year lookback. Trends of conditions that trigger for exceeding the \$100,000 threshold for medical claims remain consistent. Trends for conditions that trigger for exceeding the \$50,000 threshold have noted a significant increase in medications used to treat psoriasis, from 4 high dollar claims in 2019, to 10 high dollar claims in 2020, to 17 claims in 2021. This may be related to new evidence-based practices for this condition which include more extensive prescribing of injectable treatment methods over oral and topical medication.

Figure 18. 2019-2021 Number of Medicaid Enrollees with the Specified Special Health Care Needs

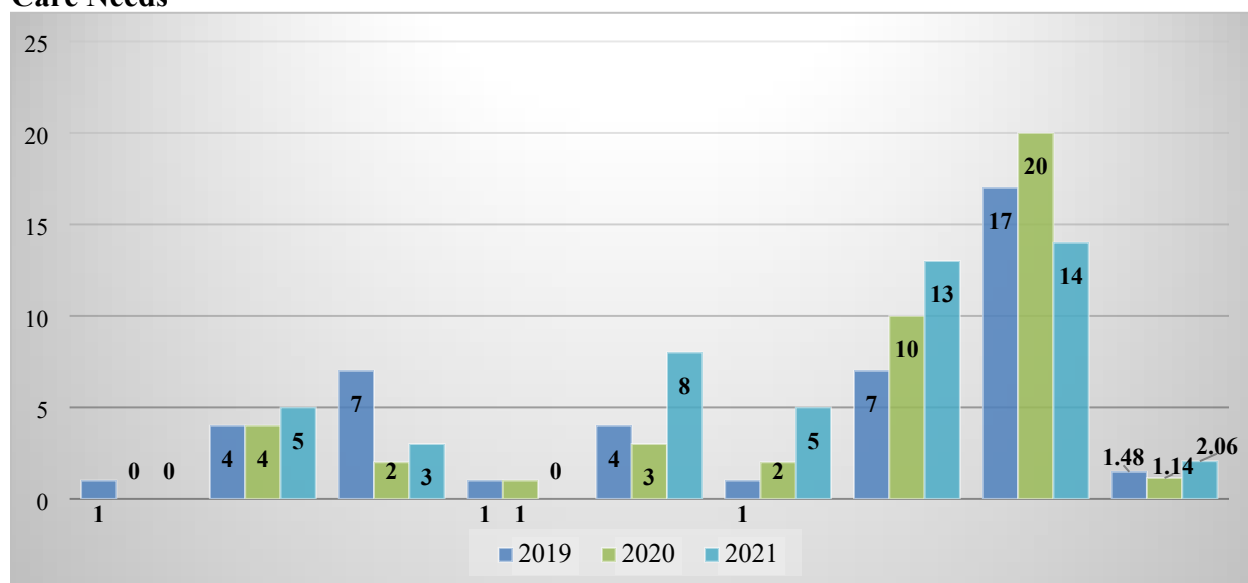
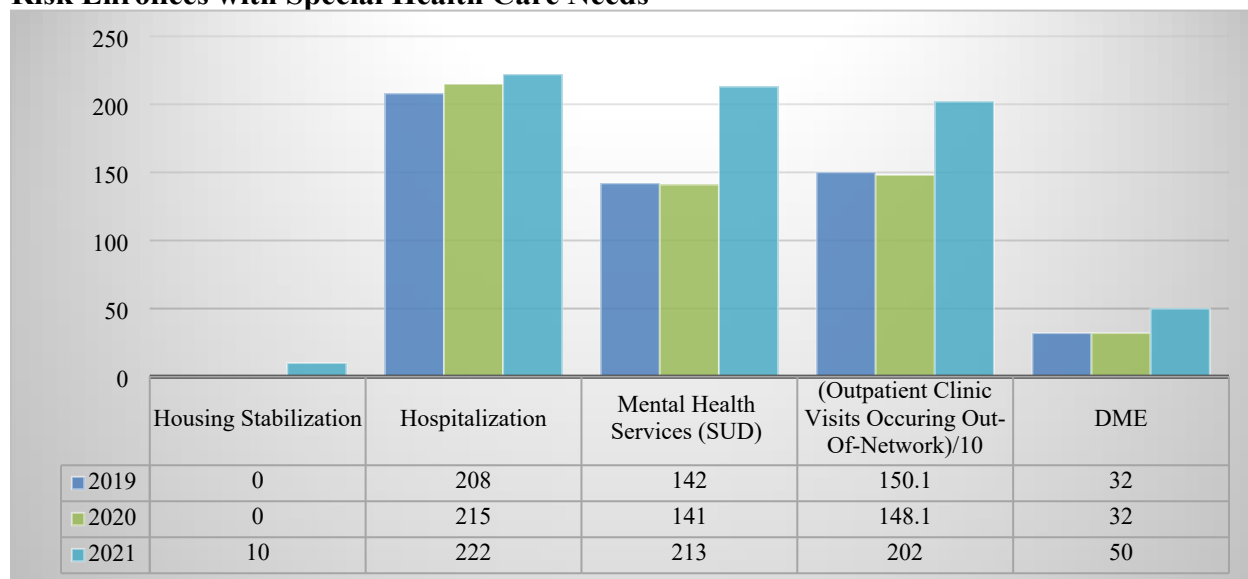


Figure 19. 2019-2021 Number of Medicaid Authorization Reviews for Potentially High-Risk Enrollees with Special Health Care Needs



Seniors (MSHO and MSC+) Special Health Care Needs

IMCare assesses the quality and timeliness of care coordination provided to seniors through the annual audit of care coordination record documentation.

A Social Worker (SW) or a Public Health Certified Registered Nurse (PHN) conducts all activities of care coordination for IMCare seniors. For an initial request, the MNChoices Assessment (MNChoices) or Long-Term Care Consultation Services Assessment (LTCC) is completed for the Elderly Waiver (EW) population. Following 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.

Itasca County Public Health (PH) provides care coordination 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 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 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 enrollees are coordinator 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 assists them.

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 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 care giver resources and involvement, evaluation of cultural and linguistic needs, preferences or limitations, as well as the evaluation of available benefits and community resources.

IMCare also works with Enrollees during a transition. The transition process utilizes the Eric A. Coleman conceptual model, “Four Pillars,” 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 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 assists them.

The results of the 2021 care coordination record documentation audit of 2020 data, in addition to the analysis of the results and planned interventions, were reported in the 2021 Care Coordination Delegation Report.

An Enrollee's access to a broad array of medical specialists is limited in the IMCare network service area. This is due to the lack of specialty providers located within Itasca County with whom a contract has been established. Because IMCare recognizes this barrier, a referral/prior authorization is not required for MSHO/MS+ Enrollees to see specialists, either in or out of network.

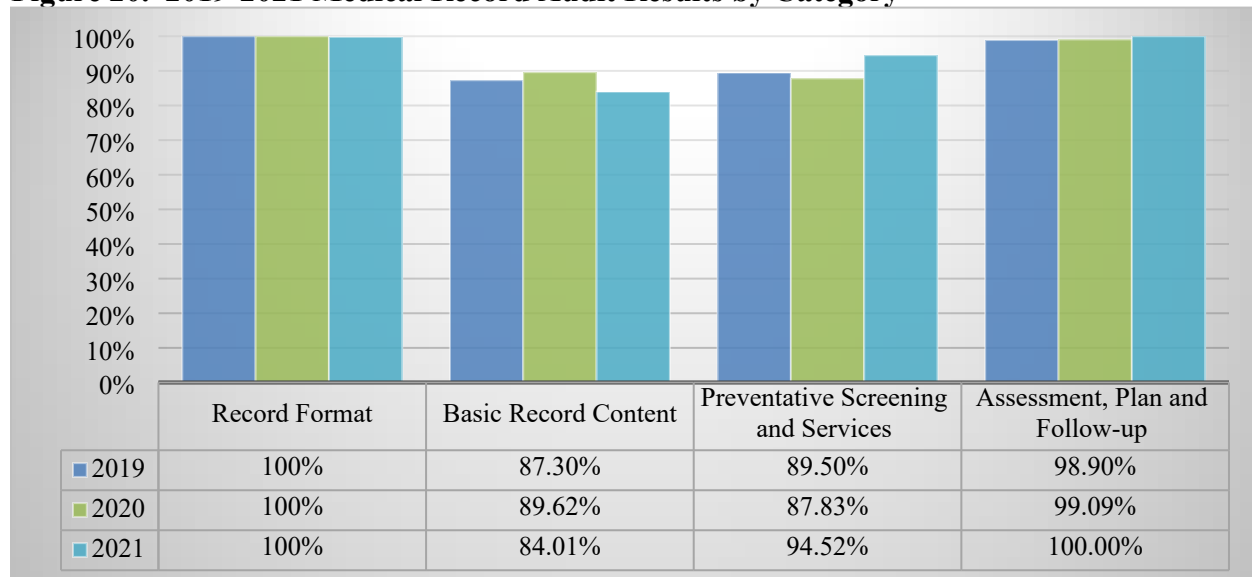
Record Audits

Medical Record (MR) Audit

Itasca Medical Care (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's medical record documentation standards.

In 2021, IMCare audited a total of 181 medical records from eight separate in-network facilities. Overall, 95.74% of measures were met for the medical record audit which is above the goal of 80% and an improvement from the previous overall score of 87.30%. There were no medical facilities that scored below 80% on the MR audit which would have triggered a mandatory corrective action plan, however, improvements on individual deficiencies were recommended in the post audit results letters.

Figure 20. 2019-2021 Medical Record Audit Results by Category



IMCare's procedure for the MR review was changed in 2019 and reflected an initial review of eight records for all measures, and subsequent review of the remainder of the clinical records for any missed measures only. After review of the results from the 2019 audit IMCare opted to resume methodology from years prior to 2019 for review of 2020 records to establish more consistent denominators for year-to-year comparisons. This methodology used reflected an

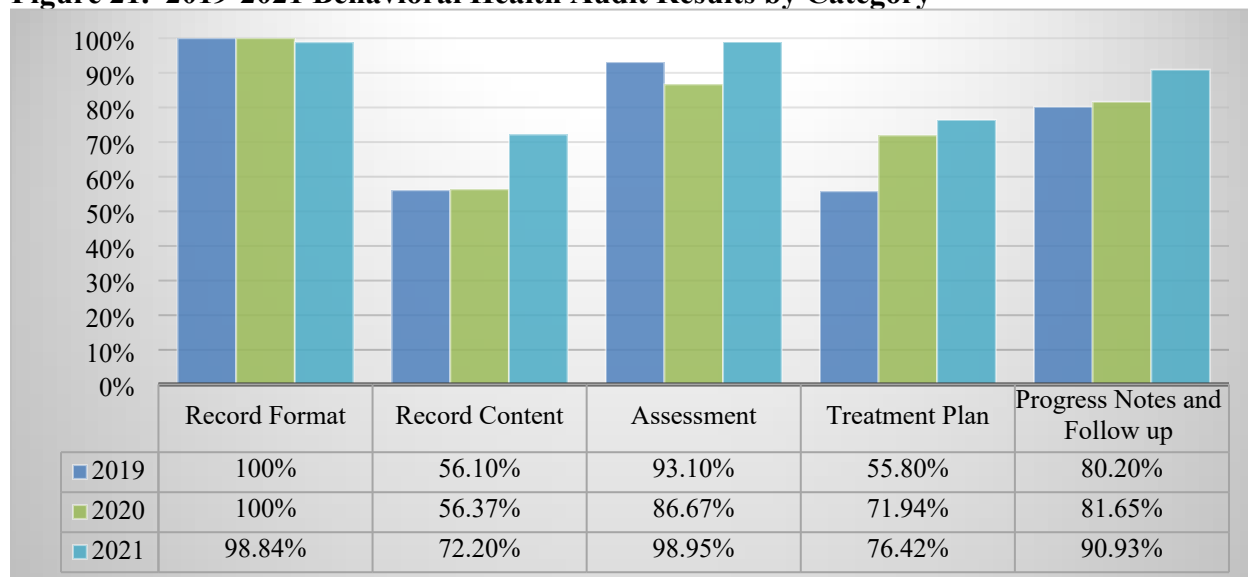
initial review of eight records for all measures, if any measures were not met the remainder of the clinical records would be reviewed for all measures.

Behavioral Health Treatment Record Audit

Itasca Medical Care (IMCare) conducts annual behavioral health (BH) treatment record audits, to determine whether providers are documenting important elements of BH treatment, as defined by regulatory requirements, National Committee for Quality Assurance (NCQA) standards, and IMCare BH treatment record documentation standards.

In 2021, IMCare audited a total of 207 BH records at 15 BH clinics, with an overall average of 91.35%, above the 80% goal. A majority of record categories met the 80% goal, and the two that did not meet goal demonstrated an increase from the previous audit. Record Format indicated 98.84% compliance, Record Content 72.2%, Assessment 93.95%, Treatment Plan 76.42%, Progress Note and Follow Up 90.93%. The Record Content and Treatment Plan section were below the 80% goal but demonstrated year-to-year improvement.

Figure 21. 2019-2021 Behavioral Health Audit Results by Category



All facilities demonstrated improvement for measures that were previously below goal including:

- “Type of diagnostic assessment is documented”
- “A health history and family health history are documented”
- “Enrollee strengths and resources are documented”
- “Informed consent for individual treatment plan documented; treatment plan is developed, reviewed, and revised with client and provider participation”
- “Encounter notes include information about the time frame of follow-up care, and any unresolved problems are addressed in the note of the follow-up visit”

IMCare changed the criteria for review of records this year to align with the Medical Record Review process. Previously five initial random records were reviewed per clinic for all measures, if any measures were not met only those measures were reviewed for the remainder of

the records. The methodology was updated to review all records if any measures were not met with the initial five records reviewed. This methodology was changed from previous reviews to allow for a more consistent denominator when reviewing results.

Providers that were audited in 2020 for measurement year 2019 received results from that year's audit between September to December and as such, results of the 2021 audit may not include the entire impact from process improvements these facilities may have implemented.

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. Effective 01/01/2022, IMCare makes the final decision whether to approve or deny a practitioner's initial credentialing application within 45 calendar days of the receipt of the application. Previously the requirement was to approve or deny applications within 180 calendar days of the date of the signature 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 2021, IMCare individual practitioner credentialing interventions included:

- All 2020 annual credentialing reports were reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC), which serves as the IMCare Credentialing Committee, on 02/10/2021.
- 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 2021 NCQA *Standards and Guidelines for the Accreditation of Health Plans* and reviewed/approved by the PAC on 05/12/2021.
- 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 2021, IMCare credentialed/recredentialed a total of 105 individual practitioners, decreased from 135 practitioners in 2020. All credentialing/recredentialing applications were processed within the required timeframes for completion. All 23 of the practitioner terminations in 2021 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 321 practitioners in 2021. All audited individual practitioner office site visit audits exceeded the 80% goal in 2021. In addition, all credentialing/recredentialing file audit measures met the 100% goal in 2021.

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. Effective 01/01/2022, IMCare makes the final decision whether to approve or deny an organizational provider's initial credentialing application within 45 calendar days of the receipt of the application. IMCare recredentials organizational providers at least every 36 months.

In 2021, IMCare organizational provider credentialing interventions included:

- The *2020 Organizational Provider Credentialing Report* and the *2020 Site Visit Audit Report* were reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/10/2021.
- Quarterly credentialing reports, including organizational provider credentialing/recredentialing information, were reviewed/approved by the PAC throughout 2021.
- IMCare credentialing policies and procedures were updated to meet the 2021 NCQA *Standards and Guidelines for the Accreditation of Health Plans* and reviewed/approved by the PAC on 05/12/2021.
- 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.

One organizational provider initial credentialing application was submitted to IMCare in 2021. Three organizational providers recredentialed in 2021. organizational provider initial credentialing application was submitted to IMCare in 2021. This organizational provider met all required elements.

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 additional 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 2021, 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 2021 and Fall/Winter 2021 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 record audits. The most recent audit showed a compliance rate of 41.14%, which is an increase of 3.23% 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

IMCare ensures enrollee access to primary care providers, specialty care providers, behavioral healthcare providers, and ancillary chiropractic, dental and optometry providers by identifying gaps in network adequacy through data analysis, as required by the National Committee for Quality Assurance (NCQA) and IMCare contracts with the Minnesota Department of Human Services (DHS).

2020-2021 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 2020 Provider Availability and Network Adequacy Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 08/11/2021 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 09/15/2021.
- The 2020 Practitioner/Facility Grievance Report was reviewed/approved by the PAC on 02/17/2021 and the External QI/UM Committee on 03/17/2021.
- The 2020 Individual Practitioner Credentialing Report was reviewed/approved by the PAC on 02/17/2021 and the External QI/UM Committee on 03/17/2021.
- The 2020 Organizational Provider Credentialing Report was reviewed/approved by the PAC on 02/17/2021 and the External QI/UM Committee on 03/17/2021.
- An article regarding IMCare Accessibility Standards was included in the Fall 2020 Provider Newsletter.

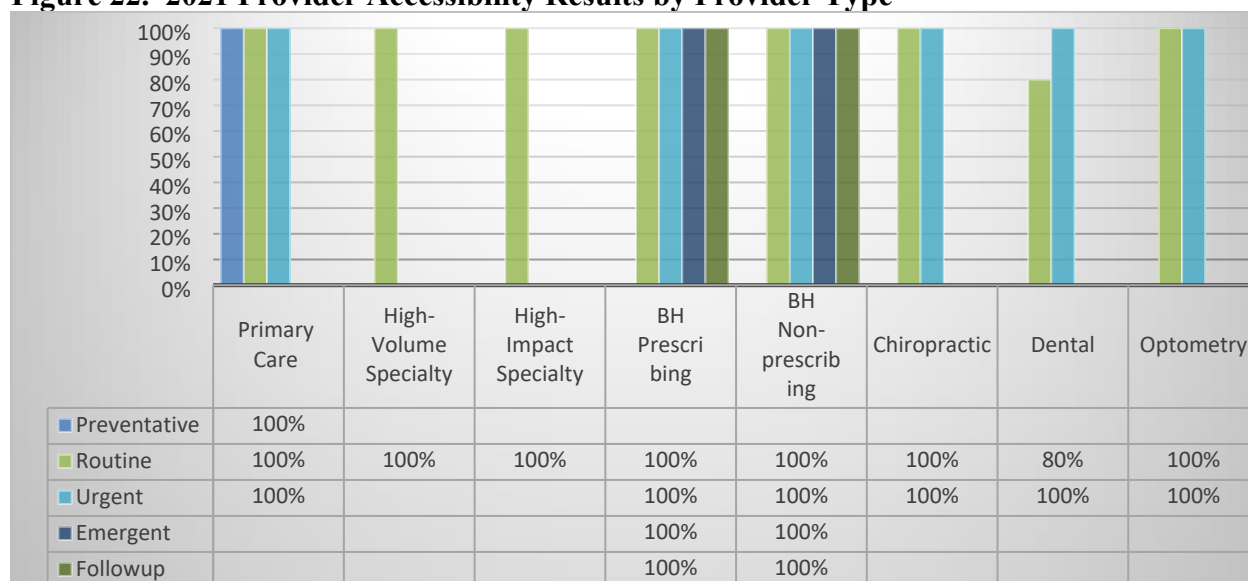
During the study period, IMCare met goal for all accessibility measurements and provider types outside of routine dental care. IMCare works closely with the dental provider pool to ensure that enrollees have access to quality dental care and can receive needed care within a timely manner.

IMCare assists all enrollees who contact IMCare with dental needs to find a provider who can see them as timely as their needs require. Overall, IMCare maintained an adequate care network as it relates to provider accessibility. In addition to the provider accessibility measurements included in this 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. 2021 Provider Accessibility Results by Provider Type



Practitioner Availability and Network Adequacy

IMCare ensures the availability of providers and services by identifying gaps in network adequacy through data analysis, as required by the National Committee for Quality Assurance (NCQA) and IMCare contracts with the Minnesota Department of Human Services (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 6.12.11, and Medicare & Medicaid Services (CMS) contracts.

2020-2021 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 2020 Provider Availability and Network Adequacy Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 08/11/2021 and the External Quality Improvement/Utilization Management (QI/UM) Committee on 09/15/2021.
- The 2020 Practitioner/Facility Grievance Report was reviewed/approved by the PAC on 02/17/2021 and the External QI/UM Committee on 03/17/2021.
- An article regarding IMCare Accessibility Standards was included in the Fall 2021 Provider Newsletter.

During the study period, IMCare met goal for primary care providers and all specialty care availability measures. There were ten 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.

Regarding behavioral health, IMCare met goal for all geographic availability measures and nearly all enrollee ratios. 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. An additional psychiatrist joined the IMCare network during the reporting period; however, due to the increase in enrollment, this did not significantly impact the provider to enrollee ratio. 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. Additionally, throughout the study period there were waivers due to COVID-19 pandemic that allowed enrollees to receive mental health services via telehealth in their home rather than traveling to a provider location. 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 ten 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 2020-2021 measurement period, enrollee 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 three denials based on the out-of-network status of the provider, when a network option was available. None were appealed timely.

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. 2021 CAHPS Survey Completion Rate

	Eligible Sample Size	# of Enrollees who Completed the Survey	Survey Completion Rate
PMAP	1,350	276	20.64%
MNCare	1,350*	447*	33.58%*
MSC+	1,224*	623*	52.03%*

* Combined Sample

IMCare was not able to participate in the 2021 Medicare CAPHS survey, extracted by a separate vendor than the Medicaid populations, therefore data is not available for analysis. DHS used the Health Survey Advisory Group (HSAG) vendor again in 2021 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 8.5% of responses for MNCare and 14.6% of responses for MSC+.

In 2021 IMCare met 15 out of 24 measures, which is an overall improvement from the previous year. IMCare improved measures in 2021 to meet goals for:

- How well doctors communicate in the PMAP and MSC+ populations
- Getting needed care in the MNCare and MSC+ populations
- Health plan customer service in the MNCare and MSC+ populations
- Getting care quickly in the MSC+ population
- Rating of healthcare received in the MSC+ population

IMCare had one measure, getting care quickly for the PMAP that was met in 2020 however declined in 2021 and was below the yearly goal. IMCare continues to not meet criteria for the measures rating of doctor/nurse across the PMAP, MNCare, and MSC+ populations, rating of specialist in the PMAP population, Rating of health care received in the PMAP population, and rating of health plan in the PMAP and MNCare population.

Measures associated with provider care have remained above goal from the 2020 to 2021 within the MSC+ population and overall are noted to have scored below goal for only the PMAP population with measures for getting needed care and getting care quickly. 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. IMCare did not meet goal in the PMAP population for measures rating of specialist, rating of health care received, and rating of health plan, however, these measures have shown a year-to-year improvement since 2019. IMCare notes a similar improvement with these measures in the MSC+ population since 2020. These measures are inconsistent within the MNCare population with a noticed decrease in the 2020 sample and an increase in the 2021 sample across all measures. Network facilities have increased the availability of specialist access through local clinics, primary care providers have expanded their telehealth care to better serve the population during the COVID-19 pandemic, and the continued hiring of new providers at many IMCare network facilities, allowing for more appointment availability.

IMCare noted an increase for all populations in the measure rating of health plan from 2020. Health plan customer services also met goals throughout all plans and showed a three-year increase for MNCare and MSC+ plans. IMCare has increased success in retention of customer service staff through 2020 and 2021, creating a better, more efficient experience for IMCare enrollees. Health plan customer services noted a new decrease, previous years were noted to be increasing this value. This may be attributed to temporary internal restructuring due to the COVID-19 pandemic, IMCare transitioned staff to primarily work from home through 2020 in accordance with the Stay Safe Minnesota rules. Some staff remained working in the office due to business, however staffing levels in the office was reduced significantly. Through this IMCare monitored the customer service timely response to enrollees and providers and adjusted in-office staffing levels based on need.

For all collective products IMCare saw a decrease in only one measure, how well doctors communicate. Though IMCare is not directly able to implement process improvements for this measure providers are made aware of the CAHPS results via the biannual provider newsletter and specific measures are called to attention when decreases and yearly downward trends are noted. IMCare also provides resources on the PHM section of the IMCare website including a free shared decision-making aid, and other educational resources designed to highlight prevalent

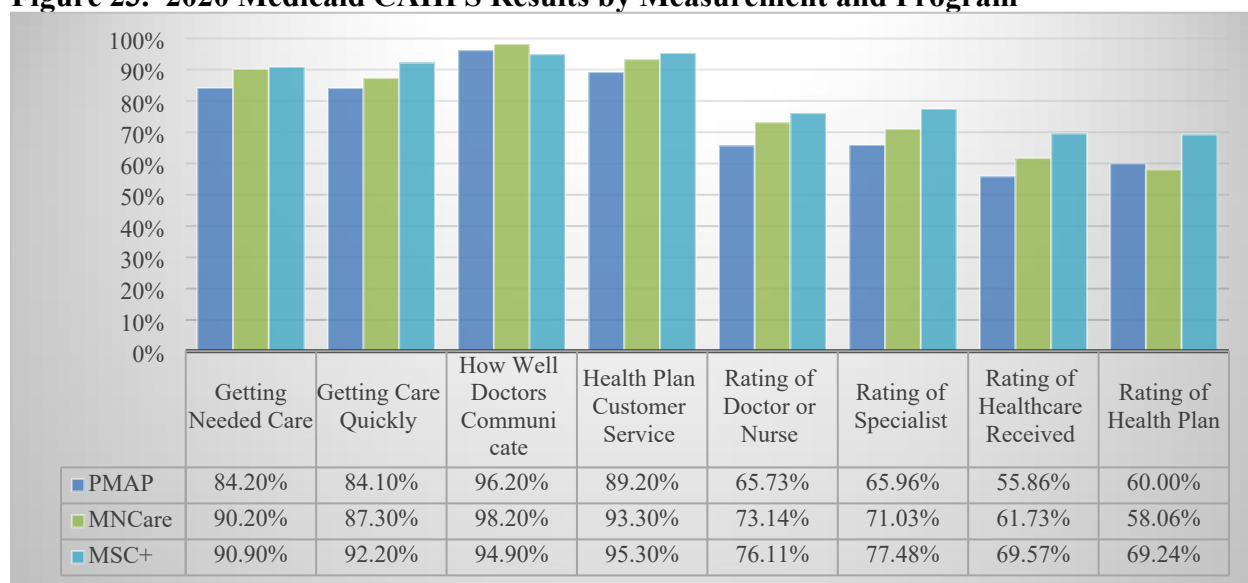
chronic conditions within the IMCare population, and provide evidence based educational content to support these conditions and provider instructions.

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.

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.

Additionally, sampling may have had an unknown effect for the MNCare and MSC+ populations as the results reflect a combined total. MNCare results include enrollees with PrimeWest Health, Hennepin Health and South Country Health Alliance, and MSC+ results include PrimeWest Health and South Country Health Alliance. These populations may have little impact and analysis as interventions and quality improvements are most often implemented on a health plan basis not based on product.

Figure 23. 2020 Medicaid CAHPS Results by Measurement and Program



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 2021, IMCare mailed the Care Coordinator Satisfaction Survey to 698 MSHO and MSC+ enrollees. Two hundred-three responses were received, 62 from Elderly Waiver (EW)

enrollees, 123 from Community Well (CW) enrollees, and 18 from Skilled Nursing Facility (SNF) enrollees. The overall response rate was 29.1%, which is a decrease of 9.61% from the response rate of 38.71% in 2020.

As a county-based purchasing 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 goal in all aspects of EW care coordination and all but one aspect of CW care coordination. 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 of 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.

The 80% goal was not met for SNF enrollees in seven questions including:

- Have you talked with your care coordinator in person or on the phone
- If you reside in a skilled nursing facility, has your care coordinator attended a care conference with you
- Did your care coordinator inform you of health and wellness opportunities that may be helpful to you
- Did your care coordinator offer you choices about which services and supports are available to you
- Did your care coordinator answer questions about services and supports that are available to you
- Were you able to talk to your care coordinator about questions or concerns you have regarding your services and supports
- If you requested, did your care coordinator make changes to your services and supports

This reflects that due to COVID-19 restrictions at SNFs, it eliminated our ability to visit enrollees, and attend care conferences face-to-face for most of the reporting year. SNF enrollees are most often not able to be contacted by phone, and they often receive services above and beyond in the SNF that what is available within the community. IMCare utilizes its electronic charting platform CaseTrakker Dynamo (CTD) to house the survey; this system still does not allow for separate surveys to be created and mailed to each population. It remains evident that several questions are not applicable to many enrollees. Once again, IMCare has included 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.

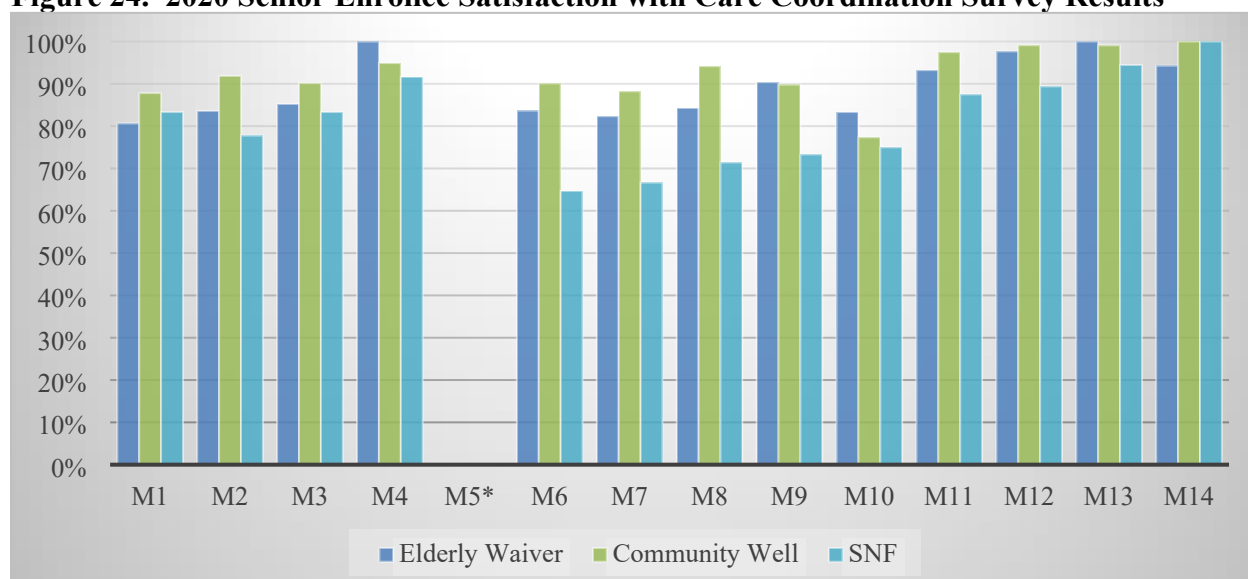
Table 2. Enrollee Satisfaction Survey Measures

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?

Table 2. Enrollee Satisfaction Survey Measures Continued

Survey Measures
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?
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



*For the Majority of 2020 SNFs limited visitors to their facilities and care coordinators were not able to attend in person. Attendance by phone conference was utilized, however it was determined that without a care coordinators physical presence this would be a skewed result and so M5 was not measured.

Enrollee Education Sessions

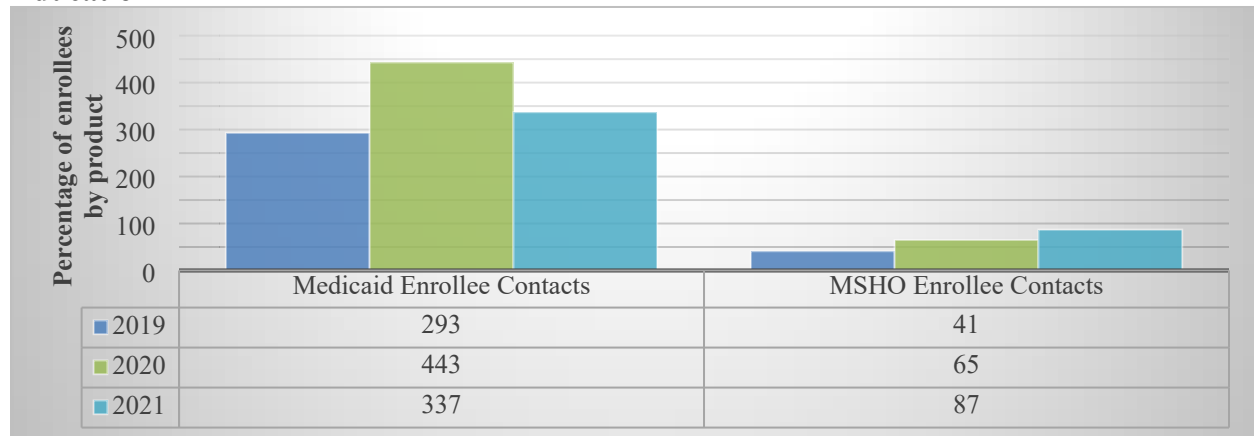
IMCare provides monthly enrollee education. The purpose of the education is for enrollees to understand how to use their IMCare medical card, review of the Enrollee Handbook and to learn how to obtain medical care.

2021 Interventions:

- 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 not held. IMCare was able to address enrollee needs via the enrollee service line and track via contact logs.

Figure 25. 2019-2021 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.

2021 Interventions:

- IMCare Director, QI/UM Director and Compliance Officer were in close contact with First Call for Help (FCFH) during 2021 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 CMS 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 1.22% of the 9252 calls handled were abandoned during 2021.

Population Health Management (PHM)

In 2020, IMCare implemented a Population Health Management program. As per the 2021 Contract for Prepaid Medical Assistance and MinnesotaCare, section 7.3, "The MCO shall create and report annually to the STATE a Population Health Management Strategy or any amendment to the original PHM strategy by July 31 of the Contract Year, including structure and processes

to maintain and improve health care quality, and measures in place to evaluate MCO's performance on its process outcomes (for example, clinical care, or Enrollee experience of care)." IMCare utilizes the most current NCQA "Standards and Guidelines for the Accreditation of Health Plans" to develop and review the PHM strategy annually. Services and supports offered through the PHM program are free and available to all IMCare enrollees.

Annually, IMCare completes a PHM Impact Analysis in which the methodology for population segmentation and stratification is described and data is reported, and a comprehensive analysis of the impact of the PHM strategy. IMCare has developed four primary areas of focus with specific goals for each within the PHM program including:

- Keeping enrollees' healthy goals:
 - increase in annual age-appropriate wellness exams for enrollees as captured in the following PMAP HEDIS measures: Well Child Visits 0-3 years of life (W15); Well Child Visits in the 3-6 years of life (W34); and Adolescent Well Care Visits (AWC)
 - increase in annual age-appropriate wellness exams for enrollees as captured in the following PMAP HEDIS measures: Breast Cancer screening (BCS); Colorectal Cancer screening (COL); Cervical Cancer screening (CCS); Chlamydia screening (CHL)
- Managing enrollees with emerging risk goals:
 - Annual reduction in patient re-admissions in target population as identified through IMCare claims review
- Patient safety or outcomes across settings goals:
 - Increase follow up after ER visits for mental illness or substance use disorder (SUD) as identified by Hedis measures: Follow up After ER Department visit for mental illness (FUM) or Follow up after ER department visit for alcohol and other drug abuse or dependence (FUA)
- Managing multiple chronic illnesses goals:
 - Annual reduction in hospital admission for chronic health conditions in target population as identified through IMCare claims review
 - Annual improvement HBA1C of 8% or lower for enrollees with diabetes by 2 percentage points as identified by HEDIS measure Comprehensive Diabetes Care (CDC)

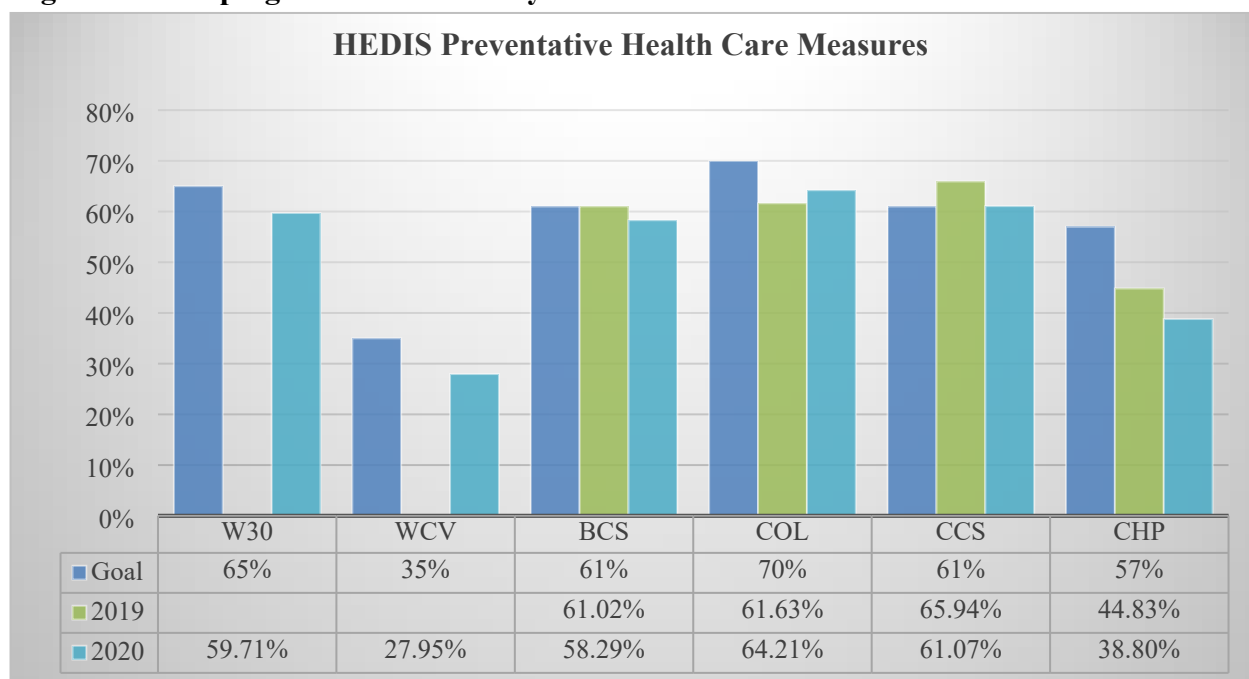
2021 Interventions:

- public health when appropriate
- Enrollee newsletter with PHM program information
- Provider newsletter with PHM program information
- Development of IMCare's PHM program resources on the IMCare website
- Staff education and development of roles in PHM and Complex Case Management programs
- Utilization of an electronic platform to house CCM program

In 2021, IMCare completed the first PHM impact analysis. IMCare saw increased enrollment from 2019 to 2020 related to the COVID-19 Pandemic and legislative changes. On March 27th, 2020, the MN executive order 20-20 directing Minnesotans to stay at home was enacted. This order urged Minnesotans to stay home unless they were deemed an essential worker and/or for

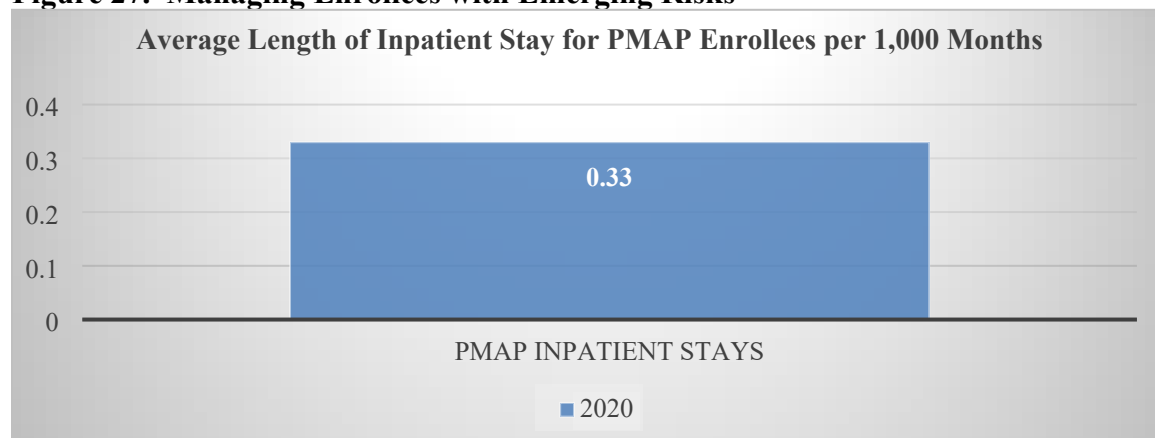
emergent services, which delayed preventative care and elective procedures for many Minnesotans. This order was lifted on May 17th, 2020, however further guidance on decontamination of public areas, utilization of personal protective equipment, and to provide service to the public at reduced capacity to prevent further spread of COVID-19 was issued. Following this three-month closure period, healthcare offices that were able to resume providing care were required to adhere to specific and extensive cleaning of patient areas between patient treatment. Related to these new requirements network providers reported the increased expectation of contact precautions required extra time be allotted between patients and the ability to schedule patients was reduced when compared to before the three-month closure. After services re-opened there may also have been some hesitancy among enrollees to seek preventative care. These changes also affected IMCare's enrollee rate as some enrollees who would have had a discontinuation of IMCare coverage remained active throughout 2020, due to the pandemic. The effects on numerators and denominators included in this report is unknown.

Figure 26. Keeping Enrollee's Healthy



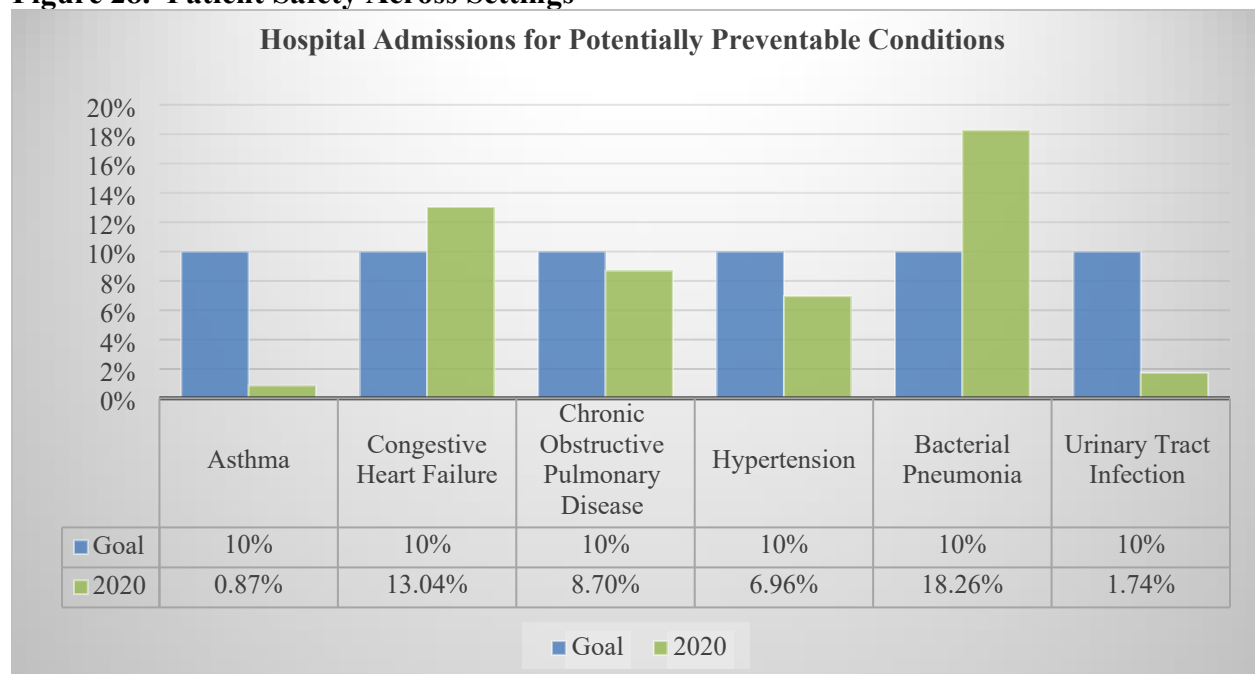
IMCare's goals for keeping enrollees healthy for age-appropriate screenings including breast cancer screening, colorectal cancer screening, cervical cancer screening, and chlamydia screening had stable or increased denominators from 2019 to 2020 HEDIS measures. Though the numerators increased from 2019 through 2020 the percentages have declined, indicating that enrollees sought out less preventative care in 2020 as compared to 2019. IMCare did not meet any of the goals that correlate with keeping enrollees healthy, except for cervical cancer screening.

Figure 27. Managing Enrollees with Emerging Risks



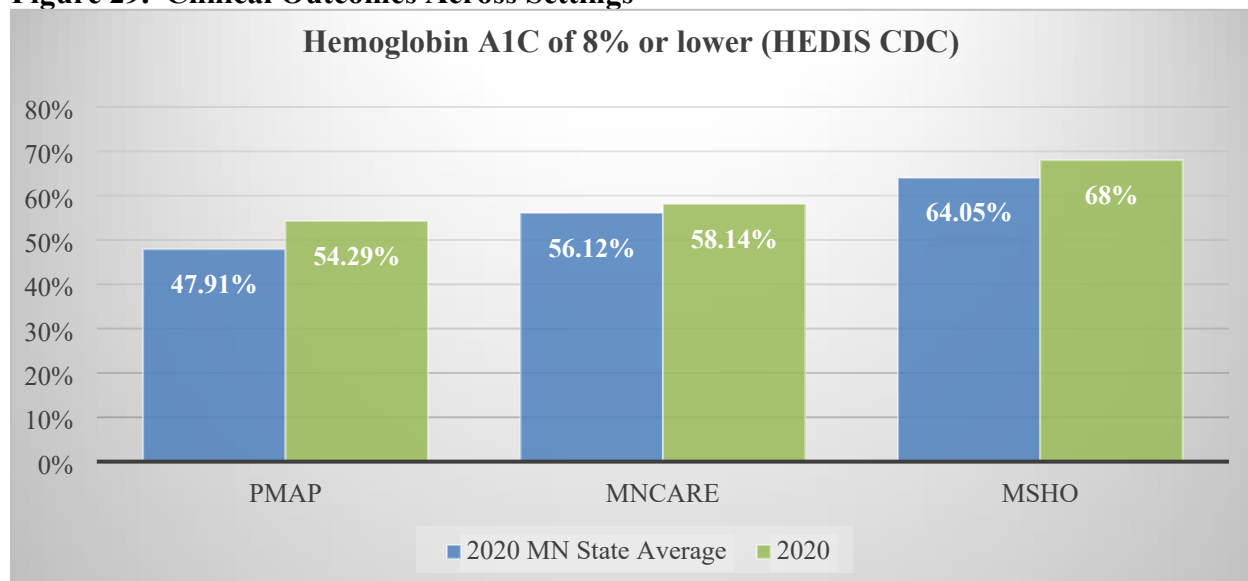
Annual reduction in in-patient length of stay is not able to be compared to historical rates and so 2020 rates will be used to review future changes within this measure.

Figure 28. Patient Safety Across Settings



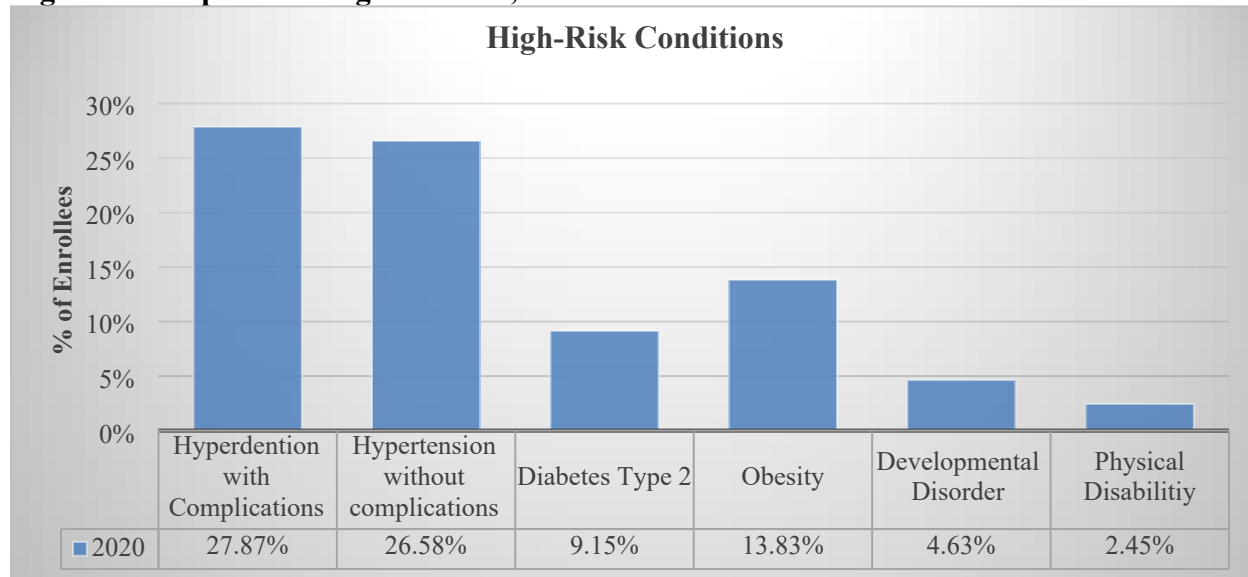
For the above conditions, 2019 rates were not available and so standards and goals were implemented based on the 2020 rate. IMCare met goals for hospitalization due to Asthma, Chronic Obstructive Pulmonary Disease, Hypertension and Urinary Tract Infection. A relationship significant to the ability to seek out preventative care and the rate of hospitalizations for acute conditions may be reflected in measures for inpatient admissions for asthma, congestive heart failure, hypertension, bacterial pneumonia, and UTI, as hospitalizations for otherwise preventable conditions may have increased in 2020 related to guidance from executive order 20-20.

Figure 29. Clinical Outcomes Across Settings



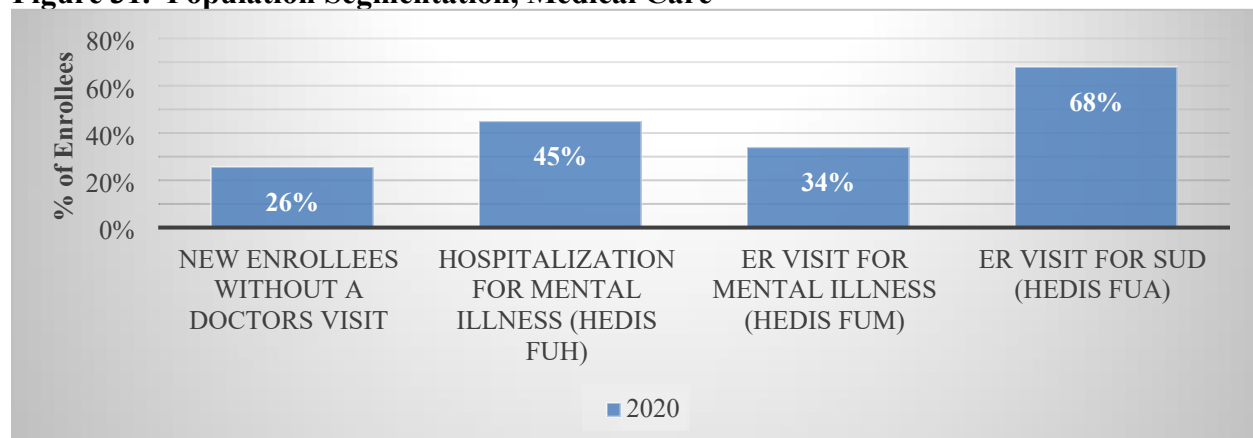
Overall, IMCare shows better diabetic control than the MN state average, IMCare has implemented targeted interventions to improve this measure through the senior care coordination program Quality Improvement Project aimed at reducing the instances of poor diabetic control for enrollees.

Figure 30. Population Segmentation, Condition Review



IMCare's population has a high rate of hypertension diagnoses across the senior population and a significant rate of hypertension with complications within this same population. IMCare additionally identified diabetes type 2 and obesity as significant conditions for the IMCare population. Of note these conditions often share a symbiotic relationship and are common co-morbidities.

Figure 31. Population Segmentation, Medical Care



IMCare saw significant rates of new enrollees reporting they had not had preventative doctor or dental visits at the start of IMCare coverage, placing new enrollees at high risk for unknown and acute health conditions at the start of IMCare coverage. These values are considered for informational purposes to guide IMCare's PHM focus and interventions.

Complex Case Management

Within the PHM program IMCare has established a Complex Case Management (CCM) program that provides enhanced services to enrollees with identified complex healthcare needs based upon their chronic condition, potential disability, health care activity or any other identified need for case management. The CCM program is an included benefit to the enrollee and is focused on enrollees younger than 65. 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.

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 based on individual criteria for the project from daily to quarterly, and referrals sources are reviewed as received.

Internal processes to identify enrollees who may benefit from CCM services include:

- Initial Enrollee Screenings reviewed as they are received
- Health Appraisals reviewed as they are received
- Medical management program, including utilization management
- Inpatient readmissions reviewed quarterly.
- Controlled Substance Focus Studies reviewed monthly
- Emergency Department Focus Studies reviewed monthly
- Stoploss report reviewed monthly
- SMRT report reviewed monthly

- High-cost claims reviewed as referred by financial
- Daily admission notifications reviewed on business days as available

Referral identification sources include:

- Medical management programs through other organizations
- Discharge planner referrals, this includes both inpatient and emergency department discharges
- Enrollee or caregiver referrals
- Practitioner, provider, or other delegated healthcare representative

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 Managed Care Nurse (MCN) will contact the enrollee to complete screening, offer case management services, complete an initial assessment, and develop a plan of care as indicated. 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 assist with access to needed services. 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:

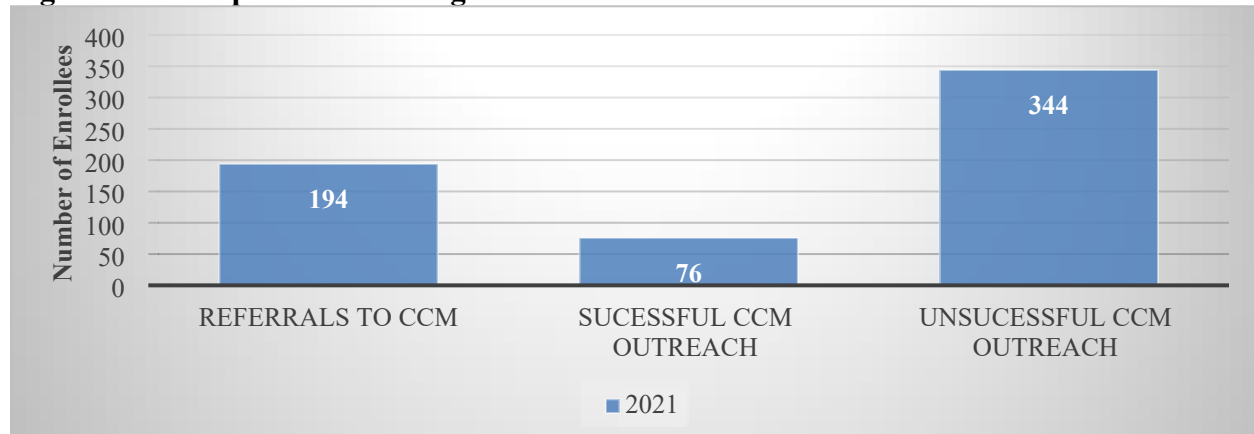
- CCM initial screening to identify need and enrollee willing to participate in CCM services
- Comprehensive initial assessment and/or reassessment of enrollee's health
- Development of an individualized care plan with Specific, Measurable, Achievable, Realistic and Timely (SMART) goals
- Facilitation of enrollee's referrals to resources
- Follow-up and communication with enrollees
- Self-management plans
- Assessment of progress against case management plans for enrollees

MCNs 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 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 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

Figure 32. Complex Case Management for PMAP and MNCare



Care Coordination

Care coordination is required for MSHO enrollees, however IMCare provides these services for all enrollees 65 years of age and older, including MSC+ 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 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 for MSHO enrollees 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 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
- 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

Care Coordination 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 case management for community non-EW MSC+ enrollees, community EW MSC+ enrollees, and MSC+ nursing facility residents.

Care Coordination 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

Care Coordination for community EW MSC+ enrollees includes:

- Risk screening and assessment that addresses medical, social, environmental, and mental health factors

- Care Coordination requirements of the Home and Community Based Services (HCBS) waiver
- Assignment of a Care Coordinator 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 care coordination 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 Care Coordinators
- 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 Care Coordinator who has lead responsibility for creating and implementing the care plan
- Evaluation of the performance of individual Care Coordinators including enrollee input

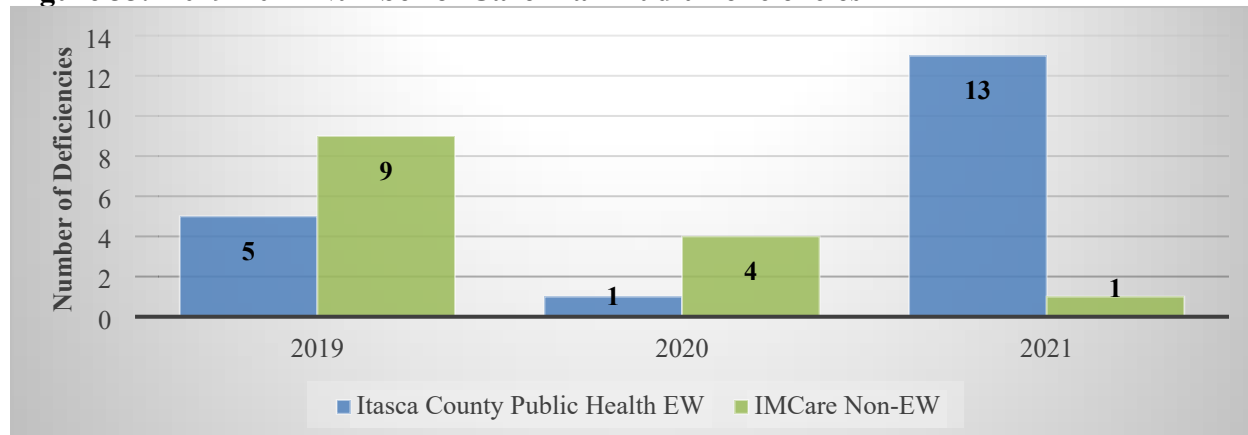
Care Coordination for MSC+ nursing facility residents includes:

- 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

Annually, IMCare completes a care plan audit for both internal care coordinators and Itasca County Public Health Care Coordinators, to ensure quality standards are met and opportunities for improvement are identified. Based on care plan audit results corrective action plans may be issued 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 initial 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. This follows the NCQA 8/30 sampling methodology. 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 2021, Itasca County Public Health EW care plans were deficient in 13 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.

Figure 33. 2019-2021 Number of Care Plan Audit Deficiencies



Corrective Action Plans (CAP) were issued in 2021 for both Itasca County Public Health (ICPH) and IMCare internal audits. Due to the large increase in ICPH deficiencies, from four in 2020 to 13 in 2021, a follow-up audit was scheduled to monitor for improvement post implementation of CAP improvements. For this follow up audit, only deficient measures were reviewed in the care plans in which assessments were conducted after the CAP interventions were implemented, though only four out of the 13 missed measures met the over 95% compliance goal, all measures showed a significant increase in compliance following the implementation of the CAP improvements and further follow up auditing was not determined to be necessary. The decline in ICPH performance was more than likely due to the ongoing pandemic and many staff being pulled from their regular duties to assist with contract tracing and vaccinations.

2021 MSHO/MS C+ Transitions Report

In accordance with the Minnesota Department of Human Services (DHS) Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus Services (MSC+) contract and Itasca Medical Care (IMCare) Model of Care (MOC), Care Transition Protocols are implemented to ensure continuity of care for their 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), case management software. 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 2021, data for transitions conducted in 2020 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.

Interventions in 2020 included:

- 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 hospitals and facility discharge planners/social workers.

Adoption of Practice Guidelines

The adoption, dissemination and application of clinical practice guidelines are required by IMCare 2021 Families and Children and Seniors contracts with the Minnesota Department of Human Services (DHS) and 42 CFR §438.236. Per Article 7.1.6 of the 2021 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 2021, 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 for Breast Cancer: Strategies and Recommendations
- Screening Tests in Children and Adolescents

- Guidelines for Adolescent Preventive Services
- Screening for Depression in Adults

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 2021, 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 made many improvements in the past year, and they are meeting the IMCare standards regarding their delegated responsibilities.

Itasca County Public Health Provider Participation Agreement

IMCare contracts with Itasca County Public Health, as their one and only delegate, to provide care coordination 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.

2021 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 2021, 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.”

2020 Interventions:

- Enrollee newsletters were sent out in spring and fall of 2020. Article topics included information about appropriate emergency room use, preventative wellness visits and screening, dental care, emergency room utilization, and mental health.
- Preventive care visit and vaccine schedules were available for public reference on the Population Health Management (PHM) enrollee information page of the IMCare website.
- Individual letters were sent out for well child reminders.
- IMCare utilized 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 HEDIS utilization measures did not meet goal for the PMAP population and saw year-to-year decline. There were greater than 5% decreases in Adults Access to Preventative/Ambulatory Health Services (AAP), Well Child Visits 0-15months (W30-fifteen) which was previously called W15, Annual Dental Visit, and Follow Up after ED Visit for Mental Illness (FUM). The decreases in preventative care are attributed to clinic policy changes, and public perception related to the COVID-19 pandemic; enrollees were less likely to seek care for non-emergent issues in 2020. There was a significant decrease in the denominator for FUM, this may again be attributed to enrollee’s hesitancy to present to the ED.

Well-Child Visits 15-30 months of life is a new HEDIS measure included in the W30 set. Similarly, Child and Adolescent Well Care Visits (WCV) replaced Adolescent Well Care, it includes a larger age span and cannot be compared to previous years rates. Both W30 and WCV were 10% or more below the MN State Average.

The IMCare Annual Dental Visit (ADV) rates had year-to-year decline, likely due to the closure of dental offices for three months per the Governor’s order. However, they 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. The percentage of enrollees 20 years and older who had an ambulatory or preventive care visit during the measurement year. (AAP)	HEDIS Data
M2. The percentage of enrollees who turned 15 months old during the measurement year and who had ≥ 6 well-child visits with a PCP during their first 15 months of life. (W30 Fifteen)	HEDIS Data
M3. The percentage of enrollees who turned 30 months old during the measurement year and who had ≥ 2 well-child visits with a PCP during 15-30 months of life. (W30 Thirty)	HEDIS Data
M4. The percentage of enrollees 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	HEDIS Data
M5. The percentage of enrollees 2-20 years of age who had at least one dental visit during the measurement year. (ADV)	HEDIS Data
M6. 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*
M7. The percentage of ED visits for enrollees 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days. (FUM)	HEDIS Data
M8. 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

*=MN average from 2020 as 2021 was not available.

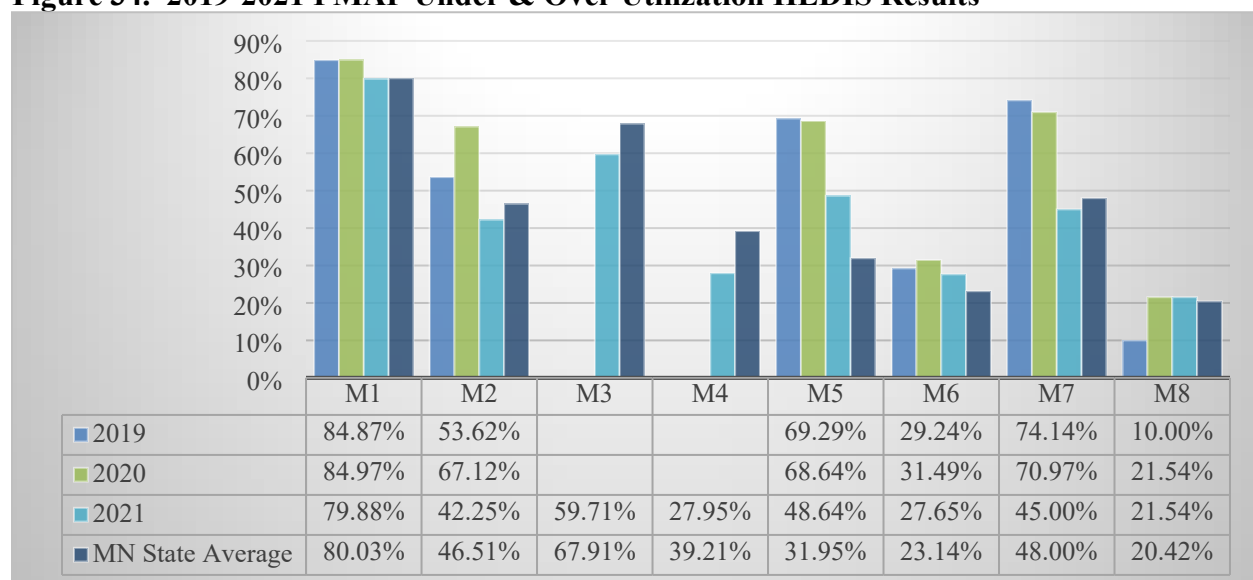
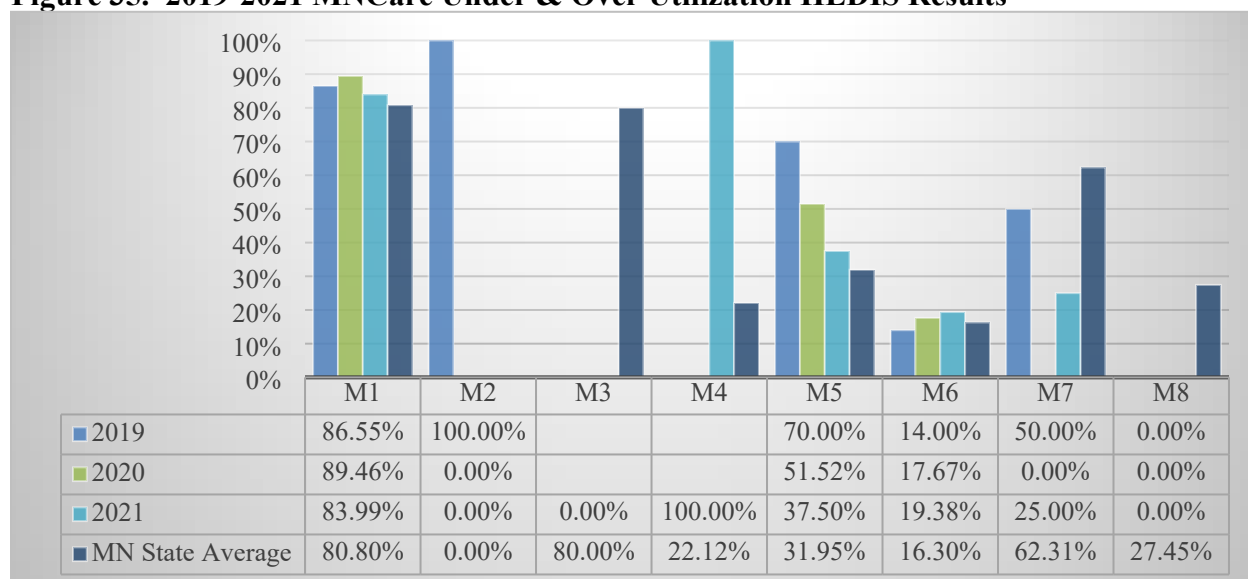
Figure 34. 2019-2021 PMAP Under & Over Utilization HEDIS Results

Figure 35. 2019-2021 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 2021 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 § 330(b)(3), this structure must include an effective mechanism and written description to detect both under- and over-utilization of services.

2020 Interventions:

- Enrollee education regarding mental health care was included in the Spring/Summer and Fall/Winter 2020 enrollee newsletters.
- 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.
- The 2019 Medicare Under and Over Utilization Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 11/04/2020 and the IMCare External QI/UM Committee on 12/16/2020.

A majority of measures met goal in 2020. All three of the unmet measures were within two percent of the MN State Average. Colorectal Cancer Screening (COL) fell just below the state average in 2021 but showed slight improvement from 2020. Transitions of Care (TRC), with four measurable components, met goal for all areas. There was a significant year-to-year increase in this component, this is attributed to the additional information allowed to count as met in the technical specifications that was obtained through clarification with NCQA.

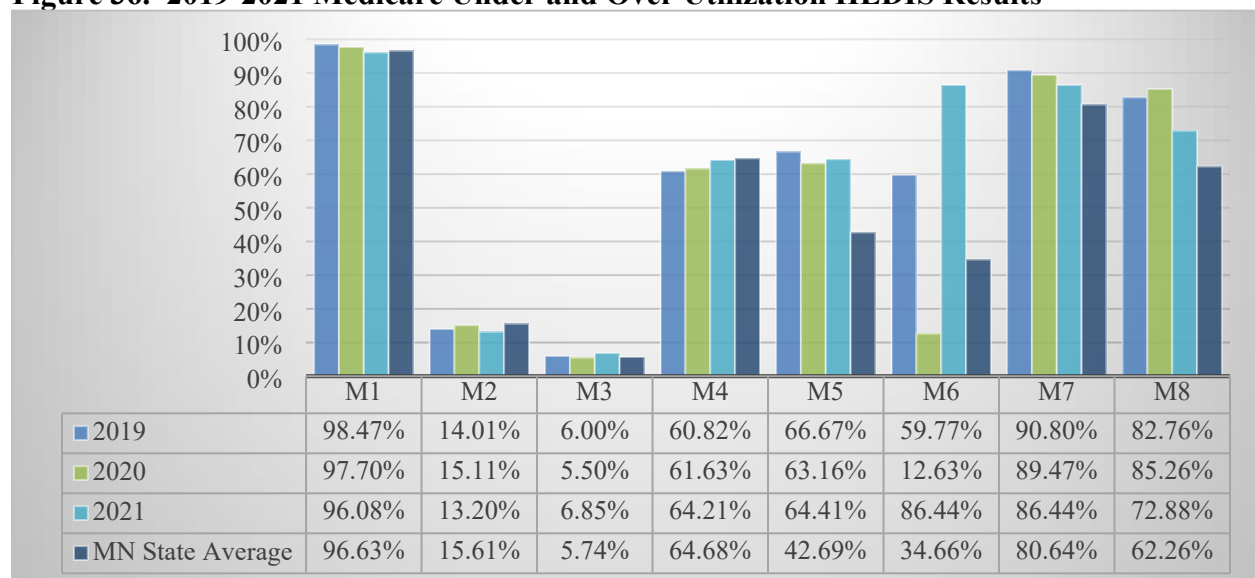
One ongoing barrier to improvement and goal setting is the NCQA national benchmarks and thresholds, which are not available until March of the year following the end of the measurement year. This impedes the ability to implement new interventions for the current measurement year.

IMCare will revisit this issue annually, but in the interim, will continue to use the MN State Average 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
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 36. 2019-2021 Medicare Under and Over Utilization HEDIS Results



Medication Therapy Management (MTM) Program

The IMCare MTMP 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. Centers for Medicare & Medicaid Services (CMS) requires that all Part D sponsors incorporate an MTMP into their plan's benefit structure as described in § 423.153(d)(1). CMS defines MTMP eligibility requirements and core program components. In 2021, CVS Caremark's MTM vendor, for the fourth year, was Outcomes MTM.

In 2021, 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 \$4,376.

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:

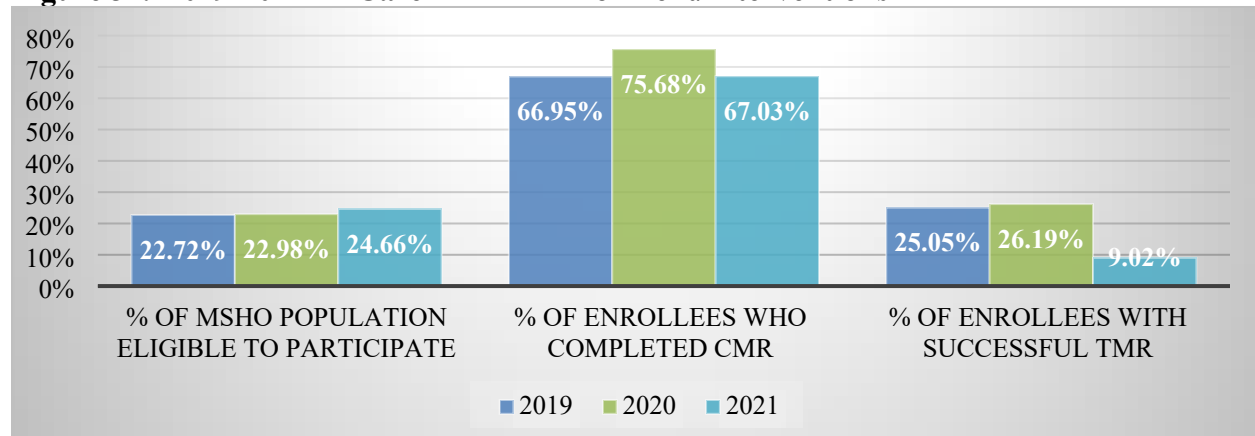
- Comprehensive Medication Review (CMR) – A CMR is an interactive person-to-person or telehealth medication review and consultation conducted in real-time between the patient and/or other authorized individual, such as prescriber or caregiver, and the pharmacist or other qualified provider and is designed 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. CMR's are how the MTMP 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 beneficiaries.

Overall, the number of complex cases targeted for the MTMP have remained consistent over time. In 2021, a similar percentage (24.66%) of the total IMCare MSHO population met MTMP targeting criteria. CMR completion rates narrowly missed the stretch goal of 70% in 2021, but achieved the target set at the beginning of the year. Of the 91 targeted eligible enrollees, 67.03% completed a CMR with a pharmacist compared to 75.68% in 2020. Local retail pharmacists and IMCare nurses continued to do a great job engaging patients, creating relationships, and completing cases.

In 2021, the TMR Success rate was 9.02%. As a percentage, the success rate was much lower than previous years due to a significantly higher number of opportunities with fewer attempts. A reduction in successful TMR interventions is likely due to the staffing shortages and increased workload associated vaccine administration that pharmacists encountered in 2021, due to the

pandemic. The most common TMR reasons were related to adherence to chronic drugs. Adherence TMRs most prevalent were for statins, inhaled steroids, RAS antagonists and long-acting insulin. Historically, adherence responds positively to patient engagement and education.

Figure 37. 2019-2021 IMCare MTMP Enrollment/Interventions



*CMR completion rate goal increased from 60% to 70% in 2020. CMS exclusions applied to denominator for 2021. CMS exclusions include those enrolled in MTM for less than 61 days without a CMR, less than 18 years of age, or enrollee is in hospice. TMR success rate methodology changed from 2018.

Provider Satisfaction Survey

As per IMCare contracts with the Minnesota Department of Human Services (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 practitioner 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.

2020 Interventions:

- 2020 IMCare UM criteria sources were reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/12/20 and by the IMCare QI/UM Committee on 03/18/20.
- IMCare authorization/referral requirements were updated throughout 2020 and changes were communicated to providers via provider updates/newsletter.
- Provider education regarding IMCare care coordination services, and the process for referral, was included in the Spring/Summer 2020 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 2020.

- Provider education regarding IMCare Quality Improvement Program efforts (e.g., focus studies, performance improvement projects, etc.) was included in the Spring/Summer and Fall/Winter 2020 provider newsletters.
- Throughout 2020, IMCare followed NCQA guidelines for credentialing individual practitioners and organizational providers.
- The 2020 IMCare Provider Satisfaction Survey Report was reviewed and approved by PAC on 08/12/20 and the QI/UM Committee on 06/17/20.
- COVID-19 pandemic provider updates were issued regularly throughout 2020.

The 2021 Provider Satisfaction Survey had a response rate of 21.97%. The overall provider satisfaction rate was 98.31%, increased from 98% in 2020. All survey question measurements exceeded goal. Quite a few individual measurements increased from 2020; however, there was decrease in satisfaction regarding formulary comprehensiveness and the non-formulary drug request process. This may be attributed to required use of the MN DHS Preferred Drug List (PDL), for which IMCare has minimal ability to impact formulary comprehensiveness, and the required drug authorization process for nonpreferred PDL drugs. 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 38. 2019- 2021 Provider Satisfaction Survey Response Rate by Provider Type

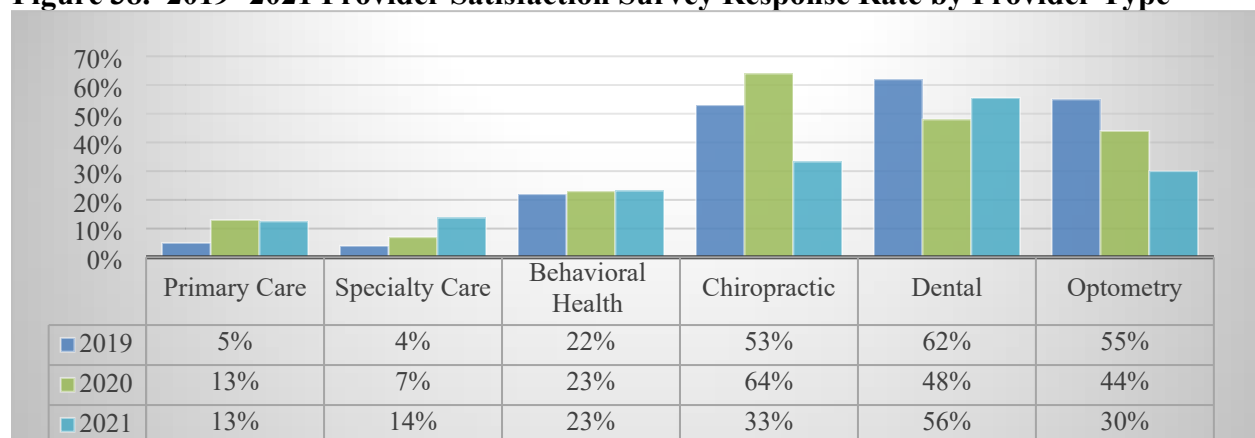
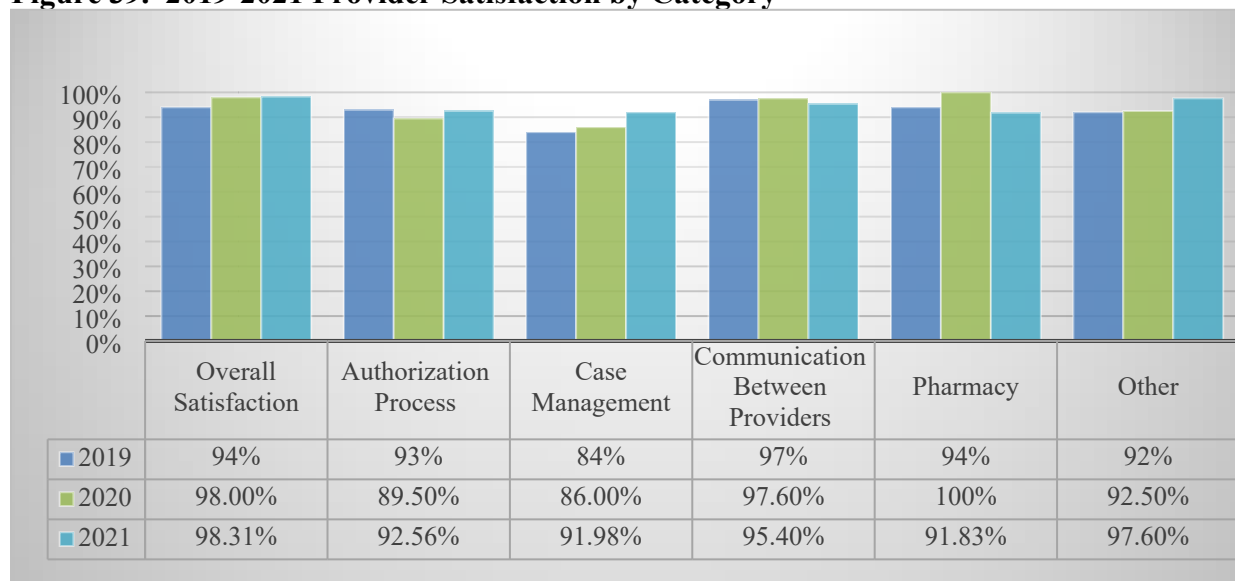


Figure 39. 2019-2021 Provider Satisfaction by Category



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 2021, 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 Enrollee 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 2021.

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 2021.

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)

2021 Interventions:

- 2021 Utilization Management Criteria were reviewed/approved by the Provider Advisory Subcommittee (PAC) on 02/10/2021 and the External QI/UM Committee on 03/17/2021.

- InterQual criteria updates were loaded into CaseTrakker (authorization review system) as they became available, throughout 2021. In December 2021, migration was completed to transition InterQual to a cloud based medical review service ensuring IMCare consistently has the most up to date content available.
- CVS/Caremark drug criteria sets were updated in January of 2021, and as they became available thereafter.
- Periodic Utilization Management Operations Workgroup (UM Ops) were held to evaluate, discuss, and modify UM criteria, application of criteria and/or processes as needed.
- Casetrakker was updated in January 2021 and training provided at UM Ops to provide oral notification if there is a technical issue preventing written notification

IMCare audited a total of 195 determinations with the following breakdown: Managed Care Nurses were audited on 160 determinations; Medical Director and Physician Consultant were audited on 35 determinations. In each measure, the Medical Director and Physician Consultant maintained the goal of 100%. The Managed Care Nurses met two of the four goals. The unmet areas were “was the correct criteria set/policy used and did the nurse apply criteria correctly.” This involved one instance a medication was identified as a nonformulary generic medication rather than a formulary brand medication; therefore, the nurse followed the nonformulary criteria rather than the preferred criteria and the criteria could not be applied correctly.

Figure 40. 2019-2021 Managed Care Nurse Interrater Reliability Audit Results

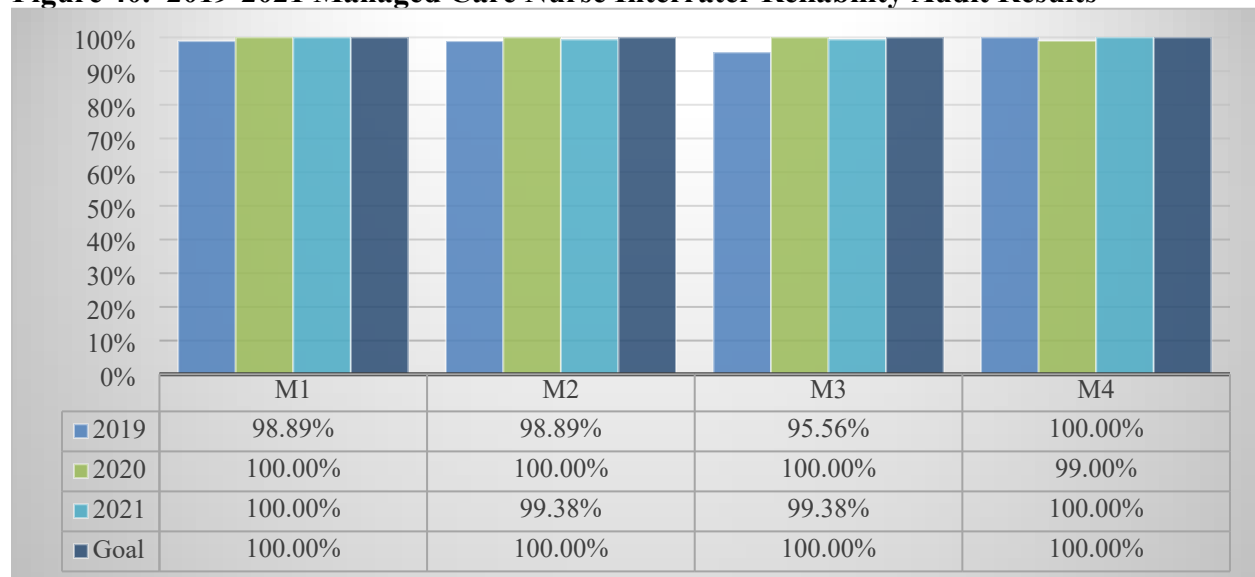
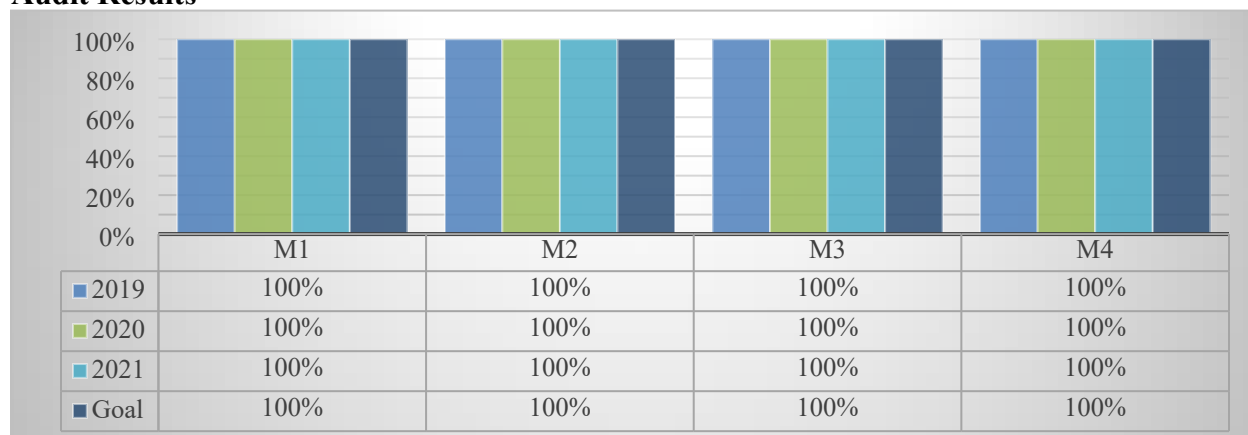


Figure 41. 2019-2021 Medical Director/Physician Consultant Interrater Reliability Audit Results



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.

2021 Interventions:

- The Managed Care Nurses (MCN) worked proactively with practitioners/practitioner staff on authorization requests to minimize lack of information denials.
- The 2020 DTR Report was reviewed/approved by the IMCare Provider Advisory Subcommittee (PAC) on 02/09/2021 and the IMCare External Quality Improvement/Utilization Management (QI/UM) Committee on 03/13/2021.
- 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 2021, IMCare sent 219 DTR Notices of action. Consistent with previous years, a majority of the DTRs were for Service Authorization (66%). 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 2021 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 (i.e.; EW and Personal Care Assistance (PCA)) and there are services where Itasca County Health and Human Services determines eligibility (i.e. Mental Health Targeted Case Management (MH-TCM) for Adults and Children). These services are typically approved through 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 at enrollee request.

IMCare MCN focuses 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, including withdrawal of the request by the practitioner when unable to make a determination. 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 Pharmacy Benefits Manager (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. Enrollees are offered the option to put their appeal in writing and any assistance they need in accomplishing that.

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 an individual that was not involved in any previous level of review or decision-making and are not subordinates of the person who made the original decision. A denial of service based on lack of medical necessity or that involves clinical issues, must be reviewed by an individual who was not involved in any previous level of review or decision making, and is a Health Care Professional with appropriate clinical expertise in treating the enrollee's health condition or disease. IMCare must ensure the physician is in the same or a similar specialty as the requesting attending healthcare professional. IMCare has contracted with 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, CaseTrakker Dynamo (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.

2021 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 is conducted via KnowBe4, an electronic platform used to rollout and track training. The training was conducted in January and February 2021.
- 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 misidentification of service categories and update systems as necessary.
- The 2020 Appeal Report was reviewed/approved by the IMCare PAC on 02/10/2021 and the IMCare QI/UM Committee on 03/17/2021.

In 2021, IMCare received 21 appeals due to billing & financial issues and 14 appeals related to services and/or benefits. Categories of service were:

- Restricted Recipient (1)
- Dental (2)
- DME (2)
- Hospital (1)
- Pharmacy (5)
- Professional Medical Services (2)
- Vision Services (1)

Nine of the service/and or benefit appeals were due to denial of service through the authorization process. Five of those appeals were upheld, three were denied and one was denied for exceeding the timeline to request an appeal. Three of the appeals were reviewed by MRIOA; these are highlighted below.

- IMCare received a letter from the prescribing provider on a denied drug. The appeal was sent to MRIOA for review by an Endocrinologist. A physician reviewer board certified in Internal Medicine and In Endocrinology, Diabetes and Metabolism overturned IMCare's original decision, so the enrollee's appeal was approved.
- IMCare received a letter from the provider on a denied service (injection). The appeal was sent to MRIOA for review by an Orthopedic Spine Surgeon. A physician reviewer board certified in General Orthopaedic Surgery upheld IMCare's original decision, so the enrollee's appeal was denied.

- IMCare received a letter from the provider on a denied mammogram for a person under 40 years old. The appeal was sent to MRIOA for review. A physician reviewer board certified in General Plastic Surgery upheld IMCare's original decision, so the enrollee's appeal was denied.

2021 General Appeal Information and Opportunities

IMCare requires appeal and grievance program staff to complete training. The goal of the education is 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. Training is administered via KnowBe4, an electronic platform used to rollout and track training.

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 enrollee 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 Enrollee 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.

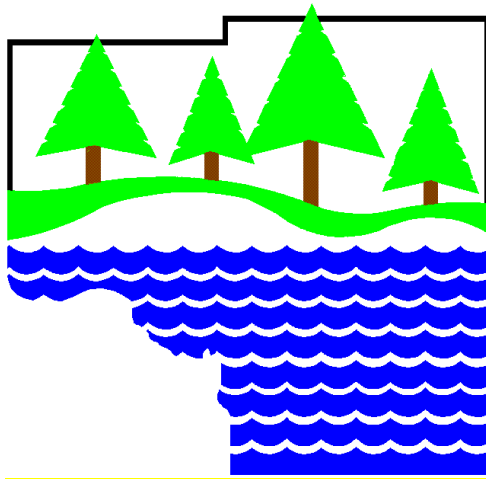
In 2021, pharmaceutical and pharmaceutical management procedures were communicated to enrollees and prescribing practitioners. This information included co-payment information; prior authorization requirements; limits on refills, doses, or prescriptions; use of generic substitutions; and covered pharmaceuticals. 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, Amber Silliman, at (218)327-6180, (800)843-9536 ext. 2180 email to Amber.Silliman@co.itasca.mn.us.



2022 ITASCA MEDICAL CARE QUALITY IMPROVEMENT PROGRAM DESCRIPTION

Approved by:

IMCare External QI/UM Committee: 03/16/2022

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.

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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 became 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 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 15 outlying providers
- Vision providers within Itasca County and three outlying providers
- Chiropractic providers within Itasca County and three outlying providers

Purpose

IMCare and its network providers are committed to the delivery of optimal and cost-effective health care to its enrollees through coordination and collaboration with local community partners and providers. 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 part of the community, 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
- 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
- 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 performance improvement projects (PIP), 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.
- 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 Director(s), 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
- 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 Subcommittee (SAC)).

In 2020, IMCare implemented a Population Health Management program. As per the 2021 Contract for Prepaid Medical Assistance and MinnesotaCare, section 7.3, “The MCO shall create and report annually to the STATE a Population Health Management Strategy or any amendment to the original PHM strategy by July 31 of the Contract Year, including structure and processes to maintain and improve health care quality, and measures in place to evaluate MCO’s performance on its process outcomes (for example, clinical care, or enrollee experience of care).” IMCare utilizes the most current NCQA “Standards and Guidelines for the Accreditation of Health Plans” to develop and review the PHM strategy annually. Services and supports offered through the PHM program are free and available to all IMCare enrollees.

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
- 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
- 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
- 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.

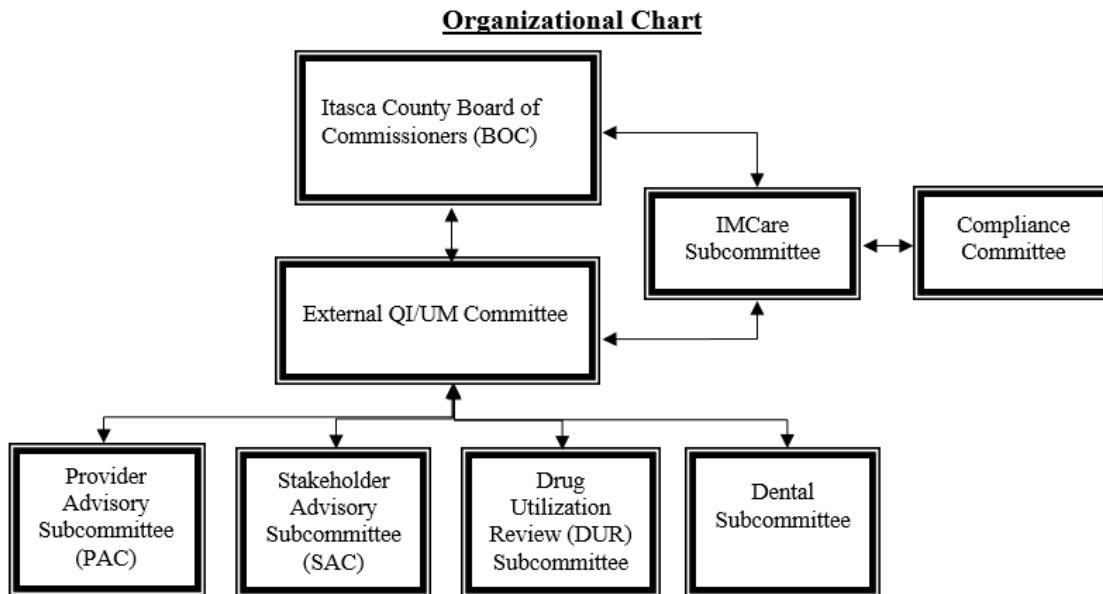
RxNavigator is a CVS Caremark web-based tool used for creating and maintaining database reports. IMCare has created customized reports to query the database on all data stored in point-of-sale pharmacy claims. IMCare has defined the parameters per business rules and reporting requirements. This system 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. A summary of the final results is included in the Annual QI Program Evaluation which is subsequently reviewed/approved by the Itasca County Board of Commissioners. 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.



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 Subcommittee 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/s
- 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 IMCare 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 written reports, presentations, educational forums, published articles, newsletters, direct mail, social media, and/or the IMCare website.

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 require 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
- substance use disorder 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 standard and 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 evaluate outcomes of clinical and administrative activities routinely and consistently. 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 processes 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, PHM 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: 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)
- 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 by 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: Psychiatrist, licensed by 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 Physician Consultant

Qualifications: Physician, licensed by the State of Minnesota

The IMCare QI/UM Physician 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 by 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/s

Qualifications: Registered nurse or social worker, licensed by 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 appropriateness, quality, and 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 or project coordination

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, 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
- 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 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 Health 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
- 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
- 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
- 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
- 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

For Clean applications IMCare makes a determination within 45 calendar days of the practitioner's signed attestation date on the application. If quality or safety concerns are noted during the credentialing process IMCare may delay determination up to 30 days to investigate these concerns. 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 as a method to ensure a sustained provider network.

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 or secure email to deliver medical records to IMCare. When medical records are received, IMCare staff links them into the care management system CTD.

2022 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 SS&C Health 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 2022 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 (MSHO)
- Childhood immunization rates (PMAP/MNCare)
- Adolescent well care visits (PMAP)
- Diabetic eye examinations (PMAP/MNCare/MSHO/MSD+)
- Potentially harmful drug-disease interactions (MSHO)
- High-risk medications (MSHO)

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 MSD+ 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 provided by the Senior Care Coordinators, 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 2022, 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, Complex Case Management (CCM), 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 CCM.
- Timely referral of enrollees who may benefit from CCM 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 2022, IMCare will continue to identify, and attempt to reduce, inappropriate CS utilization through enrollee, provider, and pharmacy interventions. Additionally, activities of care coordination, CCM and evaluation for the RRP will continue on 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. This is a free program that includes prenatal education and support. A pregnancy congratulatory letter is sent to each pregnant enrollee. The letter encourages the enrollee to seek early prenatal care, informs her about the program, and provides contact information for who she can contact to get 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, 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 historically has offered incentives for participation through solely Target gift cards. Recognizing that access to this store may be limited to some of IMCare's rural communities IMCare is planning expansion of this incentive to include a wider variety of options, for example transportation incentives, wireless communication resources, and local grocery store credits.

Plans for expansion also include allowing all American Indian women, regardless of previous participation, to earn participation incentives. Assessment and educational materials will be updated to include substance use disorder and mental health services available. For clients

engaged in treatment for substance use, or those in ongoing recovery, paraprofessionals will provide support as trained Recovery Coaches.

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, CCM referrals, and CCM 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 processing. 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 2022, survey questions will be reviewed to determine if clarification or updates for specific populations are indicated to better reflect service satisfaction. Overall, IMCare senior enrollees are satisfied with care coordination services. IMCare will evaluate the 2022 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 2022, 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 CCM. 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 and/or complex conditions with obtaining access to care and services and coordinating their care.

IMCare utilizes two distinct processes to identify enrollees for enrollment in CCM that include both administrative/electronic data and/or referral sources. Referral sources are reviewed as received and administrative data reports are reviewed as outlined in the individual report process.

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. Enrollee's 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:

Goal: Increase in annual age-appropriate wellness exams for enrollees as captured in the Goal: Increase in annual age-appropriate wellness exams for PMAP and MNCare enrollees as captured in the following HEDIS measures: Well Child Visits in the First 15 Months of Life (W30-Fifteen); Well Child Visits from 15 Months to 30 Months of Life (W30-Thirty); and Child and Adolescent Well Care Visits (WCV).

- Target population: All enrollees enrolled in the plan who met age requirements within the measurement year.
- Programs or services: Enrollee education via webpage, targeted mailings focusing on recommended wellness visits to promote healthy lifestyles and early intervention for identified risk factors.

Goal: Annual decrease in enrollees with a diagnosis of tobacco use as evidenced by a reduction to the CareAnalyzer, risk, disease prevalence measure PSY01-Tobacco use, observed per 1,000 enrollees.

- Target population: All enrollees 18 years of age and older.

- Programs or services: Enrollee education via webpage and biannual enrollee newsletter, annual clinical audit to measure evaluation for tobacco use and education/cessation information offered for all enrollees.

Goal: Increase in annual age-appropriate wellness exams for enrollees as captured in the following HEDIS measures: Breast Cancer screening (BCS) for PMAP, MNCare, and MSHO; Colorectal Cancer screening (COL) for MSHO; Cervical Cancer screening (CCS) for PMAP and MNCare; Chlamydia screening (CHL) for PMAP and MNCare.

- Target population: All enrolled adults that meet age requirements in measurement year.
- Programs or services: Enrollee education via webpage, targeted mailings focusing on recommended wellness visits to promote healthy lifestyles and early intervention for identified risk factors.

Goal: Annual increase in enrollees seeking preventative health care as captured by the HEDIS measure Adults' Access to Preventative/Ambulatory Health Services (AAP).

- Target Population: Adult Enrollees that meet the age requirements in the measurement year.
- Programs or services: Enrollee education via webpage, targeted mailings focusing on recommended wellness visits to promote healthy lifestyles and early intervention for identified risk factors.

A Healthy Pregnancy

A Healthy Pregnancy program was developed in 2007, in collaboration with Itasca County Public Health's Maternal-Child Health Division. This program is for all IMCare pregnant enrollees and aims to reduce the incidence of at-risk pregnancies and poor pregnancy outcomes through early prenatal interventions, risk assessments, and education. IMCare partners with Itasca County's Maternal Child Public Health (MCH) division to offer enhanced services.

Goal: Annual increase in the number of enrollees who received an IMCare congratulatory letter with program information and had claims for MCH prenatal or postpartum services, enrollees with one or more MCH visit during their pregnancy prior to delivery date, number of enrollees with at least one MCN nurse visit prior to deliver and one MCH nurse and Primary Care Provider visit postpartum.

- Target Population: Pregnant enrollees as identified through pregnancy diagnoses with medical claims.
- Programs or services: IMCares' *A Healthy Pregnancy* Program, Itasca Counties' *Prenatal and Healthy Beginnings* program, lactation consultations, prenatal and newborn education classes available through local hospitals, clinics, and community organizations.

Emergency Room (ER) Utilization Focus Study

IMCare implemented an ER Utilization Focus Study in 2011. This program is for all IMCare enrollees, and the goal is to identify enrollees with excessive ER use, monitor for inappropriate ER use, monitor for complex healthcare needs, and provide individual enrollee interventions as appropriate.

Goal: Annual Decrease in the number of enrollees with high ER utilization (four or more ER visits within a calendar year)

- Target Population: IMCare enrollees who trigger on the monthly high ER utilization focus study report
- Programs or Services: Education through the biannual enrollee newsletter on topics such as the definition of a medical emergency which would require ER care with examples of conditions, outreach from an IMCare nurse to assess for educational needs. Enrollees under 65 years of age may be referred to CCM for further interventions and enrollees over 65 are contacted by their assigned CC to assess if current services and supports are adequate and if more robust interventions are needed.

Controlled Substance (CS) Utilization Focus Study

IMCare implemented a CS Utilization Focus Study in 2011. This program is for enrollees under aged 65 and the goal is to identify enrollees, providers, and pharmacies to ensure enrollees are filling CS within IMCare policy, best practice prescribing is being utilized, and monitor for misuse and abuse by enrollees.

Goal: Annual decrease in the total days-supply of CS dispensed per Medicaid enrollee per year.

- Target Population: IMCare enrollees younger than 65 years old with four or more CS fills within a one month look back period.
- Programs or Services: Education through the biannual enrollee newsletter and biannual provider newsletter on IMCare CS filling policies, overviews and updates to best practice prescribing pertinent to CS, and education on the availability of CS abuse programs and CCM assistance. Direct outreach from an IMCare nurse to the enrollee assess for educational needs, referral to CCM for further interventions. Direct outreach from the IMCare nurse to providers to report prescribing and abuse concerns, and outreach pharmacies to educate on IMCare's CS dispensing and payment policies as well as reporting any instance of a medication paid by IMCare but not reported to the Minnesota Prescription Monitoring Program (PMP).

Goal: Annual decrease in enrollees with a diagnosis of obesity as evidenced by a reduction to the CareAnalyzer, risk, disease prevalence measure NUT03-Obesity, observed per 1,000 enrollees

- Target Population: All IMCare enrollees with an obesity diagnosis
- Programs or Services: Education through the biannual enrollee newsletter regarding healthy lifestyle and health promotion, and individual interventions as appropriate. Enrollees under 65 years of age may be referred to CCM for further interventions and enrollees over 65 are contacted by their assigned CC to assess if current services and supports are adequate and if more robust interventions are needed.

Goal: Annual reduction in patient re-admissions in target population.

- Target population: Enrollees 18 years of age and older in the measurement year with readmission within 15 days of discharge for same or similar diagnosis.
- Programs or services: Complex case management, enhanced care coordination services for seniors, provider/enrollee newsletter, post-discharge check list.

Goal: Annual reduction of hospitalization following discharge from a skilled nursing facility (HFS) 30 & 60 days expected.

- Target population: All enrolled adults that meet age requirements in measurement year.
- Programs or services: Enhanced care coordination services for seniors, transition support, provider/enrollee newsletter, post-discharge check list.

Goal: Annual improvement in good control of Hemoglobin A1c (HBA1C of 8% or lower) for enrollees with diabetes as identified by HEDIS measures Comprehensive Diabetes Care (CDC).

- Target population: Enrollees aged 18 years and older with diabetes.
- Programs or services: Provider/enrollee newsletter, Diabetic education referral, educational information provided through IMCare website and social media, referral for CCM and/or more enhanced care coordination services as appropriate for age.

Goal: Annual improvement in good blood pressure control as identified by HEDIS measure controlling high blood pressure(CBP).

- Target population: Enrollees aged 18 years and older who meet HEDIS specification.
- Programs or services: Provider/enrollee newsletter, educational information provided through IMCare website and social media, referral for CCM and/or more enhanced care coordination services as appropriate for age.

Goal: Improve outpatient mental health utilization and reduce emergency mental health utilization and inpatient as identified by HEDIS measure mental health utilization (MPT).

- Target Population: Enrollees aged 18 years and older who meet HEDIS specification.
- Programs or Services: ED Focus Study report and follow-up, referral to CCM for enrollees younger than 65 and enhanced care coordination services for enrollees older than 65.

IMCare plans to achieve the above goals through enrollee and provider engagement via newsletters, online resources, and individual outreach as indicated. Evaluation of program effectiveness will be evaluated through the annual PHM Impact Analysis.

Practice Guidelines

The adoption, dissemination and application of clinical practice guidelines are required by IMCare 2022 Families and Children and Seniors contracts with DHS and 42 CFR §438.236. Per Article 7.1.6 of the 2022 Seniors contract, “The MCO shall adopt preventive and chronic disease practice guidelines appropriate for Enrollees aged 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
- 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.

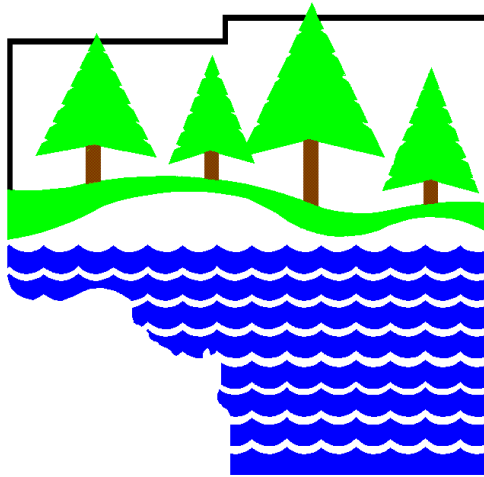
Work Plan

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, Amber Silliman, at (218)327-6180, (800)843-9536 ext. 2180, or by email to Amber.Silliman@co.itasca.mn.us.



2022 ITASCA MEDICAL CARE UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Approved by:

IMCare External QI/UM Committee: 03/16/2022

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

IMCare administers healthcare to Itasca County individuals who are eligible for benefits under Minnesota Health Care Programs: Medical Assistance (MA), MinnesotaCare (MNCare), Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+). IMCare was established in 1982 with General Assistance Medical Care (GAMC). Prepaid Medicaid was implemented on July 1, 1985, as a demonstration project and expanded to include MinnesotaCare in 1996. In 2001 IMCare became a County Based Purchasing (CBP) organization. MSC+ was added in June of 2005 and a Medicare Advantage product, MSHO, was added in January 2006. As of 12/31/2021 IMCare provides health care services for 9659 Itasca County residents.

Itasca County contracts with the Minnesota Department of Human Service (DHS) to provide MA, MNCare, MSC+ and MSHO medical benefits through the IMCare program. IMCare receives monthly capitation from DHS and CMS for 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 Itasca County Health and Human Services (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 15 outlying providers
- Vision providers within Itasca County and three outlying providers
- Chiropractic providers within Itasca County and three 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 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.

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. 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 Subcommittee (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, HealthX and Amisys reports are used to evaluate claims data. CTD contains CM and utilization review data. RxNavigator is used to evaluate pharmacy claims data. JIRA and Confluence are used to track business requirements.

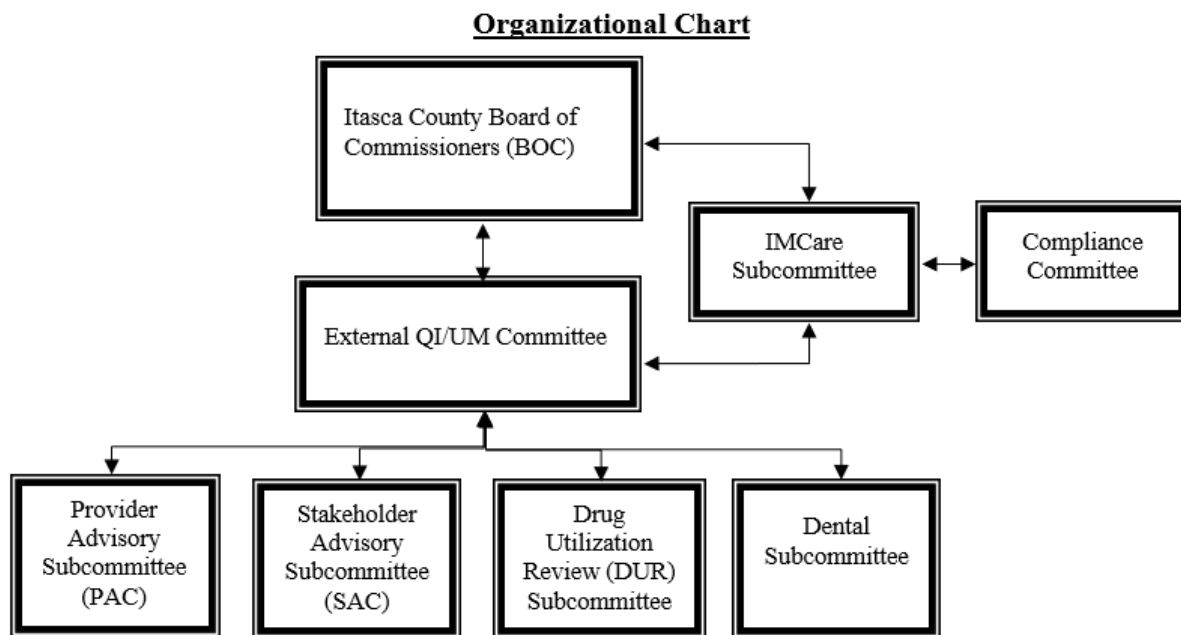
The data collected through these various systems is utilized in a variety of ways. CareAnalyzer is used to identify enrollees with co-occurring health care conditions and/or certain utilization patterns, who may benefit from intensive CM. The MCN reaches out to identified enrollees and offers case management, 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, grievances and authorizations, and it also encompasses CM and PHM activities. SSRS, HealthX, 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 QI/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 care and service provided to enrollees, rests with Itasca County Board of Commissioners (BOC). The BOC consists of five Itasca County commissioners and is responsible for ensuring the implementation of all aspects of the QI/UM 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, the UM Program Description, QI/UM Work Plan, and QI/UM Program Evaluation.



Committee Structure

IMCare Subcommittee

The IMCare Subcommittee functions in an advisory capacity to the Itasca County Board. The IMCare Subcommittee considers program proposals regarding fiscal arrangements and issues regarding management of the programs. They are providing advisement for maintaining a comprehensive provider network of health care professionals to ensure enrollee access to services, provider quality and utilization, and other issues as needed. This subcommittee meets quarterly and 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 compliance plan. It 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 of the Itasca County Board of Commissioners.

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/UMQI/UM Director (s)
- IMCare Controller
- IMCare QI/UM Consultant

Responsibilities:

- Review and approve compliance plan, standards of conduct.

- Review internal review programs.
- Address compliance issues.
- Identify opportunities for improvement and possible intervention.

Quality Improvement and Utilization Management Committee

This is an IMCare committee that coordinates actions of the clinical committees. This committee is a requirement of the National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans, and reports to the Itasca County Board of Commissioners. The purpose of the QI/UM Committee is to recommend policy decisions; review and evaluate the results of QI/UM functions, Care Coordination/Case Management and Population Health Management activities; identify opportunities for improvement; address insufficiencies; institute corrective actions; and ensure follow-up, 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:

- Review and approves QI and UM program descriptions, QI/UM work plan and the annual QI/UM Program Evaluation.
- Receive reports from IMCare subcommittees and the Compliance Committee.
- Oversee 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.
- Adopt new and revised clinical practice guidelines, medical necessity criteria, and medical and behavioral health policies recommended by the Provider Advisory Subcommittee (PAC).
- Monitors delegated functions and recommends actions to correct identified deficiencies.

Provider Advisory Subcommittee

The purpose of the Provider Advisory Subcommittee (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. PAC also ensures that providers and facilities meet IMCare's criteria for participation in the network and conducts its 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 QI/UM Consultant
- IMCare Behavioral Health 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 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 re-credential providers in its network according to State regulations, NCQA accreditation standards and CMS requirements.
- Communicate and incorporate peer review findings in the credentialing decisions
- Review and approve organizational certification including hospital, ambulatory surgical-centers, residential, home health, skilled nursing, and ambulatory clinics.
- 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 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 QI/UM Committee.

Stakeholder Advisory Subcommittee

The Stakeholder Advisory Subcommittee is a collaborative, multidisciplinary committee that enrollee or enrollee representatives are invited to participate on.

This committee focuses on seniors or enrollees receiving Long Term Services and Supports (LTSS) The committee provides direction and feedback on provision of services and enrollee materials. The subcommittee reports to the IMCare External QI/UM Committee and meets semiannually, and 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 Social Worker
- Enrollees and/or representatives
- 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.
- 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 DUR Committee advises IMCare on prospective and retrospective DUR criteria, educational interventions, drug utilization concerns and clinical appropriateness of drugs on formulary. The IMCare DUR Committee is comprised of 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
- Caremark representatives
- IMCare QI/UM staff (ex-officio)

Responsibilities:

- Ensure appropriate use therapy, while permitting sufficient professional prerogatives to allow for individualized therapy.
- Assess drug use information against predetermined standards.
- Make recommendations to IMCare concerning modification or elimination of existing or the addition of new ones.
- Advise IMCare on the establishment and implementation of medical standards and criteria for the retrospective and prospective DUR program.
- 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 Dental Subcommittee addresses all matters pertaining to dental issues, 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 2022, IMCare will utilize 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: Physician, licensed by the State of Minnesota

The IMCare Medical Director is responsible for:

- Monitoring the implementation of the QI/UM 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 by 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: Psychiatrist, licensed by 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: Physician, licensed by 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 by 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 one-year clinical nursing work experience, or a bachelor's degree in nursing.

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 (MCNs 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, QI/UM 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., Enrollee 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. A 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/or 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 services.

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.

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 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. The IMCare HPCC/Compliance Officer ensures confidentiality is maintained, documentation is complete and accurate, and the appeal process is implemented and completed according to policies and procedures.

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 PAC 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 Enrollee 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 an exception request is not approved.

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.

2022 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

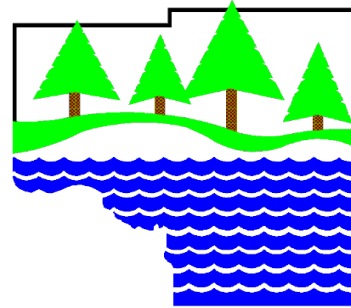
IMCare Data Project Coordinators will evaluate inpatient claims data quarterly, and all enrollees with inpatient stays less than 15 days apart for same or similar diagnoses will be referred to an MCN. The MCN will review all applicable clinical documentation to determine the relationship between the 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, Peggy Rosik, at (218)327-6199, (800)843-9536 ext. 2199, or by email to peggy.rosik@co.itasca.mn.us.



ITASCA MEDICAL CARE

2022 Annual Quality and Utilization Management Work Plan

Final Approval by:

IMCare QI/UM Committee:

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) Corrective action(s) consistent with part 4685.1120, subpart 3 and 4
- 8) 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.

2022 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
2022 Quality Program Description is filed with MDH by 5/1/22	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	2021 QI/UM Program Evaluation to identify areas needing improvement 2022 QI Program Description	QI/UM Director	Q1 2022	In progress		
2021 Quality & Utilization Management Evaluation is filed with the State by 5/1/22 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	2021 Quality Reports 2021 UM Reports	QI/UM Director	Q1 2022	In progress		

2022 Utilization Management Program Description is filed with the State by 5/1/22	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	2021 QI/UM Program Evaluation to identify areas needing revision 2022 UM Program Description	QI/UM Director	Q1 2022	In progress		
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/	• 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 2022 Q2 2022 Q3 2022 Q4 2022	In progress		4/16/2022 06/15/2022 09/21/2022 12/21/2022
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 2022 2022 2022 2022 Q2 Q3 Q4	In progress		2/22/2022

2022 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 2022	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 2022	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 2022	Complete	Presented to PAC and approved on 02/9/2022	2/9/2022
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 2022 Q2 2022 Q3 2022 Q4 2022	ongoing	Presented to PAC and approved on 02/9/2022	2/9/2022 05/11/2022 08/10/2022 11/09/2022
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 2022	Complete	Presented to PAC and approved on 02/9/2022	2/9/2022
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 2022	Complete	Presented to PAC and approved on 02/09/2022	2/9/2022
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 2022	In progress		

2022 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 11/15/2022	ATR Response Document	QI/UM Director	Q4 2022			

2022 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

[illegible]

2022 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; NCOA NET 1-6

[illegible]

2022 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Provider Satisfaction	
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99	100

Source of Standard: 42 CFR 438 Subpart C; Minnesota Rules 4685.1110 to 4685.1130; DHS Contract Sections 7.1.4, NCOA UM 1-13

[illegible]

2022 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN
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 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 2022			
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 2022			
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, Medical Record Audit Tool	QI/UM Director	Q2 2022			
Provider Newsletter	To promote provider awareness of standards within the medical record audit	Complete newsletter entry with an overview of audit results and importance of addressing measures that have declined	Providers are aware of standards around identified areas	Provider Newsletter	QI/UM Director	Q2 2022			
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 2022			
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 2022			

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 2022			
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 2022			
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 2022			

Population: PMAP,
MNCare, MSHO,
MSC+

2022 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

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; NCOA 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 improve performance.	Analyze HEDIS data, compose report and implement interventions as indicated	IMCare is able to identify areas needing improvement and strategize to implement	HEDIS 2021	Managed Care Nurse	Q4 2022	Complete		
Collaborate with Itasca County Public Health	To increase childhood immunization rates	Coordinate designate immunization nights	Enrollees will have increased access to childhood immunizations	HEDIS 2021	Managed Care Nurse	Q2 2022 Q4 2022	ongoing		
Collaborate with Itasca County Public Health	To decrease poor birthing outcomes	Collaborative efforts to offer A Healthy Pregnancy with education from the Public Health Maternal Child Health unit.	Enrollees will have increased prenatal and post partum care	HEDIS 2021	Managed Care Nurse	Monthly throughout 2022	ongoing		
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 2021 Enrollee newsletter IMCare Website	Managed Care Nurse	Q2 2022 Q4 2022	In progress		
Medicare HEDIS Report	To analyze HEDIS outcomes and identify opportunities to improve performance.	Analyze HEDIS data, compose report and implement interventions as indicated	IMCare is able to identify areas needing improvement and strategize to implement	HEDIS 2021	Senior Care Coordinator	Q4 2022	Complete		
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 2021 Enrollee newsletter IMCare Website	Senior Care Coordinator	Q2 2022 Q4 2022	In progress		

Population:
PMAP, MNCare,
MSHO, MSC+

2021-2023 Performance Improvement Project (PIP)

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Source of Standard: DHS Contract Section 7.2.2, 438 CFR Subpart E

Activities	Objectives/ Goals	Tasks
Enrollee/provider education	To increase HPV vaccination rates among male and female adolescents	Compose article for biannual enrollee/provider newsletters provide education via the IMCare website
Targeted outreach at community events as able	To increase HPV vaccination rates among male and female adolescents	Participate in Community Connect, Children's Fair and other community health gatherings to promote HPV Vaccine

Annual PIP/QIP Update

DHS PIP Report

Population:PMAP, MNCare

QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN

Human 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 2022 Q4 2022
Increase HEDIS measure by 2 percentage points above baseline	HPV Handouts	QI/UM Staff	As able

Increasing

Status	Progress/Results	Date Completed

In progress		5/1/2021

2021-2023 Quality Improvement Project**Incidence of Poor HbA1c**

Source of Standard: DHS Seniors Contract Section 7.2, 438 CFR Subp

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
Review of the enrollees due for assessment within 30 days with qualifying diabetes diagnosis	To identify seniors with diabetic diagnosis who may benefit from educational interventions	Review diabetic monthly report and identify enrollees who may benefit from education
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

Annual PIP/QIP Update

DHS PIP Report
Population: MSHO,
MSC+

E QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN**Control (>9.0%) (CDC) among the IMCare Minnesota Senior Health Option (MSHO) Enroll**

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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 2022 Q4 2022
Decrease HEDIS measure of senior enrollees within IMCare with poor HbA1c control (>9%) by 2 percentage points	Monthly Reports	Senior Care Coordinator	Monthly
Care coordinators 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	Senior Care Coordinator	Ongoing

Reducing the ees.

Status	Progress/Results	Date Completed

In Progress

Ongoing

ongoing

2021 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN
Increasing follow-up after ED use for seniors with high-risk multiple chronic conditions 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 the rate of follow up with clinic provider within 30 days following an ED visit	Direct enrollee education via Care Coordinators with each contact. Newsletter articles regarding health promotion for chronic conditions, when to seek emergency care, and the importance of treatment adherence and follow up.	HEDIS(FMC) measure improvement for MSHO	Enrollee newsletter, case notes, contact logs	Senior Care Coordinator	Q4 2022	ongoing		
Provider Outreach	To increase the rate of follow up with clinic provider within 30 days following an ED visit	Newsletter article about CCIP and goals to increase follow-up with providers after ER visits and decreasing ER visits overall by education for proactive management of chronic conditions.	HEDIS(FMC) measure improvement for MSHO	Provider Newsletter	Senior Care Coordinator	Q4 2022	ongoing		
HRA/Care Plan	To identify enrollees with high-risk conditions and provide preventative healthcare education	Complete HRA and care plan within appropriate timelines to identify chronic and high-risk conditions and provide proactive management education	Reduced ED use due to acute episodes of chronic conditions	HRA/Care Plan	Senior Care Coordinator				
CCIP Annual Attestation	Annual review and update of the CCIP topic, objectives, plan, and/or goals as needed	Evaluate HEDIS measures selected against benchmark and proposed improvement	Attestation is submitted to CMS by 12/31/2022	CCIP report	QI/UM Director	Q3 2022	completed		

Daily ED notifications	Review daily ED notifications from area hospitals notifying of IMCare enrollees seen in the ED	Contact enrollee, facility, and/or authorized contact to determine outcome of ED visit, educate on the importance of follow up with PCP, and coordinate follow up appointment	Reduced ED use, increase post ED use follow up	Facility daily ED reports	Senior Care Coordinator	Ongoing	Ongoing
Population: PMAP, MNCare, MSHO, MSC+							

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	Identify enrollees through periodic review of: ED focus study, daily facility ED notifications, CS focus study, at least one hospital readmission within five days for same or similar diagnosis, referral to complex case management, Stop loss.
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 and provider newsletters outlining PHM/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	To evaluate the outcomes and effectiveness of the activities of identification and interventions for senior enrollees with Special Health Care Needs	Review program from previous year for identification of Special Health Care Needs, compose report and evaluate opportunities for improvement

Population:
PMAP, MNCare,
MSHO, MSC+

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, decrease at-risk enrollees, d improve enrollees overall health	Claims Data Complex Case Management Work flow Case Notes	Managed Care Nurse	Monthly
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 2022 Q4 2022
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 2022 Q2 2022 Q3 2022 Q4 2022

IMCare will ensure that individuals with Special Health Care Need receive quality and appropriate care	Claims Data	Managed Care	Q1 2022
	Complex	Nurse	Q2 2022
	Case		Q3 2022
	Management		Q4 2022
	Work flow		
	Case Notes		

IMCare will ensure that individuals with Special Health Care Need receive quality and appropriate care	Annual	QI/UM Director	Q1 2022
	Medicaid		
	Special		
	Health Care Needs Report		

• 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	Timelines outlined in tasks
		PH Case	
		Managers	

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 Medicare special Health Care Needs Report	QI/UM Director	Q1 2022



Status	Progress/Results	Date Completed

ongoing

5/1/2021

In progress

Q1:
01/04/2021
Q2:
04/07/2021
Q3:
07/29/2021
Q4:
10/13/2021

In progress

SMRT:
02/08/2021
03/05/2021
04/09/2021
05/10/2021
09/14/2021
STOPLOSS
:
02/08/2021
03/10/2021
04/13/2021
09/28/2021
10/07/2021
1/31/2022

Complete

In progress

In progress

Complete

1/31/2022

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 participation
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		

CARE 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

IMCare enrollees and providers will have an increased understanding of CAHPS survey

2022 CAHPS results

QI/UM Director

IMCare will have CAHPS data available to analyze in 2022

2022 CAHPS Results

QI/UM Director

IMCare will identify opportunities for improvement and implement interventions as indicated

2022 CAHPS Report

QI/UM Director

IMCare will have increased participation in the monthly

Enrollee and provider newsletters

QI/UM Staff

IMCare will have increased participation in the monthly education sessions

Membership letters
enrollee education
attendance

OSS

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
IMCare will annually identify opportunities for improvement and implement changes to the enrollee education sessions as indicated	Enrollee Education Report	QI/UM Director-PR
IMCare will have a decrease in the call abandonment rate	Prairie Fyre reports	QI/UM Director-PR
IMCare will be compliant with call abandonment rates and have a reduction in those rates	Customer Call Performance Report	QI/UM Director-PR Compliance Officer
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
IMCare will identify opportunities for improvement and implement interventions as indicated	Senior Enrollee Satisfaction with Care Coordination Report	Senior Care Coordinator

Timeline Expected	Status	Progress/Results	Date Completed

Q4 2022

Q4 2022

Q4 2022

Q2 2022 In progress
Q4 2022

Monthly In progress

Q2 2022	In progress
Q3 2022	
Q4 2022	

Q1 2022	Complete

Q1 2022	In progress
Q2 2022	
Q3 2022	
Q4 2022	

Q1 2022	In Progress

Q2 2021	Complete

Q3 2021	In progress

2022 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN
Complex Case Management (CCM) (PMAP & MNCare)

Source of Standard: DHS Contract Section 7.3.4; NCQA PHM 5

Activities	Objectives/ Goals	Tasks	Outcome Measures	Data / Information Source	Responsible Staff	Timeline Expected	Status	Progress/Results	Date Completed
Review CCM 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 2022	In progress		
Enrollee Identification	Identify enrollees who would benefit from complex case management	Identify enrollees appropriate for CM using various methods including: •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	ongoing		
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 Screenings and refer for CCM screening	OSS	Monthly	ongoing		
Complex Case Management of enrollees	To ensure enrollees with complex health needs are able to access plan benefits	Complete CCM assessment within 30 days of opting into CCM 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	CCM workflows	Managed Care Nurses	Ongoing	In progress		

Explore CCM interventions	Expand CCM impact and scope	Develop dental missed appointments education letter and frequent ED use for COVID testing education letter	Increased dental appointment adhearance and decreased use of the ED for non-emergent needs	claims, provider referrals	QI/UM Director	Q2 2022	In progress

2022 IMCARE QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT WORKPLAN
Elderly Waiver (EW)/non-EW Care Coordination (CC) (MSHO & MSC+)

Source of Standard: DHS Senior Contract Sections 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 2022	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	Annually update electronic MOC staff training. Implement training for delegates and providers 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 online training and attestation page	QI/UM Director SM	Q3 2022	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 Coordinators	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 Coordinators	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 Coordinators	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 2022	
EW Care Coordinators 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 2022	
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 2022	
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 by 9/1	IMCare meets delegate oversight requirements and care coordination program meets required elements	Care Coordination Delegate Report	Senior Care Coordinator	Q3 2022	

Transitions of Care Audit	To ensure timeliness, completeness, and proper documentation of all transitions	Develop audit template to address timeliness, completeness, and proper documentation of transitions	IMCare will demonstrate compliance with transition requirements internally and with delegate Public Health EW staff	CaseTrakker data	Senior Care Coordinator/s	Q2 2022

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 prevalence, CCM assessment,	IMCare is able to identify and implement interventions to address needs of IMCare enrollees	Impact Analysis report submitted to DHS 7/31	QI/UM Director	Q2 2022	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 effectively based on guidance of the PD	PHM Program Description, Agenda External QI/UM Committee at which it was reviewed	QI/UM Director	Q1 2022	In progress		
Impact Analysis report	IMCare will evaluate the effectiveness of it's PHM strategy	Review quantitative 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 submitted to DHS 7/31	QI/UM Director	Q2 2022	In progress		
PHM goals communication	To promote health and wellness among IMCare enrollees by encouraging participation in PHM health promotion goals and programs	Compose article for biannual 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 2022	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.	Expand HA to electronic platforms including the IMCare enrollee portal (Currently in production)	Increased rate of health appraisals and enrollee engagement	IMCare website, enrollee portal	QI/UM Director	Q2 2022	Ongoing		
Annually review PHM self-management tools and update as indicated	Providing IMCare enrollees up-to-date tools to manage their health	Review health self-management tools and ensure they have been updated within the last two years. Review educational content on the PHM section of website to ensure current evidence based practice guidelines are outlined	Improved health outcomes for overall IMCare population due to enrollee engagement	IMCare website	MCN	Q2 2022	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 results	QI/UM Director	Q2 2022	In progress

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 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. <u>IMCARE 2020 CLINICAL PRACTICE GUIDELINES</u> (UpToDate – www.uptodate.com): • <i>Overview of General Medical Care in Nonpregnant Adults with Diabetes Mellitus</i> • <i>Overview of Preventive Care in Adults</i> • <i>Geriatric Health Maintenance</i> • <i>Screening Tests in Children and Adolescents</i> • <i>Guidelines for Adolescent Preventive Services</i> • <i>Prenatal Care: Initial Assessment</i> • <i>Prenatal Care: Second and Third Trimesters</i>	Practice Guideline Plan	QI/UM Director	Q1 2022	Complete	Report was presented and approved at PAC on 2/9/2022 and scheduled for External QI/UM Committee 3/16/2022	2/9/2022

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 up to date 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 Protocol 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 - PR w/oversight from Medical Director as indicated	Q1 2022
IMCare will identify way to improve consistency as indicated	Inter-rater Reliability Report	QI/UM Director - PR	Q1 2022
IMCare will have consistent application of the audit tool across staff.	Updated tool, annual report outcomes.	QI/UM Director- PR with oversight from Medical Director as indicated	Q2 2022
IMCare will have updated UM P&P and flow charts to ensure consistency across staff	Updated P&P	UM Ops Workgroup QI/UM Director- PR	Q1 2022

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-PR	Q2 2022
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-PR	Q2 2022
IMCare will have consistency across all UM decisions	Drug authorization training slides UM Ops meeting minutes	QI/UM Director-PR with oversight from Medical Director as indicated	Monthly
IMCare will meet all timelines for UM decisions	Timeliness report	QI/UM Director-AM	Q1 2022 Q2 2022 Q3 2022 Q4 2022
IMCare will have consistency and timeliness across all UM decisions	Quarterly Inter-rater reviews & spreadsheet	MCN Medical Director QI/UM Director-AM	Q1 2022 Q2 2022 Q3 2022 Q4 2022



Status	Progress/Results	Date Completed

In Progress	Report was presented and approved at PAC on 2/09/2022 scheduled for QI/UM Comittee on 3/16/2022	2/10/2021

In Progress	Report was presented and approved at PAC on 2/10/2021 and scheduled for QI/UM Committee on 03/16/2022	2/10/2022

In Progress

In Progress

In progress

In progress

In progress 2/22/2022

In progress

In progress	Q1:	Q2:
	Q3:	Q4:

Source of Standard: 438 CFR Subpart D; Minnesota Rules 4685.1110.1

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 2022	Complete



Progress/Results	Date Completed
In progress	

In progress

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 grievances 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 2022
IMCare will report all grievances to PAC and External QI to obtain suggestions for improvement or further intervention	Quarterly	Health Plan Compliance Coordinator	Q1 2022
	Reports/		Q2 2022
	Meeting		Q3 2022
	Minutes/ Agenda		Q4 2022
IMCare will present to PAC and external QI to identify opportunities for improvement	Annual Grievance Report / Meeting Minutes	Health Plan Compliance Coordinator	Q1 2022
IMCare will report all DTRs to PAC and External QI to obtain suggestions for improvement or further intervention	Quarterly	Health Plan Compliance Coordinator	Q1 2022
	Reports/		Q2 2022
	Meeting		Q3 2022
	Minutes/ Agenda		Q4 2022
IMCare will present to PAC and external QI to identify opportunities for improvement	Annual DTR Report / Meeting Minutes	Health Plan Compliance Coordinator	Q1 2022
IMCare will report all QOC grievances to PAC and External QI to obtain suggestions for improvement or further intervention	Quarterly	Health Plan Compliance Coordinator	Q1 2022
	Reports/		Q2 2022
	Meeting		Q3 2022
	Minutes/ Agenda		Q4 2022

IMCare will present to PAC and external QI to identify opportunities for improvement	Annual QOC Grievance Report / Meeting Minutes	Health Plan Compliance Coordinator	Q1 2022
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 2022 Q2 2022 Q3 2022 Q4 2022
IMCare will present to PAC and external QI to identify opportunities for improvement	Annual Appeals Report / Meeting Minutes	Health Plan Compliance Coordinator	Q1 2022
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

Complete

In progress

In progress

In progress

In progress

In progress

In progress

In progress

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	Q4 2022
IMCare enrollees have access to appropriate, cost-effective care	Medicaid Under and Over Utilization Report	MCN	Q4 2022

Status	Progress/Results	Date Completed

Ongoing

In progress

In progress

In progress

In progress

In progress

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 quarterly IP readmission 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	Q2 2022
To ensure that IMCare enrollees have access to safe, quality and cost-effective care	Medical claims, Case note	MCN Medical Director as needed	Q1 2022 Q2 2022 Q3 2022 Q4 2022



Status	Progress/Results	Date Completed

In progress

In progress



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2336

DEPARTMENT: Transportation

TIME REQUESTED: < 5 Minutes

PRESENTER: Kory Johnson

AGENDA ITEM:

Annual Road Maintenance Agreements with Townships and Cities

BOARD ACTION REQUESTED:

Approve the 2022/2023 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 the 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 2022/2023. 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)

04/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/26/2022 2:30 PM

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

AGREEMENT FOR WORK ON TOWNSHIP ROADS

This Agreement made this ____ day of _____, 2022, 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, 2022, 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: _____
Itasca County Highway Engineer

Date: _____

APPROVAL BY COUNTY OF ITASCA

County Board Chairperson

Date: _____

APPROVAL BY _____ TOWNSHIP

Motion

By: _____
TWP Board Member

Second

By: _____
TWP Board Member

Motion Passed:

TWP Board Chairperson

Date: _____

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

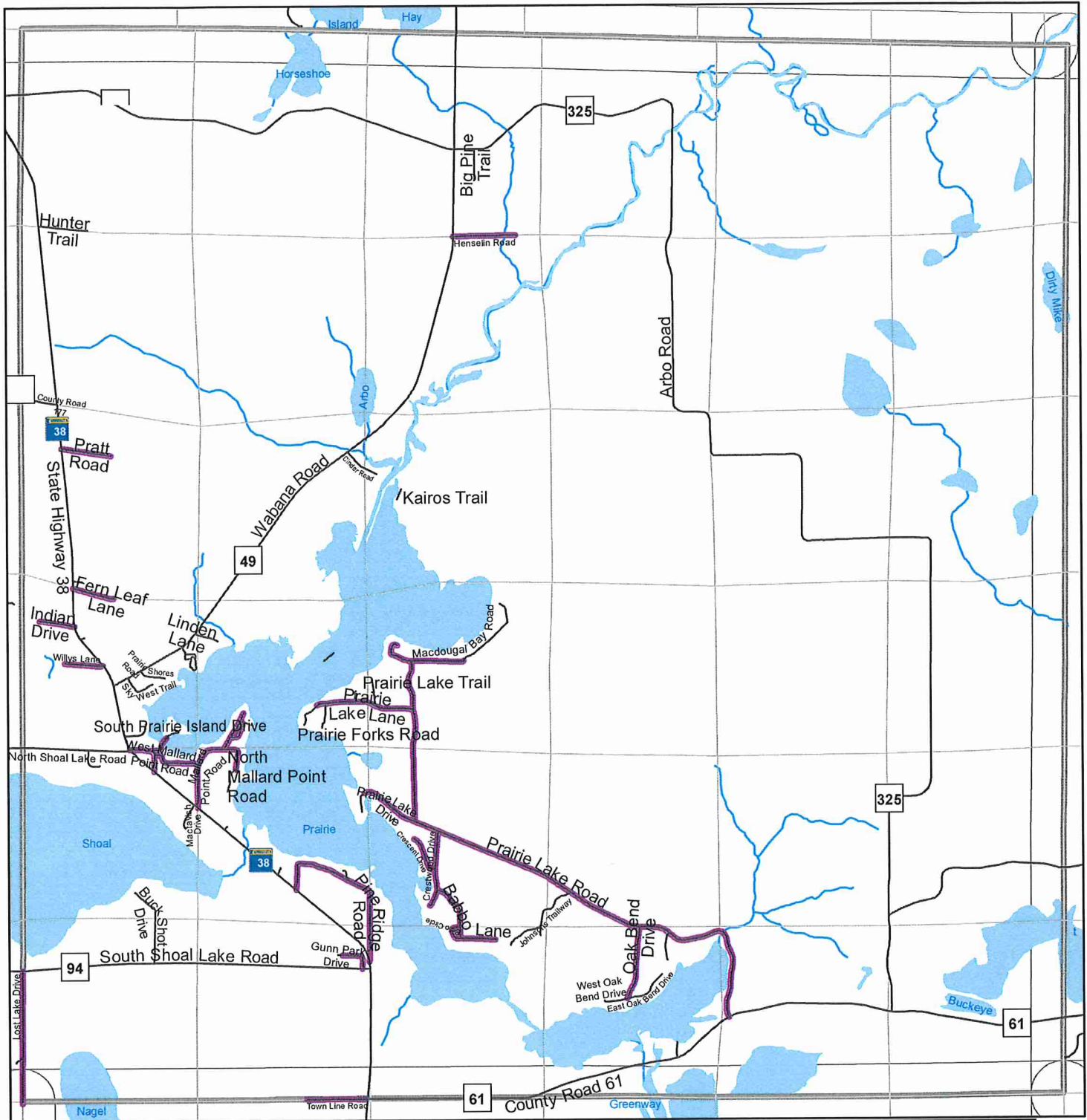
By: _____
Clerk/Deputy Clerk
Township

Your Town/Township is currently under contract with Itasca County for the services shown below. This contract expires **April 30th, 2022**. Your Town/Township must authorize continuance of this contract for the period **May 1, 2022 to April 30th, 2023**. **If there are changes, please note them in the comments section** and we will adjust new contract. Rates for 2022 Grading are: \$700/Mile for one trip per month; and \$1400/Mile for two trips per month. Rate for 2022-2023 Snowplowing is: \$700/Mile. Rate for Town Hall/Buildings is 0.25 Miles * \$700/Mile = \$175/Location Annually. **Estimated rate** for 2022 Dust Control: \$2100/Mile (18 foot width, single application). **Final rate** for 2022 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 Macdougall 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						
Totals-	11.80	2.65	0.00	11.80	0.00	last updated: March 11, 2019

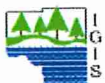
Arbo Township



Legend

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

0 0.5 1 2 Miles



Itasca Geographic Information System
"decision support through automation"

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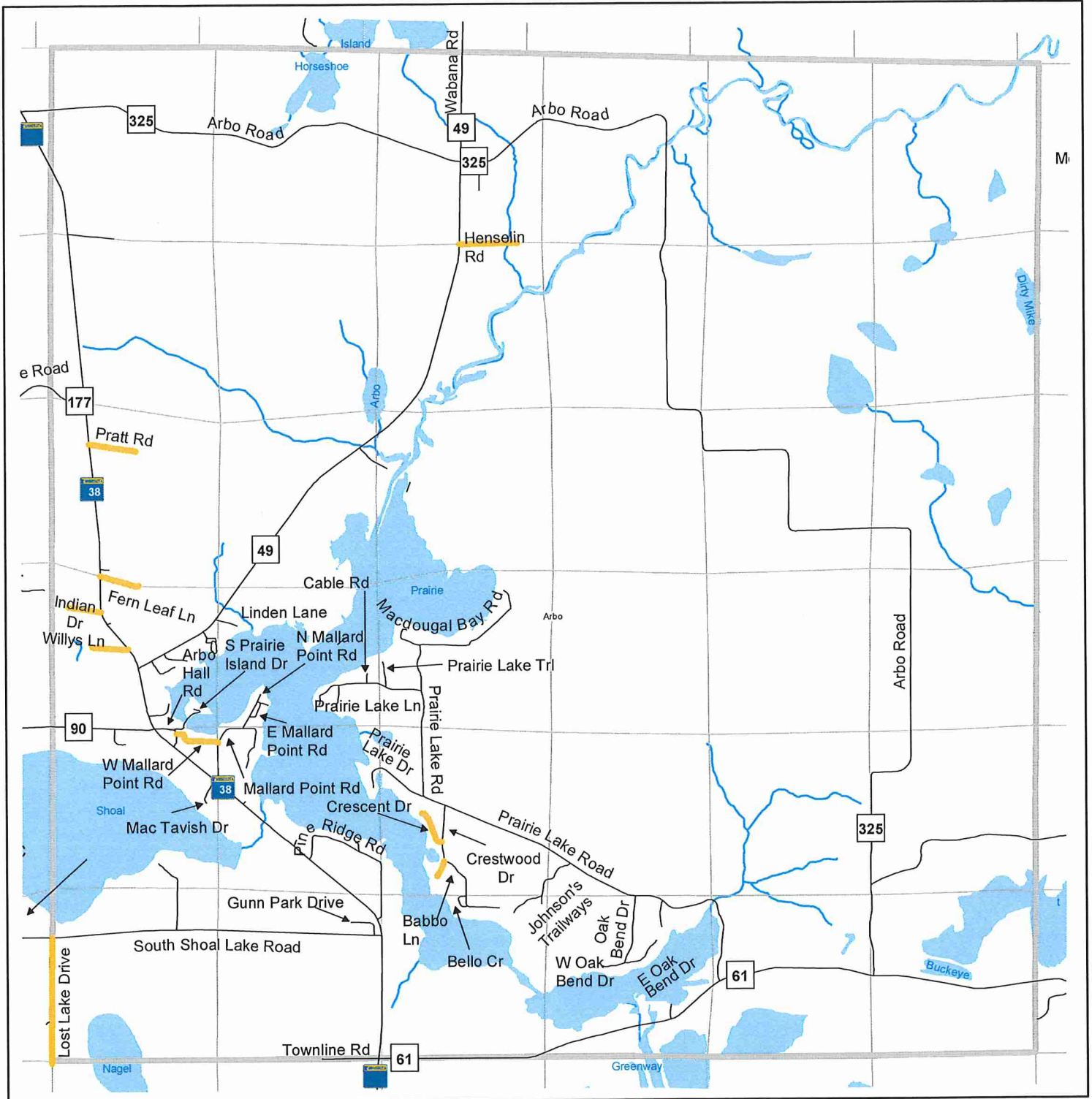
N:\MAINTENANCE\Maintenance Contracts\Twp-City Maintenance
Township Maintenance Agreement Maps\2019-2020 Maps

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



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

Arbo Township



**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"

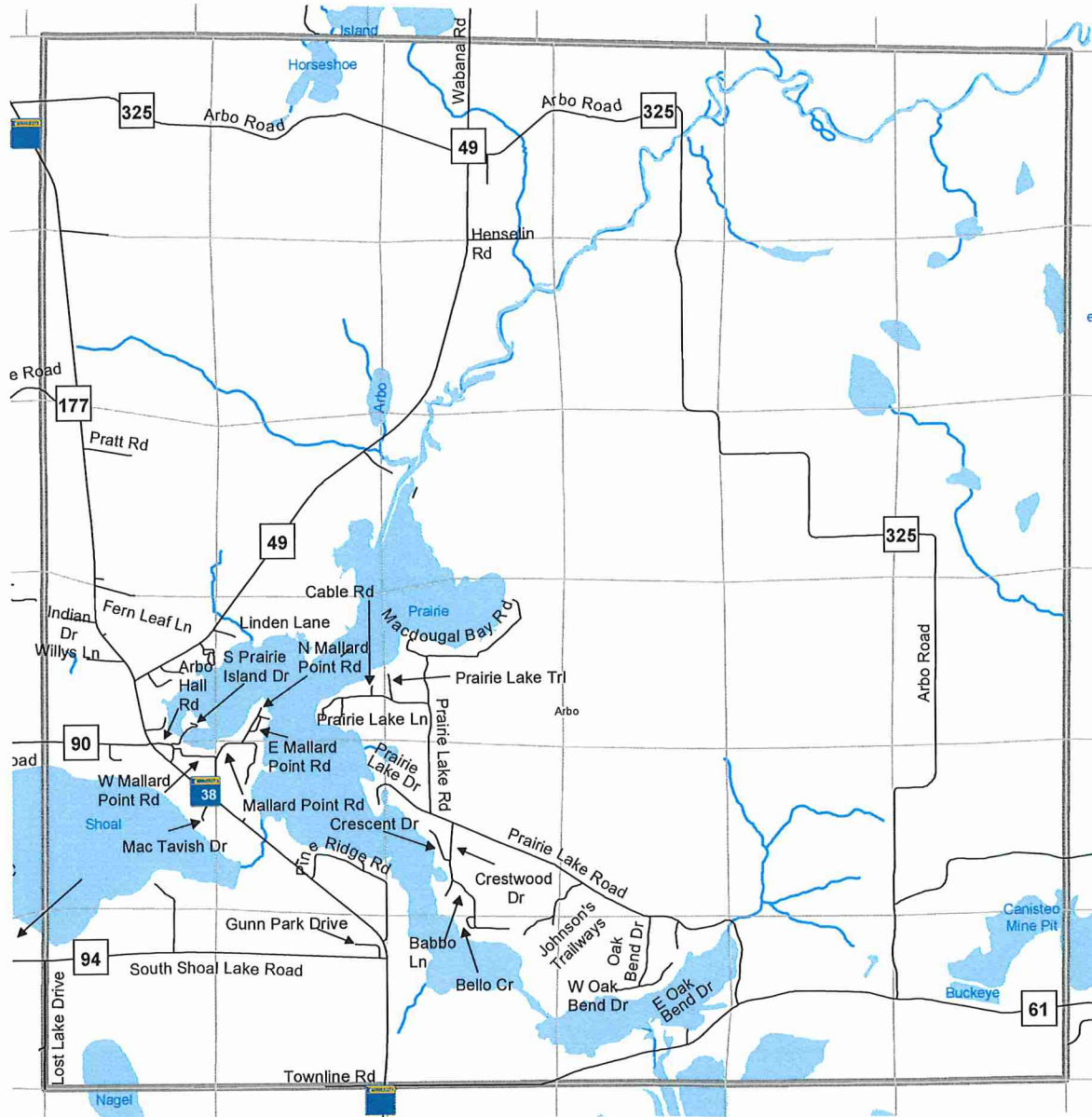
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N:\MAINTENANCE\Maintenance Contracts\Twp-City Maintenance
Township Maintenance Agreement Maps\2019-2020 Maps

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

Arbo Township



0 0.5 1 2 Miles



**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"

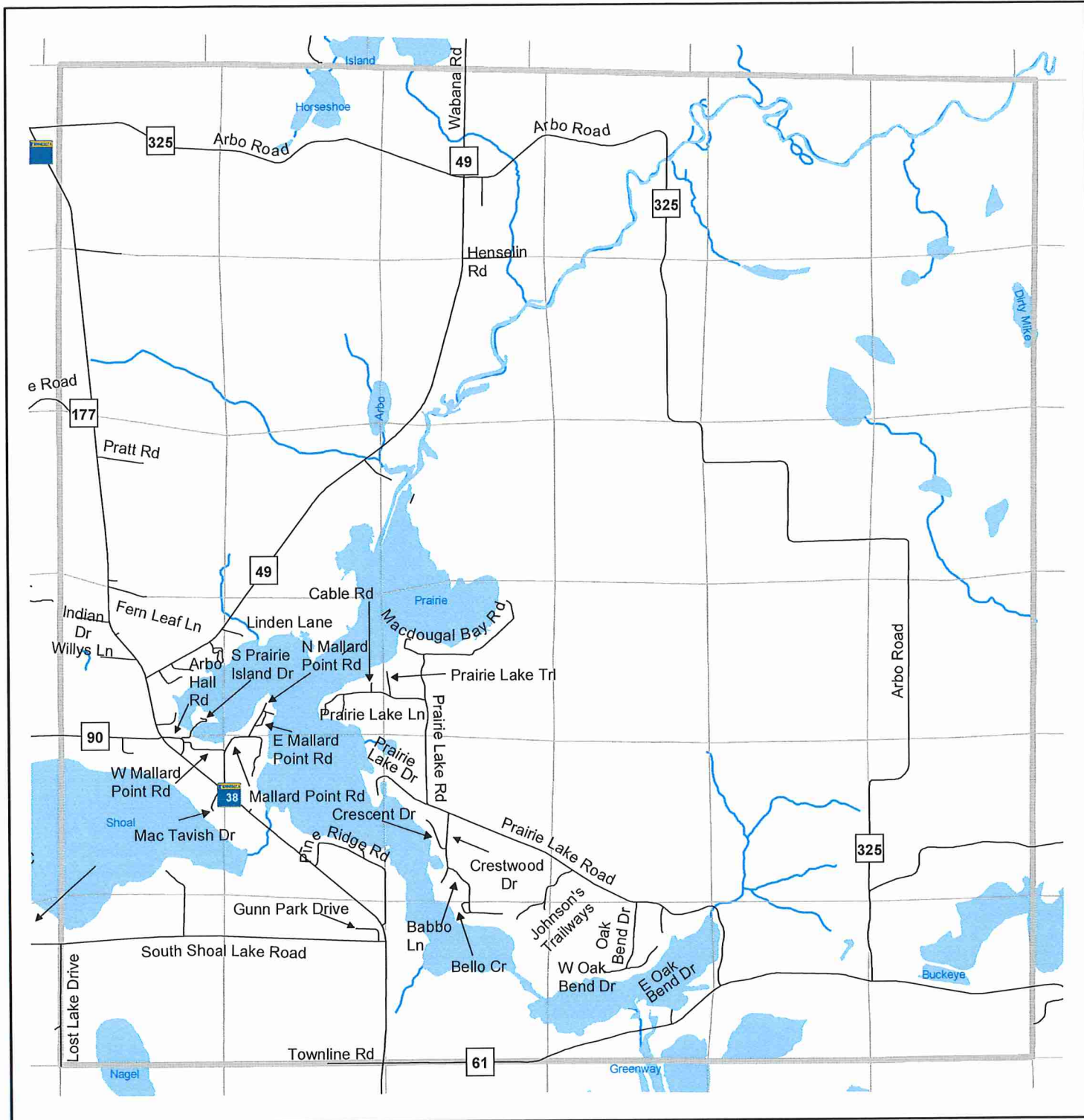
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Arbo Township



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T\Township Maintenance Agreement Maps\2019-2020 Maps

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



**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 COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2332

DEPARTMENT: Land Department

TIME REQUESTED: < 5 Minutes

PRESENTER: Kory Cease

AGENDA ITEM:

2022 Northern MN Swap Meet and Car Show Lease Agreement

BOARD ACTION REQUESTED:

Approve the 2022 Lease Agreement between Itasca County and the Northern Minnesota Swap Meet and Car Show, and authorize necessary signatures.

BACKGROUND:

The event contract layout and language used in this Lease Agreement was originally approved by the County Attorney's office (Re: CRT-4171). Proceeds will be sent to the Itasca Agricultural Association to be placed in the Fairgrounds Maintenance Fund. The security deposit will be held by Itasca County.

COUNTY ATTORNEY REVIEW: Yes and/or pending

SUPPORTING DOCUMENTATION:

1. 2022 Car Show Swap Meet Full Agreement

04/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/26/2022 2:30 PM

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

County of Itasca, Minnesota

Lease Agreement

This Agreement is made effective this 26th day of April 2022, by and between Itasca County ("Lessor"); and Northern Minnesota Swap Meet and Car Show, ("Lessee"), 1 NW 3rd Street Grand Rapids, MN 55744. 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 **August 02, 2022**. 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 **\$7,500.00** 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 **Four Thousand Eight Hundred Dollars (\$ 4,800.00)** 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, the lease-fee 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 given under this Contract 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 Lessor Land Department
c/o Land Commissioner
1177 LaPrairie Avenue
Grand Rapids, Minnesota 55744

Itasca Lessor Auditor
Lessor Courthouse
123 NE 4th Street
Grand Rapids, Minnesota 55744

Lessee

Northern Minnesota Swap Meet and Car
Show
c/o Nicole Franzone
1 NW 3rd St.
Grand Rapids, MN 55744
218 326-6619 Cell 218 360-1793

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: Northern MN swap Meet and Car Show
(Nicole Franzone)

Lessor: County of Itasca

By: _____
Its _____

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
Lease Agreement
Special Conditions Supplement

This document shall be considered the Special Conditions to the Lease Agreement between Itasca County, hereinafter referred to as “Lessor”, and Northern Minnesota Swap Meet and Car Show, hereinafter referred to as “Lessee”, which was made effective on the 26th day of April 2022.

Both Lessor and Lessee mutually agree to the following in addition to the terms contained in the Lease Agreement made effective on the 26th day of April 2022.

I. Special Terms.

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

This event will be open to the public from July 29th, 2022, through July 31st, 2022 with vendor booths, food vendors, car shows, and a beer garden. Paid Parking is required except for Mesabi Trail users. Full use of the grounds and buildings as identified in the Lease Agreement will be included.

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

1. Lessee will be responsible for providing garbage dumpsters and removal after event.
2. Lessee will be responsible for providing and maintaining additional portable restrooms.
3. Lessee will be responsible for all Parking Staff as needed.
4. Lessee will be allowed to use the Racetrack and Pit Area for additional parking, dependent on weather conditions.
5. Licensed/Permitted Activity under Section 13 “Banned Substances” of the Lease Agreement, if applicable (i.e. beer garden, etc.):
 - a. Lessee will be allowed to have a Beer Garden in accordance with the conditions set forth in the Lease Agreement.
6. Mobile Food booths will be limited to 10 mobile food booths

II. COVID-19 Addendum.

To help minimize the spread of COVID-19 within Itasca County, Lessor may need to make decisions that affect events and facilities on County property.

Lessor reserves the right to postpone or close any event pertaining to this Agreement for the protection and general welfare of the public during the Term of this Agreement. Any postponement or closer will be reduced to writing either by email or in the form of a letter. When possible, the notification will be given 24 to 48 hours in advanced but may be less if an emergency. If the Lessor postpones or cancels an event no fee will be charged for the planned event.

Lessee acknowledges there may be inherent public health risks to event staff and participants when holding this event. Lessee supports the following recommended safety practices to help reduce public health risks at the event.

1. Wearing of masks for attendees who are unvaccinated.
2. Social distancing of 6 feet between attendees from different households.
3. Minimize overall number of attendees or crowd size, limiting size of groups.
4. Manage traffic flow and prevent congregating of people at the event.
5. Avoid serving food buffet style, use single boxed foods or single server with proper PPE.
6. Have masks and hand sanitation stations available, disinfecting frequently touched surfaces.
7. Have people stay at home if sick and discourage participation of those who are at high risk.

Lessee agrees to follow all CDC and Minnesota Department of Health COVID-19 guidelines applicable at the time of the event, as well as any State of Minnesota Executive Orders applicable at the time of the event. Lessee also agrees to develop and utilize a COVID-19 Preparedness Plan for the event that is approved by the Itasca County Health and Human Services Public Health Division.

Exhibit B
Insurance Requirement

INDEMNIFICATION AND INSURANCE

- A. CONTRACTOR agrees to defend, indemnify and hold harmless COUNTY, 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 CONTRACTOR, 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 contract and against all loss by reason of failure of said CONTRACTOR to perform fully, in any respect, all obligations under this contract.
- B. CONTRACTOR 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 follows:

- a. Commercial General Liability shall list Itasca County as an additional insured with the following insurance limits:

	<u>Limits</u>
General Aggregate	\$3,000,000
Products-Completed	
Operations Aggregate	\$3,000,000
Personal and Advertising Injury	\$1,500,000
Each Occurrence:	
Combined Bodily Injury and Property Damage	\$1,500,000

- b. Automobile Liability - Combined single limit each occurrence for bodily injury and property damage covering owned, non-owned and hired automobiles
- | | |
|--|---------------|
| | <u>Limits</u> |
| | \$1,500,000 |

- c. Workers' Compensation and Employer's Liability:
- | | |
|--|---------------------|
| | Statutory
Limits |
|--|---------------------|
- If the Contractor is based outside the State of Minnesota, coverage must apply to Minnesota laws

- d. Employer's Liability
- | | |
|--------------------------|---------------|
| | <u>Limits</u> |
| Bodily injury by: | |
| Accident - Each Accident | \$500,000 |
| Disease - Policy Limit | \$500,000 |
| Disease - Each Employee | \$500,000 |

An umbrella or excess policy over primary liability coverages is an acceptable method to provide the required aggregate insurance amounts.

The above establishes minimum insurance requirements. It is the sole responsibility of CONTRACTOR to determine the need for and to procure additional coverage that may be needed in connection with this Agreement.

CONTRACTOR shall not commence work on the Site, or otherwise occupy the Site, until it has obtained required insurance and filed an acceptable Certificate of Insurance with COUNTY to the attention of Itasca County Land Department, 1177 LaPrairie Ave., Grand Rapids MN 55744 The Certificate shall:

1. List Itasca County as Certificate holder and as an additional insured with respect to operations covered under the contract for all liability coverages except Workers' Compensation and Employer's Liability and Professional Liability, if applicable; and,
 2. Be amended to show that Itasca County will receive thirty (30) days written notice in the event of cancellation, non-renewal or material change in any described policies.
- C. CONTRACTOR also agrees that any contract let by CONTRACTOR for the performance of the work on the Site as provided herein shall include clauses that will: (1) require the Contractor to defend, indemnify and hold harmless COUNTY, its elected officials, officers, agents and employees for any liability, claims, causes of action, losses, demands, damages, judgments, costs, interest, expenses (including, without limitation, reasonable attorney fees, witness fees and disbursements incurred in the defendant thereof) arising out of or by reason of the acts and/or omissions of said Contractor, its subcontractors, anyone directly or indirectly employed by them, and/or anyone for whose acts and/or omissions they may be liable for ; (2) require the Contractor to provide and maintain insurance in accordance with the following:

- a. Workers' Compensation: (Statutory Limits)

Employer's Liability Insurance:

	<u>Limits</u>
1. Bodily Injury by Accident, each accident	\$500,000
2. Bodily Injury by Disease, policy limit	\$500,000
3. Bodily Injury by Disease, each employee	\$500,000

Note: all states endorsement is required if Contractor is domiciled outside the State of Minnesota.

- b. Commercial General and Automobile Liability Insurance:

	<u>Limits</u>
1. Commercial General Liability:	
Combined Bodily Injury and Property Damage	
Each Occurrence Limit	\$1,500,000
General Aggregate Limit	\$3,000,000
Products - Completed Operations	
Aggregate Limit	\$3,000,000
Personal and Advertising Injury Limit	\$1,500,000

Coverages above shall also include:

Premises - Operations

Contractual Liability (including oral and written contracts)

Explosion, Collapse, Underground Property Damage
(XCU)

2. Automobile Liability including Hired Car and Employers Non-Ownership Liability:
Combined Bodily Injury and Property Damage:
Each Occurrence Limit \$1,500,000

The above subparagraphs establish minimum insurance requirements and it is the sole responsibility of CONTRACTOR'S Subcontractor(s) to purchase additional insurance that may be necessary for the project.

- D. **CONTRACTOR further agrees the minimum requirements set forth above shall at all times be in an amount at least equal to the maximum liability of the COUNTY under Minn. Stat. 466.04 now or as said statute is hereafter amended or as otherwise required by law, statute or rule.**
- E. In addition to any other rights contained herein the County reserves the right to terminate, suspend or rescind this contract if the Contractor is not in compliance with the requirements contained herein and retains all its rights thereafter to pursue any legal remedies against Contractor. All insurance policies shall be open to inspection by the County upon written request.



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2333

DEPARTMENT: Land Department

TIME REQUESTED: < 5 Minutes

PRESENTER: Kory Cease

AGENDA ITEM:

2022 Grand Rapids Speedway Agreement

BOARD ACTION REQUESTED:

Approve the 2022 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). 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.

COUNTY ATTORNEY REVIEW: Yes and/or Pending

SUPPORTING DOCUMENTATION:

1. 2022_Grand Rapids Speedway_Lease Agreement

04/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/26/2022 2:30 PM

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

County of Itasca, Minnesota

Lease Agreement

This Agreement is made effective this **26th day of April 2022**, 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, 2022**. 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 **\$700.00 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)

Lessor: **County of Itasca**

By: _____
Its _____

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 **26th day of April 2022**.

Both Lessor and Lessee mutually agree to the following in addition to the terms contained in the Lease Agreement made effective on the **26th day of April 2022**.

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 2022. 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, 2022 and terminating October 1st, 2022. 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

I. COVID-19 Addendum.

To help minimize the spread of COVID-19 within Itasca County, Lessor may need to make decisions that affect events and facilities on County property.

Lessor reserves the right to postpone or close any event pertaining to this Agreement for the protection and general welfare of the public during the Term of this Agreement. Any postponement or closer will be reduced to writing either by email or in the form of a letter. When possible, the notification will be given 24 to 48 hours in advanced but may be less if an emergency. If the Lessor postpones or cancels an event no fee will be charged for the planned event.

Lessee acknowledges there may be inherent public health risks to event staff and participants when holding this event. Lessee supports the following recommended safety practices to help reduce public health risks at the event.

1. Wearing of masks for attendees who are unvaccinated.
2. Social distancing of 6 feet between attendees from different households.
3. Minimize overall number of attendees or crowd size, limiting size of groups.
4. Manage traffic flow and prevent congregating of people at the event.
5. Avoid serving food buffet style, use single boxed foods or single server with proper PPE.
6. Have masks and hand sanitation stations available, disinfecting frequently touched surfaces.
7. Have people stay at home if sick and discourage participation of those who are at high risk.

Lessee agrees to follow all CDC and Minnesota Department of Health COVID-19 guidelines applicable at the time of the event, as well as any State of Minnesota Executive Orders applicable at the time of the event. Lessee also agrees to develop and utilize a COVID-19 Preparedness Plan for the event that is approved by the Itasca County Health and Human Services Public Health Division.

Exhibit B
Insurance Requirement

INDEMNIFICATION AND INSURANCE

- A. CONTRACTOR agrees to defend, indemnify and hold harmless COUNTY, 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 CONTRACTOR, 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 contract and against all loss by reason of failure of said CONTRACTOR to perform fully, in any respect, all obligations under this contract.
- B. CONTRACTOR 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 follows:

- a. Commercial General Liability shall list Itasca County as an additional insured with the following insurance limits:

	<u>Limits</u>
General Aggregate	\$3,000,000
Products-Completed	
Operations Aggregate	\$3,000,000
Personal and Advertising Injury	\$1,500,000
Each Occurrence:	
Combined Bodily Injury and Property Damage	\$1,500,000

- b. Automobile Liability - Combined single limit each occurrence for bodily injury and property damage covering owned, non-owned and hired automobiles
- | | |
|--|---------------|
| | <u>Limits</u> |
| | \$1,500,000 |

- c. Workers' Compensation and Employer's Liability:
- | | |
|--|---------------------|
| | Statutory
Limits |
|--|---------------------|
- If the Contractor is based outside the State of Minnesota, coverage must apply to Minnesota laws

- d. Employer's Liability
- | | |
|--------------------------|---------------|
| | <u>Limits</u> |
| Bodily injury by: | |
| Accident - Each Accident | \$500,000 |
| Disease - Policy Limit | \$500,000 |
| Disease - Each Employee | \$500,000 |

An umbrella or excess policy over primary liability coverages is an acceptable method to provide the required aggregate insurance amounts.

The above establishes minimum insurance requirements. It is the sole responsibility of CONTRACTOR to determine the need for and to procure additional coverage that may be needed in connection with this Agreement.

CONTRACTOR shall not commence work on the Site, or otherwise occupy the Site, until it has obtained required insurance and filed an acceptable Certificate of Insurance with COUNTY to the attention of Itasca County Land Department, 1177 LaPrairie Ave., Grand Rapids MN 55744 The Certificate shall:

1. List Itasca County as Certificate holder and as an additional insured with respect to operations covered under the contract for all liability coverages except Workers' Compensation and Employer's Liability and Professional Liability, if applicable; and,
 2. Be amended to show that Itasca County will receive thirty (30) days written notice in the event of cancellation, non-renewal or material change in any described policies.
- C. CONTRACTOR also agrees that any contract let by CONTRACTOR for the performance of the work on the Site as provided herein shall include clauses that will: (1) require the Contractor to defend, indemnify and hold harmless COUNTY, its elected officials, officers, agents and employees for any liability, claims, causes of action, losses, demands, damages, judgments, costs, interest, expenses (including, without limitation, reasonable attorney fees, witness fees and disbursements incurred in the defendant thereof) arising out of or by reason of the acts and/or omissions of said Contractor, its subcontractors, anyone directly or indirectly employed by them, and/or anyone for whose acts and/or omissions they may be liable for ; (2) require the Contractor to provide and maintain insurance in accordance with the following:

- a. Workers' Compensation: (Statutory Limits)

Employer's Liability Insurance:

	<u>Limits</u>
1. Bodily Injury by Accident, each accident	\$500,000
2. Bodily Injury by Disease, policy limit	\$500,000
3. Bodily Injury by Disease, each employee	\$500,000

Note: all states endorsement is required if Contractor is domiciled outside the State of Minnesota.

- b. Commercial General and Automobile Liability Insurance:

	<u>Limits</u>
1. Commercial General Liability:	
Combined Bodily Injury and Property Damage	
Each Occurrence Limit	\$1,500,000
General Aggregate Limit	\$3,000,000
Products - Completed Operations	
Aggregate Limit	\$3,000,000
Personal and Advertising Injury Limit	\$1,500,000

Coverages above shall also include:

Premises - Operations

Contractual Liability (including oral and written contracts)

Explosion, Collapse, Underground Property Damage
(XCU)

2. Automobile Liability including Hired Car and Employers Non-Ownership Liability:
Combined Bodily Injury and Property Damage:
Each Occurrence Limit \$1,500,000

The above subparagraphs establish minimum insurance requirements and it is the sole responsibility of CONTRACTOR'S Subcontractor(s) to purchase additional insurance that may be necessary for the project.

- D. **CONTRACTOR further agrees the minimum requirements set forth above shall at all times be in an amount at least equal to the maximum liability of the COUNTY under Minn. Stat. 466.04 now or as said statute is hereafter amended or as otherwise required by law, statute or rule.**
- E. In addition to any other rights contained herein the County reserves the right to terminate, suspend or rescind this contract if the Contractor is not in compliance with the requirements contained herein and retains all its rights thereafter to pursue any legal remedies against Contractor. All insurance policies shall be open to inspection by the County upon written request.



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2340

DEPARTMENT: Land Department

TIME REQUESTED: < 5 Minutes

PRESENTER: Michael Gibbons

AGENDA ITEM:

Notice of Oral Auction of Timber

BOARD ACTION REQUESTED:

Authorize the notice of intermediate and regular oral bid auction of timber to be given by publication in the official newspaper of the County as provided by law, and that Land Commissioner offers such tracts of timber in order in which they appear in said notice of sale, and that sale shall commence at 10:00 AM on Wednesday June 8, 2022 at Cohasset Community Center.

BACKGROUND:

Recommend for consent

COUNTY ATTORNEY REVIEW:

SUPPORTING DOCUMENTATION:

1. Notice of Intermediate and Regular Timber Auction _6-8-2022

04/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/26/2022 2:30 PM

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

NOTICE OF INTERMEDIATE AND REGULAR TIMBER AUCTION SALE

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

Pursuant to the April 26, 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 Auction at 10:00 a.m. on Wednesday, June 8, 2022, at the Cohasset Community Center, Cohasset, MN. Timber will be sold to the highest bidder at not less than the appraised value listed on the Timber Report. Bidding shall be by ORAL BID ONLY. Bid up shall be by two (or even numbered) percent 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 7, 2022.** Interested bidders are responsible to know and comply with all permit regulations and eligibility rules. 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 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.



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2341

DEPARTMENT: Land Department
PRESENTER: Kory Cease

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:
2022 Firewise Grant Application

BOARD ACTION REQUESTED:
Approve 2022 Firewise grant application, accept the grant and authorize necessary signatures if awarded.

BACKGROUND:

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:
1. Itasca County_FirewiseGrantApplication_2022_signed
2. 2022 Firewise Budget

04/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/26/2022 2:30 PM

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt



FIREWISE Community Grant Application

Application for: Mitigation within the Minnesota FireWise Community Program
Through
Northeastern Area Hazard Mitigation – Federal Assistance

Applicant

Community (Organization) applying for grant Itasca County

Community Information

Fiscal Agent: Itasca County
(Community or Organization receiving and disbursing funds)

Address: 1177 LaPrairie Ave.
Grand Rapids, MN 55744

Authorized Representative Kory Cease, Land Commissioner
(Name/Title)

Address: _____

Phone (primary): 218-327-7392

Phone (other): 218-327-2855

Email: kory.cease@co.itasca.mn.us Fax: 218-327-4160

Fire Department: _____
(If different than applicant.)

Fire Chief: _____

Other Community Contacts (Optional):

Name	Title	Phone

FIREWISE Community Grant Application (page 2)

☐ Our community is National Incident Management System (NIMS) compliant
We have a current Fire Action Plan that includes wildfire suppression and prevention. It is the:

- ☐ Yes, Itasca County CWPP County Emergency Operations Plan or CWPP (please circle).
- ☐ _____ Fire Department Emergency Operations Plan
- ☐ _____ CWPP is in the process of development.
- ☐ We would like to develop a Community Wildfire Protection Plan (CWPP) or we need assistance gaining NIMS compliance. Please contact us: phone _____.

What is the grant for?

We are applying for a FireWise Community Grant to:

The grant will further the goals of the Itasca CWPP by reducing risks from wildfire, making Itasca County a safer place to live. Itasca County is requesting funding to continue the twelfth year of the Itasca County Firewise Communities and Chipper Days programs, conducting wildfire fuels assessments and mitigation, as well as community educational activities. The Itasca County Firewise Coordinator will continue to serve as the lead for Itasca County Firewise Community activities through this grant, and continue working with communities that couldn't complete mitigation of storm damage from 2021.

Narrative summary:

1) List the assessment activities to be accomplished under this grant.

Assessment duties will continue to follow direction from Itasca CWPP, RFDs, DNR and other project partners to determine potential assessment areas. New and/or after review assessments and follow up work for individual Itasca County property owners will be done as needed and will ensure that all assessment activities conform to DNR Firewise standards. Program will encourage property owners to implement Firewise practices and participate in the Firewise Community program. Summer 2021 storm blowdown areas created exceptional challenges to several Firewise communities into 2022.

2) List the planning activities to be accomplished under this grant and describe the final product resulting from this planning effort:

Identify eligible project areas and activities for participating Firewise Community homeowner groups. Develop a timeline with neighborhood volunteers to complete authorized fuel mitigation work for individual projects, then plan and coordinate corresponding homeowner activities.

3) List and describe each mitigation activity to be accomplished under this grant:

Work with Firewise communities, Itasca County residents, homeowners, and lake associations to coordinate, organize and carry out mitigation activities. Emphasis will be placed on areas with highest wildfire risk, 2021 storm blowdown areas, those identified as needing fuel mitigation, as well as project areas that can be expanded to provide increased effectiveness of defensible spaces.

4) Describe the educational activities and products resulting from this grant:

Provide wildfire fuel reduction, home defensible space and Firewise education literature and presentations to interested organizations, community groups, and others, either identified by the Coordinator, State Firewise Specialist, or requested. COVID-19 restrictions may limit what educational activities are done and/or how they are done.

Federal funds **cannot** be used as a match for this grant.

Budget (list each activity from the narrative summary, sections 1-4, in the appropriate category)	Grant Request (\$)	Cash Match (\$)	In-Kind Match (\$)
Assessment and Planning (1 & 2) <u>Firewise Coordinator</u> <i>Coordinator will coordinate and conduct Firewise educational program goals, compile Firewise services and expense reporting, help coordinate update of CWPP, and assist with other Firewise activities where possible. Coordinator will schedule, conduct and coordinate Firewise hazardous fuel mitigation and chipper program with homeowners, services/ expense reporting and assist with other Firewise activities where possible. Mileage is included at current IRS rates for Coordinator activities.</i>	\$14,925.51	\$9,528.00	\$2,000.00 Itasca Co. Land Dept. staff and CWPP members
Mitigation Activities (3) <i>Provide fuel mitigation and equipment rental (ASV & pickup) to 30-35 (150-200 homeowners) Firewise Communities via mitigation program.</i>	\$26,669.00 Vendors and equipment rental for gathering & hauling vegetative material.	\$10,105.00 Vendors and equipment rental for gathering & hauling vegetative material.	\$94,146.00 130 Homeowners X 30 hrs. each X \$24.14 per hr. In-kind

EXHIBIT "A"

Educational Activities (4) <i>Promote Firewise program and activities through website, outreach, updating CWPP, community education to homeowner groups, lake associations, Firewise Communities, schools & educators (fire prevention week). Educate homeowners/ Firewise Communities on defensible space and property access problems. COVID restrictions may limit what and how educational materials are provided.</i>	\$4,000.00		\$4,000.00 Itasca Land Dept., Fire Departments, Sheriff's Dept., CWPP members
Totals	\$45,594.51	\$19,633.00	\$100,146.00
Total Project Cost (Add three column totals together)	\$165,373.51		

(The grant request amount must be no more than 50% of the total project cost)

SPECIAL NOTE: Applications that have activities in more than one Category (1-4 in Budget and Narrative) will receive priority, with applications that focus on mitigation activities preferred. It is understood that these preferences will not exclude applications submitted for the development of Community Wildfire Protection plans. Your Regional Firewise Specialist will work with you to make sure your grant will meet the requirements of the program.

All local governing bodies and authorities, if applicable, must approve all projects. Attach letters of approval as needed.

Estimated time it will take to complete this project? Eight (8) Month(s)
(Maximum 18 months)

Anticipated date to start this project May 15, 2022

Anticipated date the project will be finished December 31, 2022

Authorized signature: Kory Cease Digitally signed by Kory Cease
Date: 2022.04.14 10:48:46 -05'00' Date: April 14, 2022

Position: Itasca County Land Commissioner

Other signatures, as required by the community:

Authorized signature: _____ Date: _____

Position: _____

Authorized signature: _____ Date: _____

Position: _____

Return completed application to your Firewise Specialist closest to you:

Northwest Region
William "BJ" Glesener
Firewise Specialist
MN DNR – Forestry
2115 Birchmont Beach Rd.
Bemidji, MN 56601
(218) 308-2364

Northeast Region
Mimi Barzen
Program Specialist
MN DNR – Forestry
1201 E Hwy 2
Grand Rapids, MN 55744
218-327-4119

Central and Southern Region
Linda Gormanson
Firewise Specialist
MN DNR – Forestry
16543 Haven Rd
Little Falls, MN 56345
(320)616-2450 x229

FIREWISE staff only

FIREWISE Contact: _____

DNR Area: _____ Area Staff Advisor: _____

Internal Use Only:							
Speed Chart	Fund	FinDeptID	Appr. ID	Agency Cost 1	Agency Cost 2	Approved:	Date:
PC Bus. Unit	Project		Activity		Source Type		

2022 Firewise Budget

Itasca County Firewise Program

COORDINATOR	Hours	Hourly \$	Total \$	Comments
Firewise Coordinator	920	\$ 33.00	\$ 30,360.00	
Mileage			\$ 1,000.00	
TOTAL ASSESSMENT & PLANNING			\$ 31,360.00	
MITIGATION	Hours	Hourly \$	Total \$	Comments
Vendor Contract				
40 hours/week for 8 weeks	320	\$ 135.00	\$ 43,200.00	
TOTAL MITIGATION			\$ 43,200.00	
EQUIPMENT			Total \$	Comments
ASV rental	(9 weeks)		\$ 7,700.00	
Truck rental	(9 weeks)		\$ 3,974.00	
Equipment Fuel			\$ 2,500.00	
TOTAL EQUIPMENT			\$ 14,174.00	
EDUCATION			Total \$	Comments
Schools - Fire Prevention Week,				The kind of education and how it will be offered will depend on COVID restrictions
Firewise Community & Homeowner Meetings			\$ 4,000.00	
TOTAL EDUCATION			\$ 4,000.00	
2022 Firewise Program Budget:			\$ 92,734.00	

Funding Sources

<u>DNR Firewise Grant</u>	<u>2022 Budget</u>
Coordinator	\$14,925.51
Mitigation	\$18,600.00
Fuel	\$500.00
Equip. Rental	\$7,569.00
Education	\$4,000.00
Total Grant \$\$	\$45,594.51

<u>Itasca County ETF</u>	<u>2022 Budget</u>
Coordinator	\$8,528.00
Mileage	\$1,000.00
Fuel	\$2,000.00
Mitigation	\$4,000.00
Equip. Rental	\$4,105.00
Total Co. ETF \$\$	\$19,633.00

<u>County Title III Funds</u>	<u>2022 Budget</u>
Coordinator	\$6,906.49
Mitigation	\$20,600.00
Total Co. Title III \$\$	\$27,506.49

<u>Total 2022 Budget</u>	\$92,734.00

Firewise Coordinator: John Moore
(218) 244-6351
jmoorefirewise@paulbunyan.net



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2342

DEPARTMENT: Land Department

TIME REQUESTED: < 5 Minutes

PRESENTER: Kory Cease

AGENDA ITEM:

Initiate and Obligate SRS Title III County Funds (2018 & 2019)

BOARD ACTION REQUESTED:

Initiate 2018 and 2019 Secure Rural Schools Act (SRS) Title III county funds and obligate 100% of the funds for the purposes to: (1) carry out activities under the Firewise Communities program and/or (2) develop/carry out the Itasca County Community Wildfire Protection Plan. The funds can be used for these allowable Title III purposes after a 45 day public comment period and after submission of said proposal to the Itasca County SRS Resource Advisory Committee (RAC). 2018 SRS Title III funds total \$27,506.49 and 2019 SRS Title III funds total \$24,192.99.

BACKGROUND:

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

04/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/26/2022 2:30 PM

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2343

DEPARTMENT: Land Department

TIME REQUESTED: < 5 Minutes

PRESENTER: Kory Cease

AGENDA ITEM:

2022 Itasca County Firewise Coordinator Service Contract

BOARD ACTION REQUESTED:

Upon successfully being awarded the 2022 Itasca County Firewise grant, approve 2022 Itasca County Firewise Coordinator service contract to Moore Outdoor Services, LLC for \$31,360.00 and authorize necessary signatures.

BACKGROUND:

The 2022 Itasca County Firewise grant is anticipated to be awarded. However if it is not successful, the Firewise program budget will have to be adjusted, including the Firewise Coordinator budget item. In that event, an adjusted Coordinator service contract will be brought forward to the board for approval.

COUNTY ATTORNEY REVIEW:

SUPPORTING DOCUMENTATION:

1. Firewise Coordinator Contract_Moore Outdoor Services_2022
2. 2022 Firewise Budget

04/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 04/26/2022 2:30 PM

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

County of Itasca, Minnesota

Service Contract

A.1 DATES AND PARTIES

A.1.1 THIS CONTRACT, made this 26th day of April, 2022, by and between the **County of Itasca**, herein called the “County,” and **John Moore**, an individual trading as **Moore Outdoor Services LLC**, located at **38706 County Road 44, Deer River MN 56636**, herein called the “Vendor.”

B.1 AGREEMENT

B.1.1 NOW, THEREFORE, it is mutually agreed that, in consideration of the payments to be made to said Vendor, subject to the conditions, hereinafter set forth, the County shall purchase **Fire Prevention and Safety Consulting Services** from said Vendor, upon terms and at the agreed price(s), and the Vendor shall perform said services all in accordance with the specifications of County as set forth in the Special Conditions of this Agreement.

C.1 TERM OF CONTRACT

C.1.1 The term of this Contract is from **January 1, 2022 to December 31, 2022**, inclusive. The Contract may be extended if provided for in the Special Conditions.

D.1 SPECIAL CONDITIONS

D.1.1 This Contract is subject to such special conditions as are set forth in the Special Conditions Supplement attached hereto and made a part hereof.

E.1 CONTRACT AMOUNT

E.1.1 This Agreement when fully completed and fulfilled on the part of said Vendor to the satisfaction of the County or its duly authorized agent, is to be up to **\$30,360.00 for contract services** and up to **\$1000.00 for mileage expenses** to a total of up to **\$31,360.00** for the current term in the 12-month 2022 calendar year.

F.1 INCREASE

F.1.1 No increases to the above said Contract amount will be allowed to the Vendor during the term of this Contract unless provided for in the Special Conditions or mutual agreement of the parties.

G.1 PAYMENT

- G.1.1 The County does hereby agree, to pay said Vendor as services are performed to the satisfaction of the County, or its duly authorized agent as indicated in the Special Conditions. Payment terms of this Contract are Net 30.

H.1 GUARANTEE

- H.1.1 The Vendor further agrees to guarantee all materials and parts supplied under this Contract against inferiority as to specifications, such guarantee to be unconditional. Failure or neglect of the County or its designated representative to require compliance with any term or condition of this Contract or the specifications shall not be deemed a waiver of such term or condition.

I.1 BOND

- I.1.1 Minnesota Statute 574.26 requires the vendor to furnish a Performance Bond and a Labor & Materials Payment Bond in the full amount, for any contract over \$75,000, in favor of the County, to protect the County against any breach of contract. The Surety Company providing the bond must be registered to do business in the State of Minnesota and be satisfactory to the County.

J.1 INSURANCE

- J.1.1 The following insurance must be maintained for the duration of this Contract. A Certificate of Insurance for each policy which lists Itasca County as a certificate holder and as an additional insured must be on file with the Itasca County Risk Management Department within 10 days of execution of this Contract and prior to commencement of any work under this Contract. Each certificate must include a 30-day notice of cancellation, nonrenewal, or material change to all named and additional insureds.
- J.1.2 The County reserves the right to terminate, suspend or rescind any contract not in compliance with these requirements and retains all rights thereafter to pursue any legal remedies against Contractor. All insurance policies shall be open to inspection by the County, and copies of policies shall be submitted to the County upon written request. All subcontractors shall provide evidence of similar coverage.

J.1.3 General Liability Insurance

J.1.3.1

	<u>Limit</u>
General Aggregate	\$3,000,000
Products-Completed	
Operations Aggregate	\$3,000,000
Personal and Advertising Injury	\$1,500,000
Each Occurrence:	
Combined Bodily Injury and Property Damage	\$1,500,000

J.1.3.2 Policy shall contractors and subcontractors, and contractual liability.

J.1.3.3 ***Itasca County* must be named as certificate holder and an additional insured.**

J.1.4 Automobile Liability Insurance

J.1.4.1

	<u>Limit</u>
Automobile Liability - Combined single limit each occurrence for bodily injury and property damage covering owned, non-owned and hired automobiles	\$1,500,000

J.1.4.2 Must cover owned, nonowned and hired vehicles.

J.1.5 Workers' Compensation Per Statutory Requirements

J.1.5.1 Vendor must maintain statutory limits. Itasca County reserves the right to rescind any contract not in compliance with these requirements and retains all rights thereafter to pursue any legal remedies against bidder. If the Contractor is based outside the State of Minnesota, coverage must apply to Minnesota laws.

J.1.6 Employer's Liability

	<u>Limit</u>
J.1.6.1 Bodily injury by:	
Accident - Each Accident	\$500,000
Disease - Policy Limit	\$500,000
Disease - Each Employee	\$500,000

J.1.7 Professional Liability Insurance [For Professional Services Contracts Only]

J.1.6.1 Provider shall maintain at its sole expense a valid policy of insurance covering professional liability, arising from the acts or omissions of Provider, its agent and employees in the amount of not less than \$500,000 per claim and \$3,000,000 annual aggregate. (These suggested limits should be reviewed on a case by case basis)

J.1.8 Indemnification Clause

J.1.8.1 Except as may be caused by the sole negligence of the County or its employees, Contractor shall indemnify and save harmless Itasca County, its employees, and its agents from all claims, actions, demands, and judgments of any kind arising in whole or in part from any act or omission of Contractor, its subcontractors, and their agents, servants, or employees, incidental to the performance of the Contract and from all expenses in connection with such claims, actions, demands and judgments, and shall assume, without expense to the County, the defense of any such claims, actions, demands and judgments, irrespective of whether it is alleged, claimed, or proved in connection with such act or omission that negligence of the County or its representatives caused or contributed thereto.

J.1.8.2 Contractor agrees, that in order to protect itself and the County under the indemnity provisions set forth above, it will at all times during the term of this Agreement keep in force policies of insurances indicated in paragraph entitled, "INSURANCE."

J.1.8.3 This provision is not intended to create any cause of action in favor of any third party against the Contractor or the County or to enlarge in any way the Contractor's liability, but it is intended solely to provide for indemnification of the County from liability for damages or injuries to third persons or property arising from the Contractor's or the Contractor's agents' performance hereunder.

The above establishes minimum insurance requirements. It is the sole responsibility of Vendor to determine the need for and to procure additional coverage that may be needed in connection with this Agreement.

Vendor further agrees the minimum requirements set forth above shall at all times be in an amount at least equal to the maximum liability of the County under Minn. Stat. 466.04 now or as said statute is hereafter amended or as otherwise required by law, statute or rule.

K.1 UNAVOIDABLE CIRCUMSTANCES

K.1.1 The Vendor shall not be held responsible for damages caused by delay or failure to perform hereunder, when such delay or failure is due to Fires, Strikes, Acts of God, Legal acts of the public authorities, or delays or defaults caused by public carriers, or acts or demands of the Government in time of war or national emergency.

L.1 RIGHT TO TERMINATE

L.1.1 County reserves the right to terminate this Contract immediately, at any time during the contract period for failure of Vendor to perform as specified in the Special Conditions, or to the reasonable satisfaction of County, upon notification to Vendor.

M.1 ASSIGNMENT

M.1.1 Vendor shall not enter into any subcontract for performance of any services contemplated under this Contract, nor assign any part of this Contract, without the prior written approval of the County and subject to such conditions and provisions as the County may deem necessary. The Vendor shall be responsible for the performance of all subcontractors.

N.1 INDEMNIFICATION

N.1.1 Vendor shall indemnify, hold harmless and defend the County, its officers and employees against any and all liability, loss, costs, damages, expenses, claims or actions, including attorney's fees which the County, its officers or employees may hereafter sustain, incur or be required to pay, arising out of or by reason of any act or omission of Vendor, its agents, servants or employees, in the execution, performance, or failure to adequately perform Vendor's obligations pursuant to this Contract.

O.1 COMPLIANCE WITH LAWS

O.1.1 Vendor shall abide by all Federal, State and local laws, statutes, ordinances, rules and regulations now in effect or hereinafter adopted pertaining to this Contract or to the facilities, programs and staff for which Vendor is responsible.

P.1 RECORDS AUDITING AND RETENTION

P.1.1 Vendor's books, records, documents, papers, accounting procedures and practices, and other evidences relevant to this Contract 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 Contract. Vendor 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.

Q.1 WAIVER

Q.1.1 Any waiver by either party of any provision of this Contract shall not imply a subsequent waiver of that or any other provision.

R.1 MODIFICATIONS/AMENDMENT

R.1.1 Any alterations, variations, modifications, amendments or waivers of the provisions of this Contract shall only be valid when they have been reduced to writing, and signed by authorized representative of the County and Vendor.

S.1 SEVERABILITY

S.1.1 The provision of this Contract shall be deemed severable. If any part of this Contract is rendered void, invalid, or unenforceable, such rendering shall not affect the validity and enforceability of the remainder of this Contract unless the part or parts which are void, invalid or otherwise unenforceable shall substantially impair the value of the entire Contract with respect to either party.

T.1 FINAL AGREEMENT

T.1.1 This Contract 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.

U.1 EXECUTION

U.1.1 IN WITNESS WHEREOF, the County has caused this Contract to be signed by its duly authorized officers and the Vendor has hereunto set its hand.

Dated this _____ day of _____, 2022.

(Vendor Name)

John Moore
Moore Outdoor Services LLC
38706 County Road 44
Deer River, MN 56636

COUNTY OF ITASCA, MINNESOTA

By: _____
Its _____

By: _____
Its _____

By: _____
Its _____

APPROVED AS TO FORM & EXECUTION

By: _____
Itasca County Attorney

SPECIAL CONDITION SUPPLEMENT

2022 Firewise Coordinator

I. VENDOR'S DUTIES.

- A. Itasca County ("COUNTY") is contracting the professional services of Moore Outdoor Services, LLC ("VENDOR") as an independent contractor to perform the following duties for the COUNTY Firewise Program:
1. Work with Itasca County residents, homeowners, and lake associations to coordinate, organize and carry out mitigation activities in moderate to high risk areas as identified in the county wildfire protection plan.
 2. Provide a detailed reporting of costs and actions involved in the assessment, planning and development of this project, which shall be inspected by the State Firewise Specialist. Provide required grant reimbursement summaries, fulfill all grant reimbursement requirements and submit requested invoices to COUNTY for reimbursement in an accurate and timely manner.
 3. Provide Firewise literature and conduct Firewise educational training for residents within the community. Arrange open houses at surrounding fire departments focusing on Firewise mitigation opportunities following current Executive Orders, CDC and MN Department of Health COVID-19 guidelines for gatherings.
 4. Plan and coordinate work with the Department of Natural Resources and local fire department personnel to identify wildfire hazards and implement strategies and projects that will reduce wildfire risk.
 5. Conduct fire prevention presentations to interested organizations, community groups and others, either identified by the State Firewise Specialist, or requested.
 6. Work with the Department of Natural Resources to assist communities interested in becoming a recognized Firewise Community.
 7. Assist in updating and maintaining CWPP; and organizing CWPP Coordinating Committee and meetings.
 8. Provide monthly and annual reports on status updates and progress meeting Firewise position goals.
- B. The VENDOR will assist with the COUNTY Firewise 2022 Education Goals, targeting Youth Ages, Schools/ School Bus Drivers, EMS/Fire Departments, EMS/Sheriff Department and Adult Ages. The structure of these activities may be affected by COVID-19 guidelines for schools and gatherings.
- C. The VENDOR and any subcontractors agree to all provisions of the COUNTY Firewise grant agreement with the State of Minnesota.
- D. VENDOR agrees to complete and submit required Firewise grant invoices and reports for reimbursement within the grant timeline and to reconcile all program invoices between those submitted to Firewise grant and those submitted to the COUNTY.

- E. The VENDOR agrees to complete the Firewise program in accordance with the approved Firewise grant budget to the extent practicable and within the program period specified in the Firewise grant agreement.
- F. The VENDOR shall be responsible for the supervision, management, record keeping, and program oversight required for the work performed under this agreement.
- G. All services provided by the VENDOR under this grant agreement must be performed to the COUNTY's satisfaction, as determined at the discretion of the COUNTY and in accordance with all applicable federal, state, and local laws, ordinances, rules, and regulations.
- H. The VENDOR must comply with all the time requirements described in the Firewise grant agreement.
- I. Throughout the term of this agreement, the VENDOR shall monitor and report any actual, potential, or perceived conflicts of interest in the Firewise program to the COUNTY.

II. PAYMENTS.

- A. The COUNTY shall disburse funds to the VENDOR pursuant to this agreement on a reimbursement basis. The VENDOR shall submit invoices with expenditure documentation required by the COUNTY. Any and all compensation shall be subject to the availability of grant funding.
- B.
- C. VENDOR agrees to submit biweekly invoices to the COUNTY with associated professional service charges and documentation at a pay rate of \$33.00/hour.
- D. VENDOR agrees to submit biweekly invoices to the COUNTY for associated mileage charges and documentation at current IRS rate.
- E. VENDOR understands that funds made available pursuant to this agreement shall be used only for expenses incurred in performing and accomplishing the purposes and activities specified in this service agreement and the Firewise grant agreement.
- F. If necessary, advance payment on required services shall be negotiated between the COUNTY and VENDOR on a case by case basis. In order to make advance payments, the VENDOR must prepare and submit a written justification to the COUNTY for approval that details the specific need to utilize advance payment.
- G. The VENDOR agrees to comply with all federal requirements imposed on the Firewise grant funds.
- H. The VENDOR will not receive payment for work found by the COUNTY to be unsatisfactory or performed in violation of federal, state, or local law.

III. SUBCONTRACTORS, CONTRACTS, BIDDING AND AUDITS.

- A. VENDOR must follow all applicable Subcontractors, Contracts and Bidding requirements outlined in the Firewise grant agreement for any supplies, materials, equipment, or the rental thereof, or the construction, alteration, repair, or maintenance of real or personal property.
- B. VENDOR agrees to provide all temporary laborers for Firewise project related activities.
- C. VENDOR agrees to ensure and verify that all Firewise program service providers and subcontractors meet all applicable minimum COUNTY insurance and indemnification requirements.
- D. The VENDOR's books, records, documents, and accounting procedures and practices relevant to this grant agreement are subject to examination by the COUNTY, State and/or the State Auditor or Legislative Auditor, as appropriate, for a minimum of six years from the end of the Firewise grant agreement.

IV. DATA PRACTICES AND INTELLECTUAL PROPERTY.

- A. The VENDOR must comply with the Minnesota Government Data Practices Act as it applies to all data provided by the State or COUNTY under the Firewise grant agreement, and as it applies to all data created, collected, received, stored, used, maintained, or disseminated by the VENDOR under the Firewise grant agreement.
- B. The VENDOR must immediately notify the COUNTY if the VENDOR receives a request to release the data referred to in this clause.
- C. VENDOR understands that the State of Minnesota owns any intellectual property developed with funds under the Firewise grant agreement.

V. MONITORING.

- A. The COUNTY shall be allowed at any time to conduct periodic site visits and inspections to ensure work progress in accordance with this agreement.

VI. INVASIVE SPECIES AND POLLINATORS.

- A. VENDOR is required to take active steps in preventing or limiting the introduction, establishment, and spread of invasive species during contracted Firewise work.
- B. VENDOR agrees to ensure an appropriate diversity of native species to provide habitat for pollinators through the growing season in all Firewise activities, practices and guidelines.

VII. WHISTLEBLOWER RIGHTS.

- A. The VENDOR and any subcontractors working under the Firewise grant agreement will be subject to all applicable whistleblower rights and remedies.

2022 Firewise Budget

Itasca County Firewise Program

COORDINATOR	Hours	Hourly \$	Total \$	Comments
Firewise Coordinator	920	\$ 33.00	\$ 30,360.00	
Mileage			\$ 1,000.00	
TOTAL ASSESSMENT & PLANNING			\$ 31,360.00	
MITIGATION	Hours	Hourly \$	Total \$	Comments
Vendor Contract				
40 hours/week for 8 weeks	320	\$ 135.00	\$ 43,200.00	
TOTAL MITIGATION			\$ 43,200.00	
EQUIPMENT			Total \$	Comments
ASV rental	(9 weeks)		\$ 7,700.00	
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Equipment Fuel			\$ 2,500.00	
TOTAL EQUIPMENT			\$ 14,174.00	
EDUCATION			Total \$	Comments
Schools - Fire Prevention Week,				The kind of education and how it will be offered will depend on COVID restrictions
Firewise Community & Homeowner Meetings			\$ 4,000.00	
TOTAL EDUCATION			\$ 4,000.00	
2022 Firewise Program Budget:			\$ 92,734.00	

Funding Sources

<u>DNR Firewise Grant</u>	<u>2022 Budget</u>
Coordinator	\$14,925.51
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Fuel	\$500.00
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<u>Itasca County ETF</u>	<u>2022 Budget</u>
Coordinator	\$8,528.00
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Total Co. ETF \$\$	\$19,633.00

<u>County Title III Funds</u>	<u>2022 Budget</u>
Coordinator	\$6,906.49
Mitigation	\$20,600.00
Total Co. Title III \$\$	\$27,506.49

Total 2022 Budget	\$92,734.00

Firewise Coordinator: John Moore
(218) 244-6351
jmoorefirewise@paulbunyan.net



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-1987

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 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2350

DEPARTMENT: Administrative Services

PRESENTER: Loren Solberg

TIME REQUESTED: 15 Minutes

AGENDA ITEM:

Legislative Conference Call

BOARD ACTION REQUESTED:

Hold a Legislative Conference Call with Itasca County delegation and Lobbyist Loren Solberg.

BACKGROUND:

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:

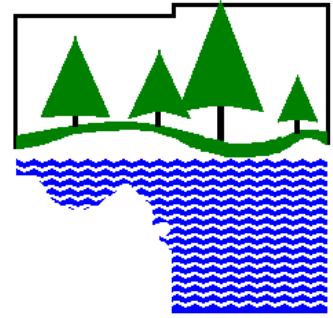
1. 2022 Legislative Priorities FINAL

RESULT:

INFORMATIONAL - NO ACTION TAKEN

ITASCA COUNTY

Courthouse
Administrative Services
123 NE 4th Street
Grand Rapids, MN 55744-2600
Office (218) 327-7363 Fax (218) 327-2848



Itasca County 2022 Legislative Priorities

- Canisteo Mine Pit – Dewatering efforts
- Hwy 169 – Support efforts for double lane completion
- Increased PILT reimbursement
- Fully fund Probation Officers Reimbursement according to M.S.A. 244.19. Reimbursement to Itasca County should be 50% of salary costs, currently at 30%.
- Short-term Rentals: VRBO's/Air B&B – State reform is needed.
- Hill Annex Mine – Support efforts to keep this open
- State property tax assessed asset valuations cases – aid for Counties in back payments and future liabilities.
- Anoka Regional Treatment Center cost shift to Counties: DHS did add the ability for the County to Appeal but DHS specifically states that the appeal cannot be on the determination that it is clinically appropriate for a client to be discharged – which completely defeats the reason for the appeal process. We will still get a \$40,000 per month bill on these clients with no appeal process – or any reimbursement mechanism.
- Keeping value-based reimbursement in place without reducing the rates – essential for Skilled Nursing Facilities who have made investments in staff and resources expecting the value-based reimbursement to continue.
- Appropriate reimbursement on ICWA funding based on costs and utilization.
- Require DHS to follow state statute regarding Medicaid/Medicare Advantage/Special Needs Basic Care Procurement processes.
- Place moratorium on cervid farms and transport.



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2144

DEPARTMENT: Auditor / Treasurer

TIME REQUESTED: < 5 Minutes

PRESENTER: Gail Guck

AGENDA ITEM:

Commissioner Warrants

BOARD ACTION REQUESTED:

Approve Commissioner Warrants with a check date of April 29, 2022, in the amount of \$3,014,721.38.

BACKGROUND:

N/A

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Burl Ives
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2122

DEPARTMENT: Health & Human Services

TIME REQUESTED: < 5 Minutes

PRESENTER: Christine Krebs

AGENDA ITEM:

ICHHS Warrants

BOARD ACTION REQUESTED:

Approve the Itasca County Health and Human Services (ICHHS) Department Warrants for April 2022, in the amount of \$2,153,083.61.

BACKGROUND:

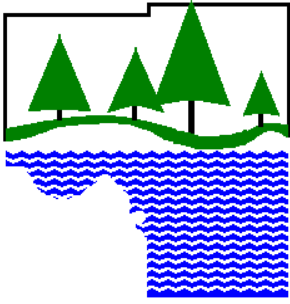
N/A

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:

1. ICHHS Warrants - April 2022

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt



ITASCA COUNTY HEALTH AND HUMAN SERVICES

ITASCA RESOURCE CENTER

1209 SE 2nd Avenue, Grand Rapids, MN 55744

Hearing Impaired Number TDD: 218-327-5549

218-327-2941

Visit us at : www.co.itasca.mn.us

April 2022

Income Maint/Admin Payments	\$ 189,065.94
Social Services - Waivers	\$ 11,512.01
Social Services - Non-Waivers	\$ 512,731.33
Foster Care/Out of Home/FamilySupport	\$ 552,814.60
Relative Custoday/Preventive Placement Costs/Incidentals	\$ 15,799.38
Public Health	\$ 54,147.99
Community Health Board	\$ 817,012.36
Total	\$ 2,153,083.61

Note : The above is a general description of payments made during the month indicated and is not intended to be a detailed itemization. The Community Health Board does not affect the Health & Human Services budget or levy.

March 2022
Out of Home Placement Breakdown

Foster Care/Out-of-Home/Family Support Comparison					
	Actual 2022	Actual 2021	Actual 2020	Actual 2019	Actual 2018
January	433,150.76	375,450.87	459,792.92	304,901.00	403,335.16
February	348,631.48	276,036.33	591,619.05	395,125.46	317,598.86
March	390,198.68	470,336.10	503,054.15	481,292.60	401,231.62
April	552,814.60	327,746.28	447,083.94	369,984.89	486,982.25
May		435,540.15	533,038.47	431,360.66	326,329.84
June		453,742.31	382,221.73	511,262.03	511,990.80
July		295,647.79	361,553.69	374,861.55	345,911.09
August		406,809.83	324,126.58	553,349.32	420,305.34
September		351,501.34	388,223.65	454,942.93	346,840.99
October		253,884.89	482,584.01	535,920.86	505,385.69
November		424,163.31	397,425.90	420,910.89	379,374.21
December		280,089.95	351,799.88	222,554.78	410,475.92
Total	1,724,795.52	4,350,949.15	5,222,523.97	5,056,466.97	4,855,761.77

Child Protection Statistics					
	Maltreatment Reports	Opened for Assessment	% Opened	Children Placed	% Placed of Open
January	44	27	61%	5	19%
February	52	21	40%	4	19%
March	42	21	50%	9	43%
April	56	32	57%	14	44%
May			#DIV/0!		#DIV/0!
June			#DIV/0!		#DIV/0!
July			#DIV/0!		#DIV/0!
August			#DIV/0!		#DIV/0!
September			#DIV/0!		#DIV/0!
October			#DIV/0!		#DIV/0!
November			#DIV/0!		#DIV/0!
December			#DIV/0!		#DIV/0!
	194	101	#DIV/0!	32	#DIV/0!
	average			average	

April 2022
Out of Home Placement Payments by Vendor

		Rate	Invoices Paid
Northwestern MN Juvenile	-	\$200-\$340/day	\$ 151,774
North Homes	-	\$175 - \$365/day	\$ 97,171
Northwood	-	\$294-\$331/day	\$ 61,465
The Bridge Residential Facility	-	\$250/day	\$ 51,500
Snyders/Foundation for Life	-	\$122/day	\$ 32,257
Go Forward Group Home	-	\$245/day	\$ 22,785
Heartland Girls Ranch	-	\$249 - \$316/day	\$ 14,621
Volunteers of America	-		\$ 14,000
Village Ranch	-	\$175 - \$231/day	\$ 6,065
Northstar	-	\$128/day	\$ 5,291
Lutheran Social Services	-	\$148-\$194/day	\$ 2,698
West Central Juvenile Center	-	\$334/day	\$ 2,140
MCF - Redwing	-	\$215/day	\$ 245
Anoka County Juvenile Center	-	\$226 - \$282/day	\$ -
Arrowhead Juvenile Center	-	\$250/day	\$ -
Bar None	-	\$475/day	\$ -
Dakota County Juvenile Serv	-	\$325 - \$340/day	\$ -
Fond Du Lac Foster Care	-		\$ -
Itaskin Juvenile Center	-	\$175 - \$328/day	\$ -
Kidspeace Corp	-	\$266/day	\$ -
Kindred Family Focus	-		\$ -
Lighthouse	-	\$128/day	\$ -
Little Sand Group Home	-	\$240/day	\$ -
Mille Lacs Academy	-	\$334 - \$403/day	\$ -
MN Dept of Corrections	-	\$269/day	\$ -
New Trails Group Home	-	\$242/day	\$ -
Pathfinders Children Treat	-	\$106/day	\$ -
Peace House	-	\$115/day	\$ -
Port Group Homes	-	\$178/day	\$ -
Prairie Lakes Youth Program	-	\$209 - \$239/day	\$ -
Serenity Christian Homes	-	\$256.69/day	\$ -
St Cloud Children's Home	-	\$221/day	\$ -
Woodland Hills	-	\$152 - \$331/day	\$ -
Individuals*	-	\$21 - \$121/day	\$ 90,803
Total			\$ 552,814

*Individuals : Includes Foster Care & Family Support Programs



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2316

DEPARTMENT: Human Resources

PRESENTER: Lynn Hart

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:

2022-2024 Labor Agreement AEA

BOARD ACTION REQUESTED:

Approve and authorize necessary signatures for the 2022-2024 Labor Agreement for Itasca County Attorney Employees Association (AEA) which represents Attorneys.

BACKGROUND:

The labor agreement committee has been negotiating the 2022-2024 collective bargaining agreement with AEA. This collective bargaining agreement has been voted on and approved by the AEA and the labor management committee recommends approval by the County Board.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:

1. AEA 2022-2024 draft contract

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

AGREEMENT
between the
COUNTY OF ITASCA
and the
ITASCA COUNTY ATTORNEY
EMPLOYEES' ASSOCIATION

JANUARY 1, 2022 - DECEMBER 31, 2024

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1
**Agreement
between the

County of Itasca

and the

Itasca County Attorney Employees Association**

PREAMBLE

It is the policy of this Agreement to promote orderly and constructive relationships between Itasca County and the Itasca County Attorney Employees Association, subject however, to the paramount rights of the citizens of this state to keep inviolate the guarantees for their health, education, safety and welfare.

The relationships between the public, Itasca County Attorney Employees Association and Itasca County imply degrees of responsibility to the people served, need of cooperation and employment protection which are different from employment in the private sector. So also the essentiality and public desire for some public services tend to create imbalances in relative bargaining power or the resolution with which either party to a disagreement presses its position, so that unique approaches to negotiations and resolutions of disputes between Itasca County Attorney Employees Association and Itasca County are necessary.

Unresolved disputes between Itasca County and the Itasca County Attorney Employees Association are injurious to the public as well as to the parties; adequate means must therefore be established for minimizing them and providing for their resolution. Within the foregoing limitations and considerations, Itasca County has determined that overall policy may best be accomplished by: (1) granting to Itasca County Attorney Employees Association certain rights to organize and choose freely their representatives; (2) requiring Itasca County to meet and negotiate with the Itasca County Attorney Employees Association and providing for written agreements evidencing the result of such bargaining; and (3) establishing special rights, responsibilities, procedures and limitations regarding public employment relationship which will provide for the protection of the rights of the Itasca County Attorney Employees Association, Itasca County, and the public at large.

Itasca County recognizes the Itasca County Attorney Employees Association, as professional employees, possess knowledge, expertise, and dedication which is helpful and necessary to the operation and quality of public services and which may assist Itasca County in developing their policies. It is, therefore, the policy of Itasca County to encourage close cooperation between itself and Itasca County Attorney Employees Association by providing for discussions and the mutual exchange of ideas regarding all matters.

ARTICLE 1. PURPOSE OF AGREEMENT

1.1 This document represents an Agreement entered into between the County of Itasca, hereinafter called the “Employer,” and the Itasca County Attorney Employees Association, hereinafter called the “Association.” The intent and purpose of this proposal is to:

- A. Express in written form an Agreement between the parties on hours, wages and other conditions of employment and to specify the duration of this Agreement;
- B. Establish orderly procedures for the resolution of disputes concerning the interpretation or application of the provisions to be set forth in this Agreement;
- C. Specify the full and complete understanding of the parties;
- D. Maintain, improve and promote greater individual productivity and quality of services;
- E. Insure against any interruptions of work and interference with the efficient and effective rendering of service to the public.

Except as expressly stated herein, the parties recognize that this Agreement is not intended to modify any of the authority vested in the County of Itasca or the Itasca County Attorney by the statutes and laws of the State of Minnesota.

ARTICLE 2. RECOGNITION

2.1 The Employer recognizes the Association as the exclusive representative, as defined under Minn. Stat. Sec. 179A.01 - 179A.30, as amended, commonly known as the

Public Employment Labor Relations Act of 1971, for a unit of Itasca County employees who are Assistant County Attorneys of the County of Itasca, Grand Rapids, Minnesota, who are public employees within the meaning of Minn. Stat. 179A.03. The Assistant Itasca County Attorneys are “essential employees” as provided in Minn. Stat. Sec. 179A.03, subd. 7.

- 2.2 The Association recognizes the County Board or its designee, as the exclusive representative of the Employer and shall meet and negotiate exclusively with such representative, except as may be otherwise specifically provided in this Agreement. No Agreement covering terms and conditions of employment or other matters made between the Association and the Employer shall be binding upon the Employer unless the signature of the Employer's designated exclusive representative is affixed thereon.
- 2.3 The Employer agrees not to enter into any Agreements covering terms of employment with members of the bargaining unit under jurisdiction of this Agreement either individually or collectively which in any way conflicts with the terms and conditions set forth in this Agreement, except through the certified representative.

ARTICLE 3. DEFINITIONS

- 3.1 The following terms used in this Agreement shall be defined as follows:
 - A. Base Pay Rate: The employee's basic hourly or monthly or annual pay rate exclusive of longevity or any other special allowances.
 - B. Employee: A member of the exclusively recognized bargaining unit as defined in the Article herein entitled “Recognition” who has been employed on the basis of permanent appointment to a continuing position, including both full-time and part-time employees as defined here:
 - Regular full-time: an employee who works a normal work week and was hired for a service duration in excess of six months and has successfully completed his/her probationary period.
 - Regular part-time: an employee who works less than the normal work week, was hired for a service duration in excess of six months, and has successfully completed his/her probationary period.
 - C. Employer: County of Itasca and its designated representatives.

- D. Grievance: A dispute or disagreement as to the interpretation or application of this Agreement.
- E. Leave of Absence: As defined in this Agreement.
- F. Permanent Employee: A member of the exclusively recognized bargaining unit as defined in the Article herein entitled "Recognition" who has completed the probationary period for newly employed or reinstated employees.
- G. Probationary Period: Every person appointed to a regular position in this bargaining unit shall be required to successfully complete a probationary period. The probationary period shall begin immediately upon appointment. The probationary period shall be 12 months. During the probationary period the supervisor must provide feedback to the employees regarding performance. An employee's probation may be extended only for non-performance related reasons for an additional period of 10 days, not to exceed 3 months. The County Attorney may at his/her discretion terminate an employee during the probationary period and the termination shall not be subject to the grievance procedure nor be deemed a breach of this Agreement.
- H. Regular Hours: As defined in this Agreement.
- I. Reinstatement: Reemployment of a former, permanent or probationary employee in the work classification to which he/she was assigned prior to termination.
- J. Association: The Itasca County Attorney Employees Association.
- K. Association Member: A member of the Itasca County Attorney Employees Association.
- L. Current: Shall mean the present time period such as hour, day, month and year.
- M. Retire: "Retire" means an employee who leaves Itasca County service when the employee is eligible for a PERA retirement annuity and who has had at least 10 years of service with Itasca County. It is not necessary that the employee will immediately receive a PERA annuity. Severance benefits are not affected by this Paragraph.

ARTICLE 4. ASSOCIATION SECURITY

- 4.1 In recognition of the Association as the exclusive representative, the Employer shall:
- A. Pursuant to Minn. Stat. c. 179A, deduct an amount sufficient to provide the payment of regular dues established by the Association from the wages of all Association members authorizing, in writing, such deduction in a form mutually agreed upon by the Employer and the Association.
 - B. Remit such deductions to the appropriate designated officer of the Association with a list of the names of the employees from whose wages deductions were made.
 - C. The Association shall certify to the Employer, in writing, the current amount of regular dues to be withheld.
 - D. Such dues deductions shall be cancelled by the Employer upon written request by the employee.
- 4.2 All employees who are not members of the exclusive representative may be required by said exclusive representative to contribute a fair share fee for services rendered by the exclusive representative in an amount equal to the regular membership dues of the exclusive representative, less the cost of benefits financed through the dues and available only to members of the exclusive representative, but in no event shall the fee exceed 85 percent of the regular membership dues. The exclusive representative shall provide advance written notice of the amount of the fair share fee assessment to the director, the Employer and to a list furnished by the Employer of all employees in the unit. A challenge by an employee or by a person aggrieved by the assessment shall be filed in writing with the director, the public Employer and the exclusive representative within 30 days after receipt of the written notice. All challenges shall specify those portions of the assessment challenged and the reasons therefor, but the burden of proof relating to the amount of the fair share fee shall be on the exclusive representative. The Employer shall deduct the fee from the earnings of the employee and transfer the fee to the exclusive representative 30 days after the written notice was provided, or, in the event a challenge is filed, the deductions for a fair share fee shall be held in escrow by the Employer pending a decision by the director pursuant to Section 3 of the Act.

The Union agrees to indemnify and hold the Employer harmless against any and all claims, suit, orders or judgments brought or issued against the Employer as a result of action taken by the Employer under all provisions of this Article.

- 4.3 Official representatives of the Association who have been certified to the Employer may come on the premises of the Employer for the purpose of investigating and presenting grievances by obtaining prior approval from the Employer or the Employer's designated representative.

ARTICLE 5. EMPLOYER AUTHORITY

- 5.1 It is recognized by both parties that except as expressly stated herein the Employer and the Itasca County Attorney shall retain whatever rights and authority necessary for them to operate and direct the affairs of the County in all of its various aspects including, but not limited to, the right to direct the working force; to plan, direct and control all of the operations and services of the department; to determine the methods, means, organization and number of personnel by which such operations and services are to be conducted; to contract with vendors for goods or services; to assign and transfer employees; to schedule working hours and to assign overtime; to hire, promote, demote, suspend, discipline, discharge or relieve employees; to make and enforce rules and regulations and to change or eliminate existing methods, equipment or facilities. It is also recognized by both parties that the Employer and the Itasca County Attorney shall retain the sole authority and prerogatives to:

- A. Operate and manage County affairs in all respects in accordance with existing laws and regulations of appropriate authorities including personnel policies and work rules.
- B. Maintain and improve the efficiency of government operations.
- C. Take whatever actions may be necessary to carry out the missions of the County to perform those acts required to protect property and the health, safety or welfare of the individuals, notwithstanding the provision of this Agreement.

ARTICLE 6. GRIEVANCE PROCEDURE

- 6.1 A grievance shall be defined as a dispute or disagreement raised by an employee against the Employer involving the interpretation or application of the specific provisions of this Agreement.
- 6.2 It is specifically understood that any matters governed by statutory provisions, County personnel rules or departmental personnel rules, except as expressly provided for in this Agreement, shall not be considered grievances under this Agreement and will not be subject to the grievance procedure herein set forth. The filing of a grievance and or seeking of remedy within or outside of the provisions of this Agreement shall serve as a bar from seeking resolution and/or remedy through any other means.
- 6.3a. Association Representatives: The Employer will recognize an Association Steward as the grievance representative of the bargaining unit having the duties and responsibilities established by this Article. The Association shall notify the Employer, in writing, of the names of such Steward or successor when so designated.
- 6.3b. Processing of a Grievance: It is recognized and accepted by the Association and the Employer that the time for processing of grievances as hereinafter provided is limited by the job duties and responsibilities of the Steward and/or aggrieved employee and shall, therefore, be accomplished during normal working hours only when consistent with such employee duties and responsibilities. Grievance processing meetings with management should be limited to 1 hour, arranged at a time mutually agreeable to both parties. The aggrieved employee and a Steward shall be allowed a reasonable amount of time without loss in pay when a grievance is investigated and presented to the Employer during normal working hours, provided that the aggrieved employee and the Steward have notified and received the approval of the designated supervisor or Department Head as to time and place of grievance meeting. Each Department Head shall designate an alternate who shall be the Department Head replacement in any circumstances required by the contract.
- 6.4 Procedure: Grievances, as defined in Section 1 of this Article, shall be resolved in conformance with the following procedure:

Step 1. The grievance will be presented in writing, signed by the grievated employee and the grievance representative.

Grievance Processing Timetable: Written grievance presented in person by grievated employee and grievance representative to the Department Head within 7 working days of grievated employee's first knowledge of occurrence.

Department Head has 10 working days from grievance presentation to respond, in writing, to the grieved employee, copy to the grievance representative and the President of the Association.

Initial grievance processing meeting involving Department Head, grieved employee and grievance representative is mandatory. Additional meetings prior to management response are at mutual agreement of both parties.

Step 2. Association has option to move grievance to Step 2 by presentation of the original written grievance and a detailed reply to the response of the Department Head indicating the reasons for which the management response is not acceptable.

Grievance Processing Timetable: Within 10 working days from receipt of management Step 1 response, the Association must communicate a written response, signed by the grieved employee and the grievance representative directing the grievance to the Department Head. Management must direct a written reply, signed by the Department Head, within 10 working days from receipt of the Association's Step 2 written grievance.

A grievance processing meeting to involve the grievance representative, Department Head and County Human Resources Director may be requested, in writing, by either the Department Head or employee representative and scheduled with the agreement of both parties. Such meeting to be scheduled within the period for management response, if at all possible.

Step 3. Association may move grievances to Step 3 at its option via presentation of written documentation to include: the original grievance, all written documentation relating to processing of the grievance of Steps 1 and 2 and a detailed reply to the Step 2 response of the Department Head indicating reasons why the response is unacceptable.

Grievance Processing Timetable: Within 10 working days from receipt of management's Step 2 response, the Association must communicate a written response, signed by the grieved employee and the grievance representative directing the grievance to the Chairman of the County Board or its designee. The County Board or its designee shall direct a written reply within a time period not to exceed 2 regular, scheduled meetings of the County Board, plus 5 working days.

Within the above time period, the grievance shall be heard by the Board or its designee at a meeting involving the grievant and a grievance representative of the Association.

Step 4. Within 10 working days from the receipt of management's Step 3 response grievance unresolved in Step 3 and appealed to Step 4 by the Association shall be submitted to arbitration, subject to the provisions of the Public Employment Labor Relations Act of 1972 as amended. The selection of an arbitrator shall be made in accordance with the "Rules Governing the Arbitration of Grievances" as established by the Bureau of Mediation Services.

6.5 Arbitrator's Authority

- A. The arbitrator shall have no right to amend, modify, nullify, ignore, add to or subtract from the terms and conditions of this Agreement. The arbitrator shall consider and decide only the specific issues(s) submitted, in writing, by the Employer and the Association and shall have no authority to make a decision on any other issue not so submitted.
- B. The arbitrator shall be without power to make decisions contrary to or inconsistent with or modifying or varying in any way the application of laws, rules or regulations having the force and effect of law. The arbitrator's decision shall be submitted, in writing, 30 days following closing of the hearing or the submission of briefs by the parties, whichever is later, unless the parties agree to an extension. The decision shall be binding on both the Employer and the Association and shall be based solely on the arbitrator's interpretation or application of the express terms of this Agreement and to the facts of the grievance presented.
- C. The fees and expenses for the arbitrator's services and proceedings shall be borne equally by the Employer and the Association, provided that each party shall be responsible for compensating its own representatives and witnesses. If either party desires a verbatim record of the proceedings, it may cause such a record to be made, providing it pays for the record. If both desire a verbatim record of the proceedings, the cost shall be shared equally.

- 6.6 Waiver: If a grievance is not presented within the time limits set forth above, it shall be considered “waived.” If a grievance is not appealed to the next step within the specified time limit or any agreed extension thereof, it shall be considered settled on the basis of the Employer's last answer. If the Employer does not answer a grievance or an appeal thereof within the specified time limits, the Association shall elect to treat the grievance as denied at that step and may, if the employee requests, immediately appeal the grievance to the next step. The time limit in each step may be extended by mutual written agreement of the Employer and the Association in each step. The term “work days” as used in this Article shall mean the days Monday through Friday inclusive (exclusive of holidays).
- 6.7 The grievance procedure contained in this Agreement is the sole and exclusive means of resolving all grievances arising under this Agreement.

ARTICLE 7. DISCIPLINE

- 7.1 Just Cause. The Employer will discipline employees who have completed the required probationary period only for just cause. A written reprimand, suspension, demotion or discharge of any employee who has completed the required probationary period may be appealed through the grievance procedure as contained in Article 6 of this Agreement, subject to the limitations as set forth in Section 7 of this Article.
- 7.2 Warnings, suspension notices, and dismissal notices shall be in written form and shall be submitted to the employee either personally or by certified mail. Employees and the Association will receive a copy of such reprimands and notice of suspension and discharge.
- 7.3 Employees may examine their individual personnel files at reasonable times, under direct supervision of the Employer. Pursuant to the Minnesota Government Data Practices Act, employees may obtain copies of all public and private data within their personnel files, at their request, upon payment of the reasonable costs associated with copying the data.
- 7.4 Discharges will be preceded by 5 day suspension, without pay.
- 7.5 Where an employee is questioned regarding an investigation of a matter that may lead to disciplinary action of said employee, such questioning will be conducted in a manner not to unreasonably embarrass the employee before other employees or the public. If in the course of an investigation, it is determined that disciplinary

action is to be taken against an employee, the employee, at his or her option, shall be permitted to have an Association representative present before the Employer proceeds to further question the employee regarding the matter. The Employer is under no obligation to inform the employee of his or her right to have an Association representative present.

- 7.6 Grievances relating to this article shall be initiated by the Association in Step 2 of the Grievance Procedure, under Article 6.
- 7.7 If, as a result of the written Employer response in Step 3, the grievance remains unresolved and if the grievance involves the suspension or discharge of an employee who has completed the required probationary period, the grievance may be appealed either to Step 4 of Article 6 or a procedure such as: Veteran's Preference or Human Rights. If appealed to any procedure other than Step 4 of Article 6, the grievance is not subject to the arbitration procedure, as provided in Step 4 of Article 6. The aggrieved employees shall indicate in writing, which procedure is to be utilized, Step 4 of Article 6 or other appeal procedure, and shall sign a statement to the effect that the choice of any other hearing precludes the aggrieved employee from making a subsequent appeal through Step 4 of Article 6.
- 7.8 All newly hired or rehired employees will serve a 12 month probationary period within the bargaining unit. At any time during the probationary period, a newly hired or rehired employee may be terminated at the sole discretion of the Employer without recourse to the grievance procedure.

ARTICLE 8. WORK SCHEDULES

8.1 Work Hours

The normal hours of work shall be 8 hours per day and 40 hours per week.

The normal office hours are 8:00 a.m. until 4:30 p.m. Monday through Friday. One-half hour for lunch each day is provided and, as service needs permit, two fifteen-minutes breaks during each eight-hour shift are provided as designated by employee's immediate supervisor or department head. Lunch period/rest breaks are not a compensated part of the work shift. An employee shall not be compensated in money or time off for refusing to take a scheduled lunch period/rest break.

8.2 Overtime Pay Rules

I. Definitions:

Overtime Compensation. Refers to compensation for employment in excess of the hours specified in parts II, III, and IV.(below) at a rate not less than 1.5 times the regular rate at which the employee is employed.

Compensatory Time Off. Refers to hours during which an employee is not working, which are not counted as hours worked during the applicable work week, or other work period for purposes of overtime compensation, and for which the employee is compensated at the employee's regular rate.

Exempt Employee. This term includes the following categories of employees: (1) those employed in a bonafide executive, administrative, or professional capacity within the meaning of the Fair Labor Standards Act, 29U.S.C. 201, et. Seq., as amended, and the Rules and Regulations of the Secretary of Labor, 29C.R.R. 541, et. Seq., as amended, or (2) one who holds a public elective office of the county provided said employee is not subject to Civil Service Laws of the county; or (3) one who is an immediate advisor to the holder of a public elective office of the county, provided said employee is not subject to the Civil Service Laws of the county as this category is defined by federal statute or rule.

II. Exempt Employee

Exempt employees who work in excess of 40 hours per week shall be entitled to overtime compensation or compensatory time off computed at a rate of one hour for each hour of employment worked in excess of 40 hours but less than 48hours and at a rate of 1.5 hours for each hour of employment worked in excess of 48 hours.

III. Accrual of Compensatory Time

Exempt employees may accrue not more than 80 hours of compensatory time off.

IV. Use of Compensatory Time Off

Employees who have accrued compensatory time off as authorized in this Agreement and who have requested the use of such compensatory time off, shall be permitted to use such time within a reasonable period after making the request provided the use of the compensatory time off does not unduly disrupt the operations of the County Department in which the employee is employed.

V. Employment Termination

An employee who has accrued compensatory time off authorized under this Agreement shall, upon termination of employment be paid for the unused compensatory time off at a rate of compensation not less than (a) the average regular

rate received by such employee during the last three years of employee's employment, or (b) the final regular rate received by such employee, whichever is higher.

VI. Assignment and Authorization of Overtime

Department heads shall be responsible for assigning overtime within the following guidelines:

- a. Employees shall be credited with hours worked past their normal shift only if authorization is obtained prior to working overtime.
- b. Overtime shall be distributed as equally as possible among employees in the department.
- c. Employees shall be expected to work overtime when requested.

VII. General Provisions

- a. Overtime pay will be paid as earned and will be included in an employee's paycheck for that period.
- b. Vacation, sick leave, holidays, compensatory time earned at straight time, and other paid time off shall count as hours worked for the purposes of calculating overtime/compensatory time.
- c. Compensatory time earned and taken may not occur in the same day. .
- d. The use of comp time in lieu of cash payment for overtime must be pursuant to some form of agreement or understanding between the employer and the employee (or the representative of the employee) reached prior to the performance of the work.
- e. Notwithstanding any other provision, it is expressly understood that the "on-call" attorney shall not receive compensatory overtime unless legal services are requested. Prior authorization by the County Attorney for the "on-call" attorney or for the attorney responsible for felony prosecutions to respond is not needed. In the event of abuse, the County Attorney may deduct the claimed compensatory time.

8.3 Travel Time

Any employee who uses their private vehicle for transportation to a site other than the normal place of work and is authorized to do so by the department head or supervisor, shall be compensated for the cost per mile as authorized by the County Board.

8.4 Reporting of Absence

Any time an employee is absent from work due to vacation, sick leave or other reason, an absence report is to be completed either before said absence takes place (if known in advance) or upon the first day of return to work. Acknowledgment of this report is to be made by both the employee and the immediate supervisor (see Payroll for Absence Report). This report is to be sent to the Payroll Department.

ARTICLE 9. HOLIDAYS

The following shall be paid holidays, provided employees perform work, are on vacation, sick leave, or are gone due to a death in the family or similar case, in the pay period in which the holiday occurs and work is scheduled or assigned both on their last scheduled work day prior to and on the first scheduled work day following the holiday:

New Year's Day	Labor Day
President's Day	Martin Luther King Day
Thanksgiving Day	Veterans Day
Day after Thanksgiving	Independence Day
Memorial Day	Christmas Eve Day
Christmas Day	3 Floating Holidays

Provided when the following holidays fall on a Sunday, the following day shall be a holiday. Provided when the following holidays fall on a Saturday, the preceding day shall be a holiday:

January 1 - New Year's Day
 July 4 - Independence Day
 November 11 - Veteran's Day
 December 24 – Christmas Eve Day
 December 25 - Christmas Day

When Christmas Eve Day is on a Friday and Christmas Day is on a Saturday, Thursday/ Friday shall be the holidays. When Christmas Eve Day is on a Sunday and Christmas Day is on a Monday, Monday/Tuesday shall be the holiday.

A floating holiday (eight hours of paid absence from work at the employee's designation and appointing authority's approval) cannot be carried over into the following year or paid upon separation.

Eligibility for Floating Holiday: Initial employment probationary employees will receive 1 floating holiday on their date of hire, 1 floating holiday May 1st and 1 floating holiday September 1st.

Attorneys employed less than full-time shall be compensated for holidays that fall on days on which the attorney is not scheduled for work. The rate of compensation shall be that amount of the attorney's daily wage for scheduled days which is proportional to the attorney's employment status, e.g. three-fifth (3/5) time.

ARTICLE 10. VACATIONS

Each employee who has received regular status shall receive an annual vacation with pay based on a bi-weekly accumulation based on vacation days figured at a rate dependent on years of service. The following table outlines these rates:

<u>Completed Years of Service</u>	<u>Rate of Accumulation of Vacation Hours/ Pay Period of Work</u>	<u>No. Working Hours of Vacation Time Earned/ Year</u>
0-5 years	3.693 hrs	96.018 hours
6-10 years	5.539 hrs	144.014 hours
beginning 11 th year	7.385 hrs	192.010 hours

Each employee who has reached regular status shall receive vacation with pay based on a pay period accrual based on vacation hours figured at a rate dependent on years of service with the County.

As vacation is earned, it shall be recorded on an HOURLY basis and may be used as it is earned during the probationary period. Per the payroll practice of Itasca County, incremental vacation credit will be credited in the pay period it occurs.

Upon termination of employment, other than retirement, an employee leaving Itasca County (including employees who have not completed their probationary period) shall be paid in a lump sum payment for any earned and unused vacation. Compensation for unused vacation time shall be paid at the employees pay rate effective on the last work day.

Employees terminating due to retirement may coordinate vacation use with their retirement date.

An employee must provide at least 30 days' advance written notice of resignation or retirement in order to be eligible for payment of accumulated vacation, unless the Department Head agrees to a shorter period of notice.

Heirs of an employee who dies, are entitled to compensation for any earned and unused vacation and will receive it in a lump sum.

Between January 1 and April 1 of each calendar year, department heads shall consult with all regular employees entitled to vacation, and from such consultation a schedule for vacation periods shall be established. In determining vacation schedule, the wishes of the employees shall be respected as to the time of taking vacation, insofar as the needs of the service will permit, it being understood that the rights of the senior employees will prevail in the selection of vacation time when agreement cannot be reached among the employees.

No one shall exceed 248 hours of vacation accrual (including bonus vacation) after December 31st. As of that date, anyone carrying more than 248 hours of vacation shall have all hours in excess of 248 converted to a contribution to their HCSP. This contribution may not exceed 50 hours and all additional hours shall be lost. Bonus vacation shall be earned per the following:

1. 3.693 hours of sick leave per pay period shall be earned, only if the beginning balance is less than 1000 hours.
2. Bonus vacation of 1.847 hours shall be earned for each pay period the beginning balance of sick leave is 600 hours or greater, except in any pay period in which sick leave is taken.

Employees classified as part-time will receive pro-rated vacation leave based on the number of hours expected to work for the first quarter and the vacation leave accrual will be recalculated and pro-rated based on the number of hours worked in the previous quarter thereafter.

ARTICLE 11. SICK LEAVE

Sick leave shall be earned at the rate of 3.693 hours for each pay period of service in which at least 40 hours have been worked, and unused sick leave may accumulate to a maximum of 1,000 hours. Employees classified as part-time will receive pro-rated sick leave based on the number of hours expected to work for the first quarter and the sick leave accrual will be recalculated and pro-rated based on the number of hours worked in the previous quarter thereafter.

Employees begin accumulating sick leave as of the first date of employment and may use sick leave during the probationary period.

An employee may use sick leave for absences for such reasonable periods as the employee's attendance with the family member may be necessary, on the same terms the employee is able to use sick leave for the employee's own illness.

- Provide care for a family member who is incapacitated as a result of physical or mental illness, injury, pregnancy or childbirth;
- Provide care for a family member as a result of medical, dental or optical examination or treatment.

Family member is defined as:

- Spouse, and parents, thereof,
- Children, including adopted and stepchildren, and spouses thereof,
- Parents, grandparents and grandchildren of the employee and/or the spouse,
- Brothers and sisters, and spouses thereof,
- Domestic partner or guardian

Upon termination of employment prior to, on, or subsequent to the normal retirement date, an employee shall allocate as severance pay 70 percent of the employee's accumulated but unused sick leave from first date of County employment. Such severance pay shall be excluded from PERA deductions and from any calculations in retirement benefits, and shall be paid, at the employee's option, in one lump sum, or in a manner mutually agreeable to the employee and Employer over a period not to exceed five (5) years from termination of employment. The employee shall apply the 30% balance to the employee's Post Health Care Savings Plan after all regular pay has been paid out.

The accumulation of sick leave shall be based on the rate of 3.693 hours per pay period, and may not exceed the maximum number of hours allowable accumulation in effect at the time of retirement. The money value of such accumulated sick leave shall be determined by multiplying the number of hours of unused sick leave by the wage or salary rate per hour being paid to the employee at the time of the employee's retirement.

Any payment made upon termination due to death will be paid in accordance with federal and state regulations. In the event of an active employee's death, 100 % of the employee's sick leave balance shall be paid to the surviving spouse or the estate of the employee who has passed away.

To qualify for severance pay benefits described in Article 11 of this Agreement, the employee's termination from employment must not be the result of discharge for "just cause." Further, eligibility for severance pay benefits shall accrue only after the employee has been employed by the County not less than 5 years. The 5 year eligibility requirement shall apply only to employees hired after the effective date of the 1994-1996 Agreement.

For employees hired after January 1, 1994, the maximum County payment for the 70% dollar value of an employee's accumulated unused sick leave (severance pay) shall not exceed \$10,000. (That is, 70% of the employee's accumulated unused sick leave shall have a maximum value of \$10,000 at retirement for use for any purpose permitted by the contract.). This limit does not apply to other County payments for retirement group insurance premiums nor does it affect the other 30% dollar value of an employee's accumulated unused sick leave which is deposited into the employee's Post Health Care Savings Plan after all regular pay has been paid out.

ARTICLE 12. LEAVE OF ABSENCE

A. Leave of absence without pay.

1. Medical leave of absence without pay

- a. Policy Statement: It is the policy of Itasca County to grant a medical leave of absence for personal physical or mental illnesses, maternity, injury, or chemical dependency treatment if such a request is accompanied by a physician's written statement documenting the inability of the employee to work.

- b. Eligibility: Any employee must be employed in a regular full-time or regular part-time position.
- c. Authorization:
 - (1) The employee shall submit a written request for a medical leave of absence to the department head at the earliest possible date.
 - (2) The County Board shall be responsible for approving requests for medical leaves of absence.
 - i. An employee who is granted a medical leave of absence shall have the option of using accrued sick and vacation leave. Arrangements for the sequence of unpaid, sick and vacation leave must be made prior to the beginning of the leave, when possible.
 - ii. The employee shall submit a physician's written statement citing that the employee is unable to work due to a personal, physical or mental illness or injury or treatment of a chemical dependency, and the projected date of return to work.
 - iii. At any time during the leave, the department head may request an updated physician's statement.
 - (3) Authorized requests and medical statements shall be filed in the employee's personnel file.
- d. Length of Leave:
 - (1) After an employee has used all accumulated earned leave and any available FMLA protected leave, the employee shall be granted a medical leave of absence without pay, with appropriate documentation from the healthcare provider, for a period not to exceed 6 months without having their name removed from the payroll. If the employee is in the process of seeking a disability determination, the time will be extended a total of up to 12 months. If the employee is certified disabled, employment shall cease.

e. Effect on Benefits, Leave and Seniority:

- (1) Sick leave shall not accrue during an unpaid leave of absence.
- (2) Vacation leave shall not accrue during an unpaid leave of absence.
- (3) Holidays shall not be paid during an unpaid leave of absence.
- (4) Seniority is not affected by a leave of absence except as provided for by the Personnel Policy. Seniority will not be lost but seniority will not be accrued.

f. Reinstatement and Termination After a Medical Leave of Absence:

- (1) Prior to returning to work from a medical leave of absence, the employee shall provide a physician's statement that the employee is able to return to work.
- (2) An employee returning to work within the authorized 6 month leave period shall be reinstated to the original position in the same classification in the same department, with the same hours and the same rate of pay, subject to employee rights by collective bargaining standards. No position shall be held open beyond the maximum 6 month period, except when an extension is granted by the department head and approved by the County Board.
- (3) An employee giving proper termination notice within the authorized leave period shall be eligible for separation benefits.

2. Personal Leave of Absence without Pay

- a. Policy Statement: It is the policy of Itasca County to consider requests for personal leaves of absence for personal matters of importance or necessity.
- b. Eligibility: An employee must be employed full-time or part-time in a regular position.

c. Authorization:

- (1) A leave of absence without pay may be granted by the department head using his/her discretion and in consideration of departmental need, for a period not to exceed 10 working days in each calendar year. The employee shall submit a written request to the department head at the earliest possible date.
- (2) A leave of absence in excess of 10 working days may be granted by the County Administrator for good and sufficient reasons given department head approval in consideration of department need.
- (3) No leaves of absence shall be granted for an employee to engage in other employment.
- (4) Authorized requests shall be filed in the employee's personnel file.

B. Leave of Absence with Pay

1. Voting in National and State Elections:

- a. Policy Statement: Time off for voting will be as per MS 204C.04 or as amended.
- b. Authorization: The employee shall inform the supervisor of absence during work time to vote prior to taking the time off to vote.

2. Appearance at Government Proceedings:

- a. Policy Statement: It is the policy of Itasca County to grant employees a leave of absence with pay for a subpoenaed appearance before a court, legislative committee, or other body as a witness in a proceeding involving the Federal government, State of Minnesota, or one of its political subdivisions, if the appearance is in connection with the employee's official duties.
- b. Authorization:

- (1) The employee shall submit a written request for a leave of absence due to subpoenaed appearance at a government proceeding to the department head at the earliest possible date.
- (2) The authorized written request shall be filed in the employee's personnel file.

3. Military Leave with Pay

- a. Policy Statement: It is the policy of Itasca County to grant employees a maximum of 15 consecutive calendar days off with pay during any calendar year for National Guard, Reserve Duty, or military pay as outlined in M.S. 192.26.
- b. Authorization:
 - (1) The employee shall submit a written request for a leave of absence due to military duty to the department head at the earliest possible date. A copy of the orders shall be presented to the department head if possible.
 - (2) The department head shall be responsible for authorizing leaves of absence.
 - (3) The authorized written request shall be filed in the employee's personnel file.

4. Bereavement Leave

a. Policy Statement: Regular employees shall be allowed to use 24 hours of bereavement leave time in case of death in the immediate family. Sixteen additional hours of death in the family leave time may be used in the event that travel is necessary to a point outside a radius of 150 miles from the employee's home or for other personal reasons related to the death such as for funeral arrangements and business transactions. Immediate family is defined as:

- Spouse, and parents, thereof,
- Children, including adopted and stepchildren, and spouses thereof,
- Parents, grandparents and grandchildren of the employee and/or the spouse,
- Brothers and sisters, and spouses thereof,
- Domestic partner or guardian.

b. Authorization:

- (1) The employee shall submit a written request for a leave of absence due to death in the immediate family to the department head at the earliest possible date. If circumstances prevent submission of a written request, the employee shall contact the department head as soon as possible.
- (2) The department head shall be responsible for authorizing leaves of absence.
- (3) The authorized written request or a notation of the verbal request shall be filed in the employee's personnel file.

C. Unauthorized Leave of Absence

Any such absence shall be without pay and may be grounds for disciplinary action. In the absence of such disciplinary action, any employee who absents him/herself for 3 consecutive work days without leave shall be deemed to have resigned.

D. Family and Medical Act Leave

Family and Medical Leave Act is available for use before or after all earned leave has been exhausted if all requirements have been met.

ARTICLE 13. WORKERS' COMPENSATION BENEFITS

The Employer shall provide workers' compensation benefits for injuries and diseases arising out of and in the course of the employment of its employees as required by law.

ARTICLE 14. SALARY RATES

- 14.1 Employees in this bargaining unit shall receive effective 01/01/2022 a 2% increase; 01/01/2023 a 2% increase; and 01/01/2024 a 2.65% increase.
- 14.2 Salary adjustments shall commence on the date when the employee becomes qualified and authorized to receive the adjustment.

It is agreed that the “salary anniversary date” for the Asst. Attorney’s shall be January 1 of each year. This date shall have no bearing on “years of service anniversary dates.”

ARTICLE 15. INSURANCE

15.1 Life Insurance:

Active Employees: Effective the first date of month following the first date of employment, the Employer will provide and pay the entire premium for the present group life insurance in the amount of \$25,000 for each eligible employee; said insurance includes a double indemnity clause, Accidental Death and Dismemberment (AD&D) coverage in the amount equal to Basic Life insurance coverage.. Active employees may opt to purchase additional Basic Life and AD&D coverage for themselves, their spouse and eligible dependents at their own expense. Both Basic Life and AD&D insurance coverage amounts reduce to 65% at age 65, 50 % at age 70 and 35% for 75 and over. All employer provided and employee elected additional insurance will terminate upon the employee leaving employment.

15.2 Group Hospital – Medical Insurance:

All regular County employees shall be eligible for hospital/medical insurance. For purposes of health insurance eligibility, coverage shall commence at the beginning date of employment upon completion of necessary application form.

Employees in regular positions, who have opted not to be covered by hospital/medical insurance, and later choose to be covered by same, may be covered by said insurance provided they are accepted by the insurance company.

Regular employees who are temporarily laid off for more than 30 days or who are on authorized unpaid leave of absence of more than 30 days (not FMLA covered), may continue their insurance coverage by paying the full amount of the premium themselves during the period of layoff or leave of absence. Upon return to work, an employee need not re-establish eligibility.

Employees returning to work after authorized leave of absence without pay shall be required to work at least 80 hours during the calendar month in which employees

return to work in order to be eligible for Employer contribution for the succeeding month.

Employees who leave County employment must have worked at least 80 hours during the calendar month in which employment termination becomes effective in order to be eligible for Employer contributions for the succeeding calendar month. (However, life and dental insurance is cancelled at the end of the month in which the employee terminates employment.) Terminated employee(s) have the option to continue coverage with carrier for up to 12 months at the employee's expense.

Employees who voluntarily terminate employment without due notice to the department head, unless such termination without notice is approved by the department head, shall forfeit all rights to Employer contributions. Employees who are discharged for cause shall forfeit all rights to Employer contributions.

Employees may choose a plan of group health and medical insurance coverage: The High Deductible Plan (Option 1) \$1750/\$3500 (in 2022) Deductible or the High Deductible Plan (Option 2) \$3500/\$7000 (in 2022) Deductible both with a Health Savings Account (HSA) shall be the hospital medical insurance coverage for all eligible employees under this Agreement. The Internal Revenue Code requires that the minimum statutory deductible for plans used with HSAs be indexed for inflation and the deductibles will automatically increase in future years in order to remain compliant with the Internal Revenue Service (IRS) guidelines for high deductible health insurance plans.

The Employer will pay 80% of the annual deductible via an HSA contribution on the single or family coverage and the Employee will pay 20% of the annual deductible on the single or family coverage while the Employee is enrolled in the Plan. The County portion of the annual deductible will be pro-rated by the number of months the employee is enrolled in the plan for employees who enroll in the plan mid-year.

Employees enrolled in County-sponsored health insurance plans who are ineligible for an HSA contribution shall have the option for the County portion of the annual deductible to be contributed to a VEBA (Voluntary Employee's Beneficiary Association).

The County portion of the annual deductible will be deposited to the HSA or VEBA accounts during the 1st payroll in January for employees who are enrolled in the health insurance plan for the year.

The premium participation for said plans shall be 80% by employer and 20% by the employee.

In the event an employee qualifies for a total disability pension under the eligibility stipulations set by the Minnesota Public Retirement Association and/or Federal Social Security, upon approval and acceptance of an employee by either of said entities for a total disability annuity pension and upon an employee drawing said annuity, the Employer shall pay for the employee and his or her dependents' hospital medical insurance in full. Upon reaching age 65, the retiree is required to enroll in both Parts A & B of Medicare (if eligible). At that point the Employer and retiree will be responsible for their payment of health insurance premium as directed within the labor contract.

Employees enrolled in one plan may switch coverage during the open enrollment period or when a qualified event occurs.

In the event during the term of the Agreement, the County Board decides to change insurance carriers, it is understood and agreed that the County shall continue to provide equivalent coverage to the present hospital/medical or dental insurance covering the employees under this Agreement. It is understood that the employee's and Association's rights as provided by state and federal statutes relating to their health and welfare insurance provided by the employer shall not be negated by the aforementioned language (Statutes such as M.S. Chapter 471, Minnesota Comprehensive Health Insurance Act 62 E 03, etc.).

The employee's portion of health insurance premiums shall be split between the first and second payroll of each month. This split shall be as close to even as possible.

15.3 Flexible Spending Account

The County may provide flexible spending account programs. Employees may elect to participate.

15.4 Part Time Employee Insurance Benefits

All employees classified as part-time will receive insurance benefits based on the number of hours expected to work for the first quarter and the benefit will be recalculated based on the number of hours worked in the previous quarter thereafter.

15.5 Insurance Advisory Committee

An Insurance Advisory Committee shall be established to examine the County's current medical insurance plan. The Committee shall be composed of representatives from each of the groups participating in the County's program as follows:

Local 639	2 representatives
Local 639A	2 representatives
Local 639-3	1 representative
Local 1626	2 representatives
Local 1452	2 representatives
Local 580	2 representatives
Itasca Co. Non-Contract Employees	1 representative
Itasca Co. Elected Officials/Dept. Heads	1 representative
Itasca Co. Attorney Employees' Assoc.	1 representative
Itasca County Employees' Association	1 representative
Itasca Co. Confidential Employees' Assoc.	1 representative
Itasca County Manager's Association	1 representative
Itasca Co. HHS Supervisor's Assoc.	1 representative
Teamsters 320	1 representative

The Committee may recommend changes in medical programs to the County Board.

If the Committee recommendations call for changes in the structure of the medical plan, this contract be subject to re-opening negotiations for medical benefits.

If the County Board deviates with the Committee recommendations, the agreement re-opening negotiations for the medical plan is void.

15.6 Post Health Care Savings Plan

All employees shall be enrolled in the Post Health Care Savings Plan (HCSP) on their date of hire. The employee shall contribute 2% of their regular wages* if that employee has 0-120 months of Itasca County Service Credit. The employee shall contribute 4% of their regular wages* if that employee has 121 or more months of Itasca County Service Credit.

*Regular wages is defined as the hourly wage stated in the Union pay plan (regular wages excludes callout pay, shift differential, meals, severance pay, overtime)

The County shall not be responsible for a contribution to any costs associated with the Post Health Care Savings Plan mentioned above.

ARTICLE 16. RETIRED EMPLOYEES

- 16.1 Hospital and medical coverage will be provided by current carrier for retired employees, who carried coverage with Itasca County prior to retirement.
- 16.2 Hospital and medical coverage provided for retirees shall be the High Deductible Plan (Option 1) \$1750/\$3500 (in 2022) Deductible or the High Deductible Plan (Option 2) \$3500/\$7000 (in 2022) Deductible both with a Health Savings Account (HSA), or its equivalent. The Internal Revenue Code requires that the minimum statutory deductible for plans used with HSAs be indexed for inflation and the deductibles will automatically increase in future years in order to remain compliant with the Internal Revenue Service (IRS) guidelines for high deductible health insurance plans.

Premium participation shall be: The Employer shall pay the full single premium and 50% of the dependency coverage cost, and the balance 50% of dependency cost shall come from the retiree until their health insurance cap is exhausted. The Employer shall pay 80% of the annual deductible via an HSA or VEBA contribution on the single or family coverage and the retiree shall pay 20% of the annual deductible on single or family coverage while the retiree is enrolled in the plan, until their health insurance cap is exhausted. The retiree may choose either of the high deductible health plans with a VEBA or HSA contribution from the County. The retiree must designate which health plan option and deductible option (HSA or VEBA) upon retirement. The County portion of the deductible will be pro-rated by the number of months the retiree is enrolled in the plan for retirees who enroll in the plan mid-year. If the retiree's health insurance cap is exhausted, the retiree may continue to stay on the county-sponsored health insurance plan and will pay 100% of the premium and 100% of the deductible.

When a retiree reaches age 65, the retiree will be transitioned from their current health plan to one of the Medicare Supplemental Plans offered by the County and the County shall pay the full single premium and 50% of the dependency coverage cost, and the balance 50% of dependency cost shall come from the retiree unless or until their health insurance cap is exhausted.

- 16.3 Retiree Defined: A retiree is defined as any employee, elected, appointed or other non-contract personnel who has reached retirement age as defined in Minnesota Statutes Chapter 353 (PERA) and has a minimum of 10 years of service in Itasca County Government.
- 16.4 For employees hired after January 1, 1994 the maximum County payment for retirement group insurance premiums shall not exceed \$10,000.
- 16.5 Employer Obligation Limited
The parties agree that any description of insurance benefits contained in this Article are intended to be information only and the eligibility of any employee for benefits shall be governed by the terms of the insurance policy. It is further understood that the Employer's only obligation is to pay such amounts as agreed to herein and no claim shall be made against the Employer as a result of denial of insurance benefits by an insurance carrier.

ARTICLE 17. DENTAL INSURANCE

- 17.1 Upon completion of 1040 hours or 6 months of continuous service, whichever comes first, the Employer will provide dental insurance under Delta Dental Plan of Minnesota or its equivalent. Authorized sick leave, authorized vacation time, and authorized leave of absence of 30 days or less shall be counted as working time for such eligibility. Coverage shall commence provided all necessary application forms have been completed.

ARTICLE 18. INDIVIDUAL RIGHTS

- 18.1 Employees have the right to join or to refrain from joining the Association. Neither the Employer nor the Association shall discriminate against or interfere with the rights of employees to become or not to become members of the Association and, further, that there shall be no discrimination or coercion against any employee because of Association membership or non-membership. The Association shall, in the responsibility of exclusive representative of employees, represent all employees without discrimination, interference, restraint or coercion.

ARTICLE 19. COMPLETE AGREEMENT AND WAIVER OF BARGAINING

- 19.1 This Agreement shall represent the complete agreement between the Association and Employer.
- 19.2 The parties acknowledge that during the negotiations which resulted in this Agreement each had the unlimited right and opportunity to make requests and proposals with respect to any subject or matter not removed by law from the area of collective bargaining and that the complete understandings and agreements arrived at by the parties after the exercise of that right and opportunity are set forth in this Agreement. Therefore, the Employer and the Association, for the life of this Agreement, each voluntarily and unqualifiedly waives the right and each agrees that the other shall not be obligated to bargain collectively with respect to any subject or matter not specifically referred to or covered in this Agreement, even though such subject or matter may not have been within the knowledge or contemplation of either or both of the parties at the time that they negotiated or signed this Agreement.

ARTICLE 20. SAVINGS CLAUSE

- 20.1 This Agreement is subject to the laws of the United States, the State of Minnesota, and Itasca County. In the event any provisions of this Agreement shall be held to be contrary to law by a court of competent jurisdiction from whose final judgment or decree to appeal has been taken within the time provided, such provision shall be voided. All other provisions shall continue in full force and effect.

ARTICLE 21. ERRORS AND OMISSIONS

The County shall defend, save harmless, and indemnify employee against any tort claim, demand, or any other cause, including actions and claims arising under the United States Constitution or the laws of the United States, and including claims, judgments for, or settlements of attorney fees, whether groundless or otherwise, arising out of an alleged act or omission occurring within the scope of his or her employment or official duties. The County shall indemnify and provide defense for each employee against judgments or any amounts paid in settlement actually and reasonable incurred in connection with any of the above-described claims, demands, causes, judgments or settlements. The County's obligation under this article shall be in accordance with Minn. Stat. Chap. 466. Employees shall be given reasonable leave of absence to enable this defense of such claims when the amount alleged exceeds the limitations in Minn. Stat. Chap. 466. The Employer shall notify the unit of any change in amount or coverage of liability insurance held by the Employer, providing errors and omissions coverage for the employees.

ARTICLE 22. PROFESSIONAL EDUCATION AND DUES

The County shall pay on the behalf of the employees, the cost of Minnesota Supreme Court Attorney license fee, the membership dues to the Minnesota Bar Association, Minnesota County Attorneys Association, National District Attorneys Association and the American Bar Association, as well as any other professional organization deemed appropriate by the Itasca County Attorney. The County shall pay on the behalf of the employees the cost of continuing legal education seminars, including the cost of travel, lodging and meals, when those seminars related to topics affecting Itasca County, and when the Itasca County Attorney has consented to the employee's attendance thereof.

ARTICLE 23. DRUG AND ALCOHOL TESTING

The provisions of the Itasca County drug and alcohol testing policy as set forth in the Itasca County Personnel Policy are incorporated herein by reference the same as if fully set forth in this Article. However, any employee submitting to a urinalysis test shall have the right to have a portion of the sample sent to another lab at his/her own expense.

ARTICLE 24. TERM OF AGREEMENT

This Agreement shall be in full force and effect upon execution of the agreement through December 31, 2024 and shall be automatically renewed from year to year thereafter, unless either party shall notify the other, in writing, by November 1, 2024, that it desires to modify or terminate this Agreement, provided that if such notice is given, the existing Agreement will remain in effect until modified or terminated.

ARTICLE 25. REIMBURSEMENT OF EXPENSES

As defined in the Itasca County Personnel Policy and Procedures Manual.

ARTICLE 26. LAYOFF

- 26.1 Seniority standing for layoffs shall be the first day of employment in a position covered in this Agreement.
- 26.2 A regular employee shall lose his/her seniority standing in the following situations:
- a. Voluntary resignation;
 - b. discharge for just cause;
 - c. retirement;
 - d. failure to accept recall from layoff;
- 26.3 In the event of a layoff, a reduction of force, or the elimination of a position, a senior employee may exert seniority preference over a junior employee in any classification of work of equal or lower pay grade in this bargaining unit in the employee's department, provided the employee has the necessary qualifications to perform the duties of the job involved. Employees who are laid off shall be rehired according to seniority in the inverse order of layoffs. There shall be a 2-year recall limit on lay-offs. Such employees shall be notified in writing regarding such layoffs, reduction of force or elimination of position, as well as rehiring, as the case may be. Such written notification shall be sent to such employees as soon as practicable by certified mail, with a copy of same submitted to the Association. Within five working days after receiving notice of layoff, an employee intending to exercise seniority preference shall advise the Human Resources Director of the specific position into which the employee intends to bump. If an employee on lay-off status does not accept a job the employee is qualified to perform within 14 calendar days, the employee's seniority status is terminated and will be removed from payroll.
- 26.4 Promotional Policy: Position vacancies in County service shall be filled by promotion of present employees who meet the requirements established for the classification and provided that the promotion would be in the best interests of the County.
- 26.5 The Human Resources Director will post the position vacancy notice in the Courthouse and other designated areas for a minimum period of 5 working days.
- 26.6 An employee interested in a posted promotional notification of vacancy must complete an application and submit it to the Human Resources Department prior to

the closing date. The appointing authority shall make the determination as to whether or not the applicant possesses the necessary qualifications. A list of interested employees, whether eligible, for each posted promotional vacancy shall be maintained. An employee's current position will not be jeopardized by expressing interest in a vacant position.

- 26.7 When an employee accepts a promotion, he/she shall receive the appropriate salary corresponding with the job classification upon the first day of work in the promotional position. If the rate of pay of that classification does not reflect an increase of one pay level, he/she should be advanced the number of steps required to show one pay level increase from the old rate of pay for such employee.
- 26.8 Employees promoted and then rejected during a probationary period or by abolishment of the position promoted to, shall have the right to assume the position from which he/she was promoted, unless that position has been abolished or filled; in such case, he/she shall be placed on the appropriate layoff list for the same or lower class.
- 26.9 Transfers: Employees may be transferred from one department to another provided that the employee has the permission of both department heads and the Human Resources Director. All employees transferring shall give their present department head 2 weeks' notice, unless this requirement is waived by the two department heads involved.
- 26.10 Employees transferring from a bargaining unit to a non-contract position or from one non-contract position to another may carry over accumulated service credit for application to fringe benefits.
- 26.11 An employee interested in a transfer to a vacant position must complete an application and submit it to the Human Resources Department prior to the closing date. The appointing authority shall make the determination as to whether or not the applicant possesses the necessary qualifications. A list of interested employees, whether eligible or ineligible, for each posted promotional vacancy shall be maintained. An employee's current position will not be jeopardized by expressing interest in a vacant position.
- 26.12 Employees transferred and who unsuccessfully complete the probationary period or the position transferred to is abolished, shall have the right to assume the position from which he/she was promoted, unless that position has been abolished or filled; in such case, he/she shall be placed on the appropriate layoff list for the same or lower class.

26.13 Seniority lists shall be brought up to date on March 1 of each calendar year and posted on employees' bulletin boards. Copies of seniority lists shall be sent to the President of the Association.

26.14 Nothing herein shall be construed to affect the status of war veterans in contravention of existing laws relating to war veterans' employment, discharge, or promotion.

[Remainder of page intentionally left blank]

IN WITNESS WHEREOF, the parties have caused this agreement to be executed this _____ day of _____, 20____

**ITASCA COUNTY ATTORNEY
EMPLOYEES' ASSOCIATION**

By:_____

Date of Signature_____

By:_____

Date of Signature_____

**EMPLOYER:
ITASCA COUNTY BOARD
OF COMMISSIONERS**

By:_____

Terry Snyder
County Board Chair

Date of Signature_____

By:_____

Brett Skyles
County Administrator

Date of Signature_____

APPENDIX A-Pay Plan

APPENDIX A										
01/01/2022 AEA ANNUAL PAY PLAN				2.00% on 2021 base						
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6	STEP 7	STEP 8	STEP 9	
GRADE 12	\$31.89	\$33.06	\$34.28	\$35.57	\$36.86	\$38.24	\$39.73	\$41.27	\$42.87	GRADE 12
GRADE 13	\$35.25	\$36.56	\$37.92	\$39.33	\$40.81	\$42.33	\$43.98	\$45.68	\$47.48	GRADE 13
GRADE 15	\$41.19	\$42.73	\$44.34	\$46.00	\$47.74	\$49.54	\$51.49	\$53.51	\$55.60	GRADE 15

IN THE EVENT THERE IS A ROUNDING DIFFERENCE BETWEEN THIS APPENDIX AND PAYROLL, PAYROLL SHALL GOVERN.

APPENDIX A										
01/01/2022 AEA ANNUAL PAY PLAN				2.00% on 2021 base						
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6	STEP 7	STEP 8	STEP 9	
GRADE 12	\$66,331.20	\$68,764.80	\$71,302.40	\$73,985.60	\$76,668.80	\$79,539.20	\$82,638.40	\$85,841.60	\$89,169.60	GRADE 12
GRADE 13	\$73,320.00	\$76,044.80	\$78,873.60	\$81,806.40	\$84,884.80	\$88,046.40	\$91,478.40	\$95,014.40	\$98,758.40	GRADE 13
GRADE 15	\$85,675.20	\$88,878.40	\$92,227.20	\$95,680.00	\$99,299.20	\$103,043.20	\$107,099.20	\$111,300.80	\$115,648.00	GRADE 15

IN THE EVENT THERE IS A ROUNDING DIFFERENCE BETWEEN THIS APPENDIX AND PAYROLL, PAYROLL SHALL GOVERN.

APPENDIX A										
01/01/2023 AEA ANNUAL PAY PLAN				2.00% on 2022 base						
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6	STEP 7	STEP 8	STEP 9	
GRADE 12	\$32.53	\$33.72	\$34.97	\$36.28	\$37.60	\$39.00	\$40.52	\$42.10	\$43.73	GRADE 12
GRADE 13	\$35.96	\$37.29	\$38.68	\$40.12	\$41.63	\$43.18	\$44.86	\$46.59	\$48.43	GRADE 13
GRADE 15	\$42.01	\$43.58	\$45.23	\$46.92	\$48.69	\$50.53	\$52.52	\$54.58	\$56.71	GRADE 15

IN THE EVENT THERE IS A ROUNDING DIFFERENCE BETWEEN THIS APPENDIX AND PAYROLL, PAYROLL SHALL GOVERN.

APPENDIX A										
01/01/2023 AEA ANNUAL PAY PLAN				2.00% on 2022 base						
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6	STEP 7	STEP 8	STEP 9	
GRADE 12	\$67,662.40	\$70,137.60	\$72,737.60	\$75,462.40	\$78,208.00	\$81,120.00	\$84,281.60	\$87,568.00	\$90,958.40	GRADE 12
GRADE 13	\$74,796.80	\$77,563.20	\$80,454.40	\$83,449.60	\$86,590.40	\$89,814.40	\$93,308.80	\$96,907.20	\$100,734.40	GRADE 13
GRADE 15	\$87,380.80	\$90,646.40	\$94,078.40	\$97,593.60	\$101,275.20	\$105,102.40	\$109,241.60	\$113,526.40	\$117,956.80	GRADE 15

IN THE EVENT THERE IS A ROUNDING DIFFERENCE BETWEEN THIS APPENDIX AND PAYROLL, PAYROLL SHALL GOVERN.

APPENDIX A										
01/01/2024 AEA ANNUAL PAY PLAN				2.65% on 2023 base						
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6	STEP 7	STEP 8	STEP 9	
GRADE 12	\$33.39	\$34.61	\$35.90	\$37.24	\$38.60	\$40.03	\$41.59	\$43.22	\$44.89	GRADE 12
GRADE 13	\$36.91	\$38.28	\$39.71	\$41.18	\$42.73	\$44.32	\$46.05	\$47.82	\$49.71	GRADE 13
GRADE 15	\$43.12	\$44.73	\$46.43	\$48.16	\$49.98	\$51.87	\$53.91	\$56.03	\$58.21	GRADE 15

IN THE EVENT THERE IS A ROUNDING DIFFERENCE BETWEEN THIS APPENDIX AND PAYROLL, PAYROLL SHALL GOVERN.

APPENDIX A										
01/01/2024 AEA ANNUAL PAY PLAN				2.65% on 2023 base						
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6	STEP 7	STEP 8	STEP 9	
GRADE 12	\$69,451.20	\$71,988.80	\$74,672.00	\$77,459.20	\$80,288.00	\$83,262.40	\$86,507.20	\$89,897.60	\$93,371.20	GRADE 12
GRADE 13	\$76,772.80	\$79,622.40	\$82,596.80	\$85,654.40	\$88,878.40	\$92,185.60	\$95,784.00	\$99,465.60	\$103,396.80	GRADE 13
GRADE 15	\$89,689.60	\$93,038.40	\$96,574.40	\$100,172.80	\$103,958.40	\$107,889.60	\$112,132.80	\$116,542.40	\$121,076.80	GRADE 15

IN THE EVENT THERE IS A ROUNDING DIFFERENCE BETWEEN THIS APPENDIX AND PAYROLL, PAYROLL SHALL GOVERN.

APPENDIX B-Classifications and Pay Grades

CLASSIFICATIONS, PAY GRADES AND FLSA STATUS

<u>CLASSIFICATION</u>	<u>PAY GRADE</u>	<u>FLSA STATUS</u>
Assistant County Attorney - Entry Level	12	Exempt
Assistant County Attorney Level -Intermediate	13	Exempt
Assistant County Attorney Level -Senior	15	Exempt



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2268

DEPARTMENT: Health & Human Services

PRESENTER: Kelly Chandler

TIME REQUESTED: 10 Minutes

AGENDA ITEM:

COVID-19 Update

BOARD ACTION REQUESTED:

Receive informational update regarding COVID-19.

BACKGROUND:

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:

1. COVID report- 4-26-2022

RESULT:

INFORMATIONAL - NO ACTION TAKEN



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2351

DEPARTMENT: Administrative Services

TIME REQUESTED: 5 Minutes

PRESENTER: Brett Skyles

AGENDA ITEM:

PILT Resolution

BOARD ACTION REQUESTED:

Adopt the Resolution Re: Support for Increase in Payment in Lieu of Taxes (PILT) Payments to Itasca County.

BACKGROUND:

COUNTY ATTORNEY REVIEW:

SUPPORTING DOCUMENTATION: None

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Burl Ives
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

RESOLUTION 2022-27

**RE: SUPPORT FOR INCREASE IN PAYMENT IN LIEU OF TAXES (PILT) PAYMENTS TO
ITASCA COUNTY**

WHEREAS, the Payment in Lieu of Taxes (PILT) Program passed into Minnesota law in 1979 with the statutory purpose “to address the disproportionate impact of state land ownership on local units of government with a large proportion of state land;” and

WHEREAS, 95% of all PILT acreage is located in the northern-half of Minnesota; and

WHEREAS, since 1995, nearly all PILT payment increases have gone to southern Minnesota and metro area counties; and

WHEREAS, , in 1979 when PILT payments began, the biggest disparity between the highest PILT compensated county to the lowest compensated county was 8:1 or, 8 times higher, yet today that disparity has grown to a whopping 170:1 or, 170 times higher; and

WHEREAS, the principal cause PILT payments are so inequitable across MN, is because in 1995, the Acquired Acres category of PILT Payments switched from a flat rate to instead, a land value basis, yet all other major PILT Payment categories remained at a flat rate; and

WHEREAS, the Northern Counties Land Use Coordinating Board (NCLUCB) recently completed a Comprehensive Study re: State PILT and Payments to Counties which verifies all of the above-mentioned inequities; and

WHEREAS, SF 2793 (Bakk) & HF 3073 (Ecklund) have been introduced to help rectify these huge inequities in PILT Payments by substantially increasing PILT payments to Northern MN counties, including a 56% increase in Itasca County.

NOW THEREFORE BE IT RESOLVED, that Itasca County hereby urges the 2022 Legislature to pass the respective Bakk-Ecklund PILT Bills through the necessary committees and include them in their final Omnibus Tax Bill.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Ben DeNucci
SECONDER:	Commissioner Burl Ives
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

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 26th day of April A.D. 2022 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 26th day of April A.D. 2022.

A handwritten signature in black ink, appearing to read "Brett Skyles", is written over a horizontal line.

Administrator



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2311

DEPARTMENT: Administrative Services

PRESENTER: Brett Skyles

TIME REQUESTED: 5 Minutes

AGENDA ITEM:

County Government Appreciation Day

BOARD ACTION REQUESTED:

Adopt the Resolution Re: County Government Appreciation Day.

BACKGROUND:

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

RESOLUTION 2022-28

RE: COUNTY GOVERNMENT APPRECIATION DAY

WHEREAS, Minnesota's 87 counties employ over 36,000 people to provide essential services to create healthy, safe and vibrant communities; and

WHEREAS, the work of county employees is fundamental, whether it's a newborn well-check by a public health nurse, a passport renewal at a license center, or voter registration and ballot processing; and

WHEREAS, through their commitment to public service, county employees dedicate their time, skills, and expertise for the benefit of their neighbors, and at times, risk their personal safety by coordinating emergency management and managing justice and public safety systems; and

WHEREAS, the vital work of counties promotes healthy communities, fosters conditions for economic growth, strengthens infrastructure, and improves residents' quality of life.

NOW THEREFORE BE IT RESOLVED, the Itasca County Board of Commissioners recognizes the commitment and dedication to public service excellence of county staff and officials and proclaims April 26, 2022 County Government Appreciation Day.

RESULT:	APPROVED (3 TO 0)
MOVER:	Commissioner Burl Ives
SECONDER:	Commissioner Ben DeNucci
AYES:	Terry Snyder, Burl Ives, Ben DeNucci
ABSENT:	Davin Tinquist, Leo Trunt

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 26th day of April A.D. 2022 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 26th day of April A.D. 2022.

Administrator



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, April 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2354

DEPARTMENT: Human Resources

TIME REQUESTED: < 5 Minutes

PRESENTER: Brett Skyles

AGENDA ITEM:

Recognition of County Employees

BOARD ACTION REQUESTED:

To recognize those employees who have either experienced a job change, given notice of leaving employment, received commendation, or to welcome any new employees.

BACKGROUND:

- Welcome new employee, Nevada Childs, Corrections Agent, Probation Department effective April 18, 2022.
- Farewell to Ryan Dowell whose last day as a Highway Maintenance Worker will be April 28, 2022 after 4 months of service.
- Congratulations to Walker Maasch in taking a new job assignment from an Assessment Technician to Assessor/Appraiser I, Assessor Department effective May 1, 2022.
- Welcome new employee, Matthew Grossell, Deputy Sheriff/Road Deputy, Sheriff's Department effective April 25, 2022.
- Farewell to Tanya Elich whose last day as an Assessment Technician, Assessor's Office, will be April 29, 2022 after 4 years of service.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

RESULT:	INFORMATIONAL - NO ACTION TAKEN