



ITASCA COUNTY BOARD OF COMMISSIONERS

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

Tuesday, July 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: Pull Items #6.5 (HHS Family & Child Services Update) and #6.6 (COVID-19 Update) and approve the agenda, as amended.

RESULT:	APPROVED (5 TO 0)
MOVER:	Commissioner Burl Ives
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, July 19, 2022 County Board Work Session.

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

V. CONSENT AGENDA

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

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

1. Approve a One Day Liquor License, as requested by Great Tails Animal Rescue, for a fundraiser on Friday, October 21, 2022 at Barn in the Woods located at 27037 Baich Road, Bovey, MN.
2. Approve the IMCare Compliance Plan, Standards of Conduct and related policies and procedures.
3. Award contract 59201 for Harris Township, Sunny Beach Road Project to the lowest responsible bidder, Hawkinson Construction, in the amount of \$1,731,486.25 and authorize the required signatures on the contract documents.

4. Adopt the Resolution Re: Repurchase of South 197' Lot 8, BLK 8 1st Add Cohasset by John Valentine.
5. Adopt the Resolution Re: Stepping Up Initiative to Reduce the Number of People with Mental Illnesses in Jails.

VI. REGULAR AGENDA

1. Citizen Input
Doug Carpenter provided citizen input regarding payment for maintenance of unorganized township roads.

RESULT:	INFORMATIONAL - NO ACTION TAKEN
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2. Commissioner Warrants
Motion To: Approve Commissioner Warrants with a check date of July 29, 2022, in the amount of \$2,367,835.78.

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

3. ICHHS Warrants
Motion To: Approve the Itasca County Health and Human Services (ICHHS) Department Warrants for July 2022, in the amount of \$1,483,100.17.

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

4. Itasca County Farm Family of the Year
County Extension Committee member Conley Janssen recognized the Jack & Mary Burt and Eric & Alaina Mousel families of Shady Oaks Red Angus as the 2022 Itasca County Farm Family of the Year.

RESULT:	INFORMATIONAL - NO ACTION TAKEN
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VII. COMMISSIONER COMMENTS

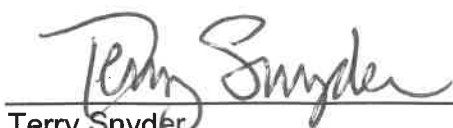
Commissioner Ives provided comment on recent calls he has received regarding Airport Road and candidate forums.

VIII. CLOSED SESSIONS

IX. ADJOURN

Chair Snyder adjourned the meeting at 2:48 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, July 26, 2022

RESOLUTION 2022-49

RE: REPURCHASE OF SOUTH 197' LOT 8, BLK 8 1ST ADD COHASSET

WHEREAS, Minn. Statute 282.141 provides that the State of Minnesota held in trust for the taxing districts may be repurchased by the owner at the time of forfeiture, or the owner's heir, devisee, or representative, or any person to whom the right to pay taxes was given by statute, mortgage, or other agreement, subject to adoption of a resolution the County Board any payment of the sum of all delinquent taxes, penalties, interest and associated costs, and

WHEREAS, the applicant, John Valentine, has applied to repurchase State of Minnesota land held in trust for the taxing districts legally described as: South 197' Lot 8, BLK 8 1st Add Cohasset, Cohasset, MN, and

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

WHEREAS, approving the repurchase will promote the use of land that best serves the public interest.

NOW THEREFORE BE IT RESOLVED, that the Itasca County Board approves the repurchase application by John Valentine, subject to payment including taxes, penalties and interest of \$1,905.47; deed tax \$1.65; deed fee \$25.00; recording fee \$46.00; repurchase application fee \$300.00 for a total of \$2,278.12.

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

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

I, BRETT SKYLES, Administrator of the County of Itasca, do hereby certify that I have compared the foregoing with the original resolution filed in my office on the 26th day of July 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 July A.D. 2022.

Administrator



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

RESOLUTION 2022-45

RE: STEPPING UP INITIATIVE TO REDUCE THE NUMBER OF PEOPLE WITH MENTAL ILLNESSES IN JAILS

WHEREAS, counties routinely provide treatment services to the estimated 2 million people with serious mental illnesses booked into jail each year; and

WHEREAS, prevalence rates of serious mental illnesses in jails are three to six times higher than for the general population; and

WHEREAS, almost three-quarters of adults with serious mental illnesses in jails have co-occurring substance use disorders; and

WHEREAS, adults with mental illnesses tend to stay longer in jail and upon release are at a higher risk of recidivism than people without these disorders; and

WHEREAS, county jails spend two to three times more on adults with mental illnesses that require interventions compared to those without these treatment needs; and

WHEREAS, without the appropriate treatment and services, people with mental illnesses continue to cycle through the criminal justice system, often resulting in tragic outcomes for these individuals and their families; and

WHEREAS, Itasca County and all counties take pride in their responsibility to protect and enhance the health, welfare and safety of its residents in efficient and cost-effective ways; and

WHEREAS, Itasca County Jail division has hired a mental health professional, implemented a Release Advanced Planning Program, cognitive programming, mental health services tracking system, designed a mental health unit in the new jail facility; and

WHEREAS, through *Stepping Up*, the National Association of Counties, the Council of State Governments Justice Center and the American Psychiatric Association Foundation are encouraging public, private and nonprofit partners to reduce the number of people with mental illnesses in jails;

NOW THEREFORE BE IT RESOLVED, THAT Victor Williams, Itasca County Sheriff, will hereby sign on to the Call to Action to reduce the number of people with mental illnesses in our county jail, commit to sharing lessons learned with other counties in the state and across the country to support a national initiative and encourage all county officials, employees and residents to participate in *Stepping Up* and Itasca County resolves to utilize the comprehensive resources available through *Stepping Up* to:

* Convene or draw on a diverse team of leaders and decision makers from multiple agencies

committed to safely reducing the number of people with mental illnesses in jails.

- * Collect and review prevalence numbers and assess individuals' needs to better identify adults entering jails with mental illnesses and their recidivism risk, and use that baseline information to guide decision making at the system, program, and case levels.
- * Examine treatment and service capacity to determine which programs and services are available in the county for people with mental illnesses and co-occurring substance use disorders, and identify state and local policy and funding barriers to minimizing contact with the justice system and providing treatment and supports in the community.
- * Develop a plan with measurable outcomes that draws on the jail assessment and prevalence data and the examination of available treatment and service capacity, while considering identified barriers.
- * Implement research-based approaches that advance the plan.
- * Create a process to track progress using data and information systems, and to report on successes.

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

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

I, BRETT SKYLES, Administrator of the County of Itasca, do hereby certify that I have compared the foregoing with the original resolution filed in my office on the 26th day of June 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 June A.D. 2022.



Administrator



July 26, 2022

Chair:

PULL:

1. Item #6.5 – HHS Family & Child Services Update
2. Item #6.6 – COVID-19 Update

ADDITIONS: None

CHANGES: None

INFORMATIONAL:

1. Item #6.3 – Additional Information

Amanda



ITASCA COUNTY BOARD OF COMMISSIONERS

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

Tuesday, July 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 #6.9 (Water Appropriations Permit) and approve the agenda, as amended.

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

IV. MINUTES APPROVAL

Motion To: Approve the minutes of the Monday, July 11, 2022 County Facilities Tour at the Swan River Garage; Monday, July 11, 2022 County Facilities Tour at the Nashwauk Garage; Monday, July 11, 2022 County Facilities Tour at the Togo Garage; Monday, July 11, 2022 County Facilities Tour at the Balsam Garage; and Tuesday, July 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 a One Day Liquor License, as requested by Great Tails Animal Rescue, for a fundraiser on Friday, October 21, 2022 at Barn in the Woods located at 27037 Baich Road, Bovey, MN.

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 07/26/2022 2:30 PM
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2. Award contract 59201 for Harris Township, Sunny Beach Road Project to the lowest responsible bidder, Hawkinson Construction, in the amount of \$1,731,486.25 and authorize the required signatures on the contract documents.

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 07/26/2022 2:30 PM
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3. Adopt the Resolution Re: Stepping Up Initiative to Reduce the Number of People with Mental Illnesses in Jails.

RESULT: **RECOMMENDED FOR CONSENT** **NEXT: 07/26/2022 2:30 PM**

VI. DISCUSSION / INFORMATIONAL

1. Receive Citizen Input

W. D. (Bill) Hamm provided citizen input regarding the proposed Local Option Sales Tax.

2. Gambling Permit

Motion To: Approve a Premises Permit Application for gambling, as requested by American Legion Post 122, to conduct lawful gambling at Chapman Resorts LLS, 55960 County Road 4, Spring Lake, MN 56680.

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

3. County Based Purchasing (IMCare) Division Update/Presentation

Contract Compliance Officer Laura Grover provided a County Based Purchasing (IMCare) Division Update, including information regarding the IMCare Compliance Plan, Standards of Conduct and associated policies and procedures.

RESULT: **INFORMATIONAL - NO ACTION TAKEN**

4. Public Hearing Re: Conditional Use Permit for Ryan Boldt

Motion To: Open the Public Hearing Re: Conditional Use Permit (CUP) submitted by Ryan Boldt for off-season boat storage.

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

Motion To: Approve the Conditional Use Permit submitted by Ryan Boldt for off-season boat storage, as approved by the Planning Commission at their regular meeting on July 13, 2022.

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

5. Public Hearing Re: Conditional Use Permit for Brandon Jahn

Motion To: Open the Public Hearing Re: Conditional Use Permit (CUP) submitted by Brandon Jahn for commercial office space and shop/storage for a contracting business.

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

Motion To: Approve the Conditional Use Permit submitted by Brandon Jahn for commercial office space and shop/storage for a contracting business, as approved by the Planning Commission at their regular meeting on July 13, 2022.

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

6. Construction Update – July 2022

Transportation Engineer Rachel Metelak and Assistant County Engineer Ryan Sutherland provided a construction update for July 2022.

RESULT:	INFORMATIONAL - NO ACTION TAKEN
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7. Right of Way Application from Bureau of Indian Affairs for CR 149

Motion To: Approve the submittal of the right of way application to Leech Lake Band of Ojibwe/Bureau of Indian Affairs for the CR 149 Bridge Replacement project and authorize the County Engineer to sign the required documents, pending approval of the County Attorney.

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

8. The Master Woodland Owner Course Final Report

University of Minnesota Extension Regional Director Keri Cavitt provided a final report regarding The Master Woodland Owner Course.

RESULT:	INFORMATIONAL - NO ACTION TAKEN
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9. Water Appropriations Permit

It was the consensus of the County Board to direct County Administrator Brett Skyles to proceed with the request from the Department of Natural Resources for Itasca County to submit a Water Appropriations Permit to facilitate de-watering efforts of the Canisteo Pit.

VII. COMMITTEE REPORTS

Commissioner Ives reported on his attendance at recent Labor Negotiations and candidate forums.

Commissioner Tinquist reported on his attendance at recent Itasca Waters and Extension Committee meetings, as well as County Facilities Tours and Labor Negotiations.

Commissioner Trunt reported on his attendance at recent Fair Board, Itasca County Township Association (ICTA), Western Mesabi Mine Planning Board (WMMPB), and Risk Commission meetings, as well as County Facilities Tours and Canisteo Pit meetings.

VIII. ADMINISTRATOR UPDATE

IX. COMMISSIONER COMMENTS

X. CLOSED SESSIONS

XI. ADJOURN

Chair Snyder adjourned the meeting at 3:36 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, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2512

DEPARTMENT: Auditor / Treasurer

TIME REQUESTED: < 5 Minutes

PRESENTER: Deb Davis

AGENDA ITEM:

One Day Liquor License

BOARD ACTION REQUESTED:

Approve a One Day Liquor License, as requested by Great Tails Animal Rescue, for a fundraiser on Friday, October 21, 2022 at Barn in the Woods located at 27037 Baich Road, Bovey, MN.

BACKGROUND:

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

07/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 07/26/2022 2:30 PM
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RESULT:	APPROVED (5 TO 0)
MOVER:	Commissioner Leo Trunt
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2519

DEPARTMENT: Health & Human Services

TIME REQUESTED: 5 Minutes

PRESENTER: Sarah Anderson

AGENDA ITEM:

IMCare Compliance Plan, Standards of Conduct and Related Policies and Procedures

BOARD ACTION REQUESTED:

Approve the IMCare Compliance Plan, Standards of Conduct and related policies and procedures.

BACKGROUND:

IMCare is required to update and obtain approval of these documents annually.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:

1. Compliance Plan, Standards of Conduct and Related Policies and Procedures

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

COMPLIANCE PLAN

JUNE 2022



Itasca Medical Care (IMCare)

1219 SE 2nd Avenue

Grand Rapids, MN 55744

Website: www.imcare.org

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A. INTRODUCTION

Itasca Medical Care (IMCare) is a prepaid Medical Assistance plan contracted with the State of Minnesota to provide managed care health services to people on Minnesota Health Care Programs. IMCare Classic is a Medicare Advantage-Prescription Drug Dual -Eligible Special Plan (D-SNP) through an MOU with the Centers for Medicare and Medicaid and the State of Minnesota to provide managed care health services for people who are over 65 and eligible for Medicare and Medicaid (Minnesota Senior Health Options [MSHO]). The purpose and the mission of IMCare/IMCare Classic is: An organized and coordinated Minnesota HealthCare Program Delivery System that addresses the goals of improving access to quality care, assuring appropriate utilization of services, enhancing patient and provider satisfaction, and achieving cost efficiencies in the delivery of health care.

IMCare is committed to completing its mission while maintaining full compliance with all applicable laws, rules and regulations and ethical standards. This commitment to the highest ethical standards of behavior extends beyond our enrollees to everyone we partner and work with. The primary responsibility for ensuring that IMCare's values are upheld lies with all employees, who are expected to be aware of and in full compliance with all applicable laws, rules and regulations, and avoid even the appearance of impropriety. It is critical that ethics and compliance be an integral part of every employee's decision-making process. Inappropriate business ethics and non-compliant actions cannot and will not be tolerated and will be grounds for disciplinary action, up to and including termination of employment.

To help IMCare fulfill its commitment to the high ethical standards and foster a culture of compliance, the Compliance Program plays an important part in an overarching strategy to uphold IMCare's values. The Compliance Program establishes a process for education on relevant laws, rules and regulations; monitoring to ensure compliance; and documenting IMCare's efforts to obey the law.

This Compliance Plan outlines and explains the structural and operations elements of IMCare's Compliance Program and discusses some relevant laws, regulations, and policies and procedures. The Plan, which will be amended as warranted by changes in applicable laws and regulations, is distinct from the Compliance work plan, which is prepared annually.

B. DEFINITION OF TERMS

Audit Period: The period of time in which the Plan is assessed and reported upon. The annual period begins January 1 and ends December 31. The compliance officer may change the Audit period for administrative necessity, but the audit period will never be less than one year in length.

Board of Commissioners: The governing body of Itasca Medical Care, and IMCare Classic.

Compliance Plan: A system of standards developed to assure compliance with the conformity to all guidelines governing managed care organizations.

Compliance Committee: This 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 Itasca County Health and Human Services Director, and the IMCare Subcommittee of the Itasca County Board of Commissioners.

Contract Compliance Officer: The individual having direct daily responsibility for the administration, implementation, and oversight of the Compliance Plan as it relates to Itasca Medical Care operations and compliance. The Compliance Officer reports to the IMCare Director, the Itasca County Health and Human Services Director and Itasca County Board of Commissioners.

External Reviewers: Any employee from an external source approved to review medical charts and billing practices for compliance rules and regulations.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, including all past or future amendments thereto, and all regulations now or hereafter promulgated under its authority.

HIPAA Requirements: Any obligations imposed by HIPAA.

IMCare Subcommittee to the Itasca County Board of Commissioners: Reviews and monitors IMCare business activities, including the compliance program, and reports to the Itasca County Board of Commissioners. The committee includes two County Commissioners, the County Attorney, the County Auditor, the County Administrator, the Itasca County Health and Human Services Director, the IMCare Director and two community members.

Information Security Officer/Security Officer: The individual having direct daily responsibility for the administration, implementation, and oversight of the Compliance Plan as it relates to security compliance under HIPAA.

Medicaid: The jointly funded, Federal-State health insurance program for certain low-income, needy and disabled people.

Medicare: Federal program, which provides health insurance to people age 65 and over and those who have permanent kidney failure and certain people with disabilities.

Privacy Officer: The individual having direct daily responsibility for the administration, implementation, and oversight of the Compliance Plan as it relates to privacy compliance under HIPAA.

Provider: A provider of medical services.

Regulatory Notices: This includes any written documentation received from or on behalf of any governmental authority including, but not limited to, the Centers for Medicare & Medicaid Services (CMS), the State, and other agencies authorized by law to provide interpretation of standards of practice, privacy and security regulations.

C. STANDARDS OF CONDUCT

In support of this Compliance Plan, the *Standards of Conduct* defines and articulates the guiding principles and business conduct applicable to all activities conducted by IMCare management, staff, contractors, Board and First Tier, Downstream and Related Entities. It gives guidance in areas where staff needs to make personal and ethical decisions. The *Standards of Conduct* provides a non-exclusive summary of ethical and legal principles for partners of IMCare based on compliance requirements applicable to IMCare activities and business. Except as otherwise stated, it does not replace any existing IMCare or Itasca County policies. All partners must read, understand and abide by the principles outlined in the IMCare *Standards of Conduct* through signed attestation. The *Standards of Conduct* is reviewed at least annually and updated to incorporate changes in applicable laws, regulations, and other program requirements. The *Standards of Conduct* is then reviewed and approved by the Itasca County Board of Commissioners.

D. COMPLIANCE OVERSIGHT

IMCare has designated the Compliance Committee and Contract Compliance Officer identified below to assist in the development and oversight of the IMCare Compliance Plan. The Contract Compliance Officer, working with the Compliance Committee, is responsible for implementing and monitoring a continuous, collaborative and proactive culture of compliance at IMCare. The Compliance Officer and Compliance Committee will periodically report to the Board of Commissioners on the activities and status of the Compliance Program, including issues identified, investigated, and resolved by the Compliance Program.

E. GOVERNING AUTHORITY

The Itasca County Board of Commissioners is vested with final jurisdiction of IMCare. The IMCare Director reports to the Itasca County Health and Human Services Director and reports directly to the Itasca County Board of Commissioners and is responsible for the management and operation of IMCare administration. The Board of Commissioners are knowledgeable about the content and operation of IMCare's compliance program and exercise reasonable oversight with

respect to the implementation and effectiveness of the program. This includes review and approval of the *Standards of Conduct* and the Compliance and Fraud, Waste and Abuse Plan.

F. IMCARE COMPLIANCE COMMITTEE

Membership

The Compliance Committee is appointed and co-chaired by the IMCare Director and the IMCare Contract Compliance Officer. The committee is made up of the following individuals:

- IMCare Director/CEO
- IMCare Quality Director
- IMCare Utilization Management Director/COO
- IMCare Medical Director
- IMCare Pharmacy Director
- IMCare Dental Director
- IMCare Claims Supervisor
- IMCare Contract Compliance Officer
- IMCare Controller/CFO
- Itasca County Administrator
- Itasca County Health and Human Services Director/Privacy Officer
- Itasca County MIS Director/Security Officer
- Health Plan Compliance Coordinators

The Compliance Committee reports to the IMCare Subcommittee of the Itasca County Board of Commissioners via the IMCare Director.

Meetings

The Compliance Committee shall meet at least quarterly at predetermined times and dates, and at any time a meeting is needed. A summary of the items addressed, or actions taken at each meeting shall be made and retained by the Contract Compliance Officer.

Role and Responsibilities

The Compliance Committee's responsibilities and duties include:

- a) Overseeing the implementation and operation of the Compliance Plan;
- b) Review and give approval of the Plan, *Standards of Conduct*, and policies and procedures, and any amendments thereto, related to compliance.
- c) Furnish adequate resources for and support of the Plan.
- d) Review and evaluate compliance-related risk assessments prepared by the Contract Compliance Officer or Health Plan Compliance Coordinator and approve compliance monitoring plans.
- e) Review confidential final investigative compliance reports presented to verify that findings of non-compliance are addressed through appropriate corrective actions plans

and/or disciplinary action to assist in reducing the risk of similar non-compliance in the future.

- f) Enforce consistent application of compliance standards, including fair, equitable and consistent disciplinary action of individuals identified as responsible for confirmed non-compliance.
- g) Provide guidance to the Contract Compliance Officer in the development of policies and standards related to compliance awareness, training, monitoring, and response (including corrective action, sanctions and enforcement) to identify, avoid and/or minimize non-compliance with applicable laws, regulations and policies.
- h) Receiving and acting upon reports and recommendations from the Contract Compliance Officer and IMCare Director;
- i) Serve as appellate body for employees contesting compliance reports;
- j) Evaluating the performance of the Compliance Plan and making recommendations accordingly;
- k) Evaluating the effectiveness and overall operation of the Compliance Program;
- l) Reporting actions and making recommendations to the appropriate officials, regarding employee performance;
- m) Performing other functions that may be reasonably necessary to fulfill the Compliance Committee's responsibilities and purpose.
- n) Committee members are expected to regularly attend the scheduled and called Compliance Committee meetings;
- o) Any sensitive information regarding employees, or information identified as confidential or proprietary learned by a member during his/her tenure on the Compliance Committee shall be considered confidential and the Compliance Committee members shall not disclose such information unless otherwise directed.
- p) Subcommittees may be formed from the Compliance Committee's membership to address specified issues.

G. CONTRACT COMPLIANCE OFFICER

The Contract Compliance Officer reports administratively to the IMCare Director and is responsible for the operations of IMCare's compliance area. As a member of the Compliance Committee, the Contract Compliance Officer also reports to this committee regarding project status. The Contract Compliance Officer shall be given adequate resources and authority to carry out such responsibility and shall report on the implementation and effectiveness of the Compliance Plan directly to the IMCare Director, the Compliance Committee, the IMCare Subcommittee of the Itasca County Board of Commissioners, and the Itasca County Board of Commissioners. The responsibilities of the Contract Compliance Officer include the following:

Responsibilities of the Contract Compliance Officer

The Contract Compliance Officer shall:

- a) Develop and implement the IMCare Compliance Plan, including providing oversight and monitoring of its implementation and periodic review;
- b) Monitor and oversee the Compliance Plan in conjunction with the County Privacy Officer and County Security Officer relating to HIPAA;
- c) Develop policies and procedures for implementation and operation of the Compliance Plan;
- d) Maintain, distribute and promote IMCare's *Standards of Conduct*;
- e) Maintain, distribute and promote IMCare's Conflict of Interest policies and procedures;
- f) Maintain current knowledge of laws and regulations, keeping abreast of recent changes that may affect IMCare policies, procedures, and processes through personal research, seminars, peer contact, and bench-marking compliance monitoring practices and implementation strategies;
- g) Coordinate efforts of staff, delegates, and provider to implement the Plan;
- h) Encourage awareness among employees, delegates, and contractors about compliance matters and the importance of adherence to the *Standards of Conduct* by developing, coordinating, and participating in a training program that focuses on compliance-related issues;
- i) Provide guidance to administration, governing body, and staff to facilitate compliance with statutory, regulatory, and IMCare requirements;
- j) Oversee monitoring, auditing and reporting of activity within the scope of the Compliance Plan;
- k) Investigate possible noncompliance;
- l) Maintain a retribution-free system for reporting of non-compliance or concern about Compliance Plan matters, which includes implementing and publicizing a "Compliance Hotline";
- m) Ensure that a compliance risk assessment is completed by IMCare at least annually and report results and recommended areas of focus to control or manage the identified risks;
- n) Assist in development of corrective action plans;
- o) Report any violations of HIPAA requirements to the County Privacy Officer and/or County Security Officer, as applicable;
- p) Serve on the Compliance Committee;
- q) Routinely report results of monitoring, auditing, and reporting activity to the Compliance Committee;
- r) Provide leadership for IMCare's compliance efforts;
- s) Ensure that the HHS-OIG's list of excluded individuals, SDN, and entities and the General Services Administration's list of parties debarred from federal programs have been checked with respect to physicians, staff, contractors, and vendors;
- t) Work with all departments/areas of IMCare to identify high risk compliance areas.

The Compliance Officer shall have the authority to carry out the above-mentioned duties.

H. SENIOR MANAGEMENT ROLE IN COMPLIANCE PLAN

Senior Management plays an important role in the development, implementation and enforcement of the Compliance Plan. It is important for IMCare to maintain "top down"

commitment for the Compliance Program. This is integral to the success and effectiveness of the program.

Role of Senior Management

Senior Management will:

- a) Work with the Contract Compliance Officer, County Privacy Officer, County Security Officer, and the Compliance Committee to assure compliance with the Compliance Plan in their departments, and otherwise oversee departmental compliance and encourage a culture of compliance throughout their departments;
- b) Implement corrective/disciplinary action as necessary to assure compliance, and as recommended;
- c) Cause their departments to develop and adopt departmental policies and procedures to enable their department to adhere to the Compliance Plan;
- d) Review departmental policies, at least annually, to assure that they conform with the Compliance Plan;
- e) Provide information to the Contract Compliance Officer, County Privacy Officer, County Security Officer, and Compliance Committee, as necessary, regarding the departments and their compliance efforts; and
- f) Apprise employees of the results of monitoring, auditing and reporting of activities of the Compliance Plan.

I. COMPLIANCE AWARENESS

The *Standards of Conduct* will be provided to all IMCare employees who will be required to attest to their understanding and agreement to abide by the *Standards of Conduct*.

IMCare will post the Plan and the *Standards of Conduct* on the IMCare website. The Contract Compliance Officer shall periodically publish information in various resources regarding the Plan, *Standards of Conduct*, and related policies to raise awareness regarding general and specific compliance issues.

J. COMPLIANCE EDUCATION AND TRAINING

Compliance education and training is a critical element of an effective compliance program. IMCare is committed to providing general and specific compliance education and training so that IMCare employees understand their obligations and responsibilities in accordance with applicable laws, regulations and policies.

Employees are expected to complete required compliance education and training within the time frames and frequencies established by the department or committee requiring and/or providing the compliance education. Notification of compliance education requirements will be

communicated through various means, including, but not limited to supervisors, written memorandum, internet and/or e-mail.

General and specific compliance education and training programs and related information shall be periodically reviewed and updated to address current risk areas and improvement opportunities. A variety of educational methods, materials and tools, will be utilized to present general and specific compliance and training programs.

The Contract Compliance Officer shall be responsible for developing the content for delivery of general compliance education and training for IMCare. The content of general compliance education and training will include, but is not limited to, the IMCare *Standards of Conduct*, the IMCare Compliance Plan, IMCare risk areas, roles and responsibilities and other information necessary to maintain an effective general compliance education and training program. General compliance education and training requirements shall be published and advertised as necessary to communicate the information.

It will be the responsibility of the individual, department or committee having regulatory compliance oversight to develop the content and deliver specific compliance education and training related to their area of regulatory oversight responsibility. The content of these educational and training programs shall include those areas mandated by law, regulation and/or policy and may include a review of relevant compliance requirements applicable to that regulatory compliance area, identified or potential risk area, responsibilities, and methods to improve compliance. The scope of specific compliance education and training includes but is not limited to the education as may be required by compliance requirements and/or IMCare policy. Specific compliance education and training requirements shall be communicated by the department responsible for the content and delivery.

Records of completion of required compliance education and training shall be maintained by the department or committee responsible for delivery of the education and training. Summary reports of compliance with mandatory compliance education and training requirements shall be compiled by the department responsible for the education and training at least annually or more often as necessary and be made available for review, upon request.

The promotion of and adherence to the Compliance Plan by IMCare management is considered an integral part of their job performance. Specifically, supervisors shall:

- Complete all required compliance education and training for their respective position.
- Inform employees of required compliance requirements specifically related to their job function and appropriately monitor employees to verify compliance with those requirements.

Failure to complete required education and training will result in corrective action, up to and including termination of employment or association with IMCare.

K. CRIMINAL BACKGROUND AND SANCTION CHECKS

Employees

All new IMCare employees undergo sanctions checks and, as applicable, a criminal background check. IMCare prohibits the employment of any person listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation in federal or state funded programs to maintain compliance with federal and/or state laws.

Contractors/Vendors

IMCare shall conduct applicable searches of vendors and contractors against federal and state sanction lists. IMCare shall not contract with any individual or entity which is listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation in federal or state funded programs.

L. MONITORING AND RISK ASSESSMENT

Annual Compliance Risk Assessment

The Contract Compliance Officer shall ensure that a compliance risk assessment is completed at IMCare at least annually. This information shall be shared with the Compliance Committee as part of its annual risk assessment activities.

Work Plan

Upon risk assessment completion, the Contract Compliance Officer will develop the monitoring and auditing work plan. The work plan will include IMCare auditing activities, compliance issues, routine monitoring activities and oversight of FDRs.

Routine Monitoring Activity

IMCare will conduct routine monitoring in accordance with identified risks. The Compliance Committee shall review high risk compliance areas monitoring plans, including activities, based upon applicable laws, regulations and policies.

M. REPORTING RESPONSIBILITIES AND RESOURCES

Reporting Responsibility

Reporting suspected fraud, violations of law or non-compliance is essential to the effectiveness of IMCare's Compliance Plan. IMCare employees shall report suspected violations of, or non-compliance with, federal or state laws, and/or IMCare policies. There are various methods and resources to report suspected fraud, violations of law or non-compliance. Any member of the IMCare community who has a reasonable basis for believing fraud, violation of law or other non-

compliance has occurred has a responsibility to promptly notify his/her supervisor, the Contract Compliance Officer, or use the confidential e-mail or confidential phone line.

All employees are expected to promptly report to the Contract Compliance Officer any suspected fiscal misconduct, whether by members of the IMCare community or by persons outside of IMCare but involving IMCare resources.

Compliance Hotline

1-866-269-0584 or imcarecompliance@co.itasca.mn.us

IMCare employees who have concerns of any kind stemming from possible non-compliance with compliance requirements, related IMCare policies, and/or errors or irregularities in IMCare's financial accounting practices or policies can report them. If you have information about unethical behavior, criminal activity or any other work-related concern, you should first speak with your supervisor or someone who has oversight authority for the policy or law. This service is not a substitute for, nor does it supersede, any existing reporting methods or protocols already in place for reporting suspected problems or complaints. Instead, the Compliance Hotline provides an additional means of reporting such issues. Any suspected problems or complaints reported via the Compliance Hotline will be reviewed in accordance with current IMCare policies and procedures. All reports of compliance issues will be handled in the confidence to the extent practicable. Employees who report concerns in good faith will not be subjected to retaliation, retribution, or harassment.

Non-Retaliation Policy

Knowledge of or suspicion of misconduct, violations of law, or other wrongdoing must be immediately reported to IMCare management, Contract Compliance Officer, imcarecompliance@co.itasca.mn.us, or the Compliance Hotline. No employee is permitted to engage in retaliation, retribution, or any form of harassment against another employee for reporting compliance-related concerns. Employees cannot exempt themselves from the consequences of wrongdoing by self-reporting, although self-reporting may be considered in determining the appropriate course of action.

Confidentiality

Insofar as legal and practical, confidentiality of employee concerns will be maintained. Only those personnel who have a need to know will be informed.

N. RESPONSE AND CORRECTIVE ACTION

Response to Allegations

The Contract Compliance Officer will maintain a reporting system and initiate a prompt and confidential investigation of questionable practices. Upon receipt of a report of questionable practice, the Contract Compliance Officer and/or other officials will conduct a confidential

investigation. The IMCare officials conducting the investigation shall report to appropriate IMCare management and employees the result of the investigation and whether corrective action will be recommended. The Contract Compliance Officer will also report the results of the investigation to the Compliance Committee. IMCare staff shall cooperate during any compliance investigation and shall not alter or destroy any documentation during the investigation.

Corrective Action and Appeal Rights

Failure or refusal to comply with this Plan, applicable compliance requirements, and/or IMCare policies will result in corrective action. An employee's supervisor may also be subject to corrective action when he/she (i) directs or approves the employee's improper actions; (ii) is aware of the improper actions and fails to correct them; or (iii) otherwise fails to exercise appropriate supervision. Corrective action may also be imposed where an employee should have detected improper action but did not. Corrective action includes, but is not limited to, any of the following actions:

- Mandatory training;
- Increased monitoring/auditing;
- Reclassification or reassignment of duties;
- Termination of contractual relationship; or
- Appropriate disciplinary action, up to and including, termination of employment.

Any appeal or grievance rights are those provided in existing policies and contracts.

O. TRACKING AND DOCUMENTING COMPLIANCE AND COMPLIANCE PROGRAM EFFECTIVENESS

The Contract Compliance Officer, with guidance and assistance from the Compliance Committee, is responsible for tracking and documenting all IMCare compliance efforts to include formal audits and monitoring. Issues of non-compliance will be shared with the Compliance Committee and the Board of Commissioners. The Contract Compliance Officer will complete a self-assessment of program effectiveness no less than annually.

P. COMPLIANCE PLAN MAINTENANCE

In order to ensure an effective compliance plan, the Contract Compliance Officer and Compliance Committee will periodically review the overall effectiveness of the compliance plan at least annually. In forming recommendations and conclusion about the compliance plan, the reviewers will consider, among other things, the ongoing review, trend analysis, increase or decrease in questionable practices, and other relevant issues. The Itasca County Board of Commissioners have exclusive authority for approving any changes to the compliance plan that would substantively affect the integrity of the plan or would constitute a material change to the overall compliance plan or to any policy or policies comprising the plan.

STANDARDS OF CONDUCT

JUNE 2022



Itasca Medical Care (IMCare)
1219 SE 2nd Avenue
Grand Rapids, MN 55744

Website: www.imcare.org

Dear Employee and Contracted Partners,

Itasca Medical Care is dedicated to providing high quality health services in order to improve the health of the people in Itasca County, Minnesota. A key element of this is having high ethical standards and integrity. We are committed to achieving our purpose in full compliance with our values as well as all applicable Federal and State laws and regulations. To assist in fulfilling this commitment, IMCare implemented a voluntary Compliance Program. An important part of our Compliance Program is our Standards of Conduct.

The Standards of Conduct create a uniform code and are guidelines to clarify specific ethical questions that may arise in the course of your work. Please become familiar with the basic concepts outlined in the Standards of Conduct. If any aspect of the Standards of Conduct is unclear to you or if you have questions or concerns about a situation you are facing, I hope you will feel comfortable discussing your questions and concerns with your supervisor. If you do not wish to do so, or if your supervisor is not able to address your issue, you may discuss your questions or concerns with the Contract Compliance Officer or the IMCare Director.

We are committed to honoring the community's trust at Itasca Medical Care and are asking you to partner with us in maintaining our uncompromising values.

Sincerely,



Sarah Anderson
Director
Itasca Medical Care

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INTRODUCTION TO THE STANDARDS OF CONDUCT

Itasca Medical Care is committed to the goal of serving our participants, providers, employee partners and the communities that we serve in an ethical, legal and responsible manner. Further, Itasca Medical Care is committed to providing all services in full compliance with all applicable laws, regulations and guidelines, as well as with our own policies and procedures. We are particularly sensitive to requirements applicable to federal and state health care programs.

The *Standards of Conduct*, as well as all statutes, regulations, guidelines, and Itasca Medical Care policies and procedures must be observed by everyone: employee partners, contract labor, enrollees, providers, and anyone else engaged in our work environment or acting on behalf of Itasca Medical Care including FDRs – First Tier, Downstream and Related Entities. No one, regardless of position, will be allowed to compromise adherence to the *Standards of Conduct*, statutes, or regulations. Failure to comply can result in serious damage to our standing in the community, regulatory action against Itasca Medical Care and individual employee partners, and employee partner corrective action.

If you have questions about the *Standards of Conduct* or about any Itasca Medical Care policies or practices, you should raise the question with your supervisor first. If the response received from your supervisor does not resolve the issue(s) concerning application of the *Standards of Conduct*, you are invited to address your concerns to the Contract Compliance Officer.

The *Standards of Conduct* adopted by Itasca Medical Care are intended to ensure that we meet our compliance goals in a highly regulated business environment. The *Standards of Conduct* are designed to provide general guidance, and not replace the policies and procedures of the organization. If there is no specific policy, the *Standards of Conduct* becomes the policy. If a policy and the *Standards of Conduct* seem to conflict, the *Standards of Conduct* should be followed. In seeking additional guidance and direction regarding the *Standards of Conduct*, employee partners are encouraged to refer to Itasca Medical Care Policies and Procedures. The *Standards of Conduct* are a “living document”, which will be updated periodically to respond to changing conditions. Therefore, Itasca Medical Care reserves the right to modify or amend the *Standards of Conduct* at any time.

PURPOSE

Itasca Medical Care (IMCare) is a non-profit, county-owned, county-based purchasing (CBP) organization dedicated to providing high quality health services in order to improve the health of the people of the IMCare service area.

The guide that follows presents the *Standards of Conduct* for all IMCare employees, contracted employees, Itasca County Board of Commissioners, and first tier, downstream and related entities (FDRs). IMCare's *Standards of Conduct* are intended to serve as guiding principles for how IMCare and first tier and downstream entities conduct themselves in the course of doing business. All persons acting as representatives of IMCare are expected to conduct themselves with the highest professional ethics.

The principles included in these *Standards of Conduct* reflect IMCare's commitment to:

- Uphold its duty to protect confidentiality
- Demonstrate strong business integrity
- Encourage a culture that promotes open and candid communication
- Meet regulatory responsibilities

VALUES

IMCare's values help guide our business and how we conduct ourselves in our relationships with others.

- Integrity is the driving force behind our obligation to provide quality health care services and our commitment to honest, forthright, and respectful communications with all
- Respect that fosters a work environment based on teamwork, encouragement, and trust, along with honest and open communication among all employees and business partners
- Responsibility for adhering to the highest legal and ethical standards for our business
- Promoting stewardship by responsibly managing our resources, using them in the best way possible for our members
- Protecting, promoting, and improving the health of all people, families, and communities of the service area

ADDRESSING INTEGRITY CONCERNS

IMCare's business is governed by complex, demanding, and ever-changing laws, rules, and regulations. We recognize that the application of these laws, rules and regulations can create uncertainty for employees and other IMCare representatives in some situations. IMCare is committed to providing each responsible person with the resources and training needed to make ethical and legal decision while performing his/her job.

Questions and concerns about the proper way to handle different situations may, and often do, arise. Open discussion of issues and concerns by all employees without and fear of retaliation is essential to the success of the Compliance Program and IMCare. We are expected to ask questions and raise concerns when we have doubts about whether an action or situation is proper.

We all have the responsibility to engage in appropriate business conduct. In addition, we must report any activity that we, in good faith, believe may be a violation of any applicable laws, regulations, policies and this *Standards of Conduct*. IMCare policy and procedure 1.05.14: Non-Retaliation/Non-Retribution Policy forbids retaliation against any employee who bring forward a good faith concern. Any person who violates this policy is subject to disciplinary action up to and including termination. We are encouraged to talk to our supervisors first about any questions or concerns we may have. However, there are alternative channels and resources available, as outlined in the following steps:

Step 1: When in doubt, ask and continue asking until you get an answer that makes sense.

- Is there a law or regulation being violated?
- Is the situation consistent with IMCare values, policies and *Standards of Conduct*?
- Could the situation harm IMCare's reputation?
- How would the situation be described in a newspaper headline?

Step 2: Discuss your issue or concern with your direct supervisor. Give them a chance to participate in problem-solving your issue or concern. If you still have concerns after talking with them or you are not comfortable discussing the issue with them, go to the next step.

Step 3: Discuss your issue or concern with the Contract Compliance Officer or IMCare Director. If you are not taking this step, go to the next step.

Step 4: Call the IMCare Compliance Hotline at **1-866-269-0584**. Issues may also be reported via email to **IMCareCompliance@co.itasca.mn.us**. Reporting by email is not considered anonymous.

INTEGRITY STANDARDS

Compliance with Laws/Regulations

IMCare is committed to complying with all federal, state and local laws and regulations that govern its business. We are each responsible for ensuring our own compliance with laws, rules, regulations and contractual obligations applicable to IMCare. Understanding the laws and regulations that apply to our roles at IMCare is a part of our job responsibilities.

IMCare's commitment to complying with laws and regulations applies to applicable common business practices and laws and the laws, regulations and guidance that govern the State and Federal health care programs that IMCare administers.

Your Duties:

- Reporting promptly to the Contract Compliance Officer when any possible violation of law, regulation, guidance or policy has occurred.
- We will not provide or accept kickbacks, bribes, rebates or anything else of value in order to influence providers or contractors.
- Never jeopardize your job, your coworkers' jobs or IMCare's future by taking part in a potentially illegal or unethical activity.
- We shall not employ or contract with individuals who have been suspended or barred from providing services under federal or state healthcare programs.
- We shall voluntarily self-report potential fraud or misconduct to the federal and/or state agency, or its designee, as it is detected and/or required.

Lobbying and Political Activity

IMCare supports all employees' right to participate in and contribute to political activities as citizens of their country, state, county, city, and neighborhood. This includes voting in elections and educating yourself on issues that may affect you or your community. However, your political involvement must be separate from your duties as at or for IMCare. There should never be an appearance that IMCare is connected to or endorses your political activities.

Federal law restricts the use of IMCare funds in connection with federal and state elections.

Lobbying involves the advocacy of an interest that is affected, actually or potentially, by the decisions of government leaders. IMCare commissioners, managers, supervisors, employees, and where appropriate, contractors and other agents, must not engage in any lobbying or political activity that is not compliant with applicable law.

COMPLIANCE AND FRAUD, WASTE AND ABUSE OVERSIGHT PROGRAMS

We have a duty to live up to our regulatory responsibilities. Because IMCare work involves serving Minnesota Health Care Programs members in Itasca County, it naturally falls into the public spotlight. Everything said and done must meet professional and ethical standards. The only course of action you should ever take is to do what is right, every time and under every circumstance.

IMCare has government program contracts with the Minnesota Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS). IMCare is firmly committed to complying with all applicable federal and state standards and requirements included in the DHS and CMS contracts, including applicable Medicare and Medicaid statutes, regulations and program manuals, the federal and state False Claims Acts, the federal and state Anti-Kickback Statutes, the STARK law, and the Health Insurance Portability and Accountability Act (HIPAA). IMCare employs policies and procedures to ensure that illegal remuneration is not permitted, and if any unlawful remuneration scheme is uncovered, IMCare will take appropriate steps to remedy.

IMCare management fully supports the policies and procedures that require reporting of non-compliance with any law, or policy. You may report any concerns related to IMCare's business, 24 hours a day, 7 days a week by calling 1-866-269-0584 or emailing IMCareCompliance@co.itasca.mn.us.

Reporting a Compliance Concern or Incident

We are all expected to do what is right. Laws, regulations and organizational policies can be complex and sometimes confusing. While IMCare expects that its representatives try to do what is right, the right thing to do may not always be clear.

To avoid confusion and to facilitate compliant behavior, all employees, and first tier, downstream and related entities are expected to promptly report any good faith belief of a violation of the laws and regulations that govern IMCare's business.

Compliance reports may include:

- Questions or concerns about fraud, waste and abuse
- Possible violations of laws or regulations
- Questions about ethical business behavior
- Concerns about possible violations of IMCare policies
- Concerns about financial reporting

No employee or first tier, downstream or related entity will suffer any penalty or retribution for reporting in good faith any suspected misconduct or noncompliance. IMCare is compliant with protection under enhanced whistleblower rights under 41 U.S.C section 4705.

Any employee or first tier, downstream or relation entity who knows of, but fails to report, suspected misconduct or noncompliance may be subject to termination of employment or contract.

Ways to report a compliance concern or question:

- Compliance Hotline: **1-866-269-0854**
- **IMCareCompliance@co.itasca.mn.us**
- CMS designee, such as CMS MEDIC (Medicare concerns) at: **1-877-772-3379**

Fraud, Waste and Abuse Reporting

IMCare employees and first tier, downstream and related entities are obligated to comply with the fraud, waste and abuse laws, which have a significant impact on health care and health insurance costs.

Fraud, waste and abuse deterrence is not only good business practice by IMCare and its employees and first tier, downstream and related entities. But deterrence also contributes to the efficiency and quality of the health care system. IMCare is committed to complying with all Medicaid and Medicare law, regulations, guidance and standards.

IMCare closely examines allegations of fraud, waste and abuse, investigates the evidence and seeks appropriate remedies. The federal and state False Claims Acts have what is known as whistleblower protections. Individual with specific knowledge of false claims submissions have the right to file a claim and will be protected under both the federal and the state False Claims Acts for doing so.

Ways to report suspected fraud, waste and abuse concerns or questions:

- Report any incidence of suspected fraud, waste or abuse, to the IMCare Health Plan Compliance Coordinator at **218-327-6766 or 1-800-843-9536, ext. 2766**
- Compliance Hotline: **1-866-269-0854**
- **IMCareCompliance@co.itasca.mn.us**
- CMS designee, such as CMS MEDIC at **1-877-772-3379**

First tier, downstream and related entities must:

- Widely publicize methods for reporting fraud, waste and abuse to your employees
- Take disciplinary action with employees when non-compliance or unethical behavior is involved and according to contract.

CONFLICT OF INTEREST

IMCare demonstrates good stewardship by avoiding situations where our own personal interests may conflict, or appear to conflict, with the interests of IMCare. IMCare maintains a policy that protects itself from any conflict of interest that could result in situations where a personal financial interest may affect the ability to make fair and objective decisions on behalf of IMCare. A conflict of interest occurs whenever a person permits the prospect of direct or indirect personal gain to influence his/her judgment or actions in making decisions regarding IMCare business. We must be free of actual, apparent, or potential conflicts of interest when dealing with people of business entities on behalf of IMCare. We must award business solely on merit, getting the best value for IMCare and, wherever practical, on a competitive basis.

We all have an obligation to be free of actual, perceived, or potential conflicts of interest when conducting business on behalf of IMCare. A potential conflict of interest may arise in several ways, including but not limited to, when we or a family member:

- Are employed by, or owners of, a competitor, customer, provider, or supplier of IMCare;
- Use information that comes to us as representative of IMCare for personal investment or gain; or
- Take advantage of any situation for personal gain that may disadvantage IMCare.

Avoid conflicts of interest by:

- Making decisions in the best interests of IMCare
- Avoiding situations that improperly influence or appear to improperly influence your business decisions
- Asking for help if you are not sure

GIFTS AND KICKBACKS

We are all prohibited from accepting gifts or gratuities of any value that may result in undue influence on our decision-making and vendor selection. Acceptance of modest entertainment such as meals is permissible if consistent with common business practice and of nominal value. Any sort of kickback or gifts of cash or cash equivalents are always prohibited, even if of nominal value.

IMCare's business involves dealing with federal and state government officials and employees who are bound by specific laws and regulation governing gifts and gratuities. IMCare is committed to ensuring compliance with these laws and regulations. Therefore, as a general rule, IMCare employees and representatives must not offer any gift or gratuity to any government official or employee. If a government official or employee demands a gift or gratuity, this must be reported to your manager, supervisor, or the Contract Compliance Officer right away.

All employees and representatives are prohibited from engaging in any conduct that violates the federal Anti-Kickback Statute. The federal Anti-Kickback Statute makes it illegal to knowingly or willfully offer, pay, solicit or receive anything of value in return for the referral of business reimbursed by Medicare, Medicaid or any other federal health care program. A violation of the Anti-Kickback Statute provides for severe criminal, civil and monetary penalties not only for individual who offer kickbacks, but also for IMCare and involved employees and representatives.

CONFIDENTIALITY OF INFORMATION

IMCare takes the obligation to maintain the confidentiality of our member's personal information very seriously. It is our obligation to do all we can to provide the necessary protections to ensure that a member's protected health information and nonpublic personal information is not used or disclosed in a manner not allowed by state or federal law. Employees and representatives must follow all IMCare policies and procedures to ensure that confidential information about our members is protected. In addition, we will only access the member's information on a need to know basis as a part of our responsibilities at IMCare.

Any unauthorized access, use or disclosure of confidential information is prohibited. Confidential information includes anything that is generally not known or shared with the public or outside IMCare.

Examples of confidential information are:

- Sensitive information that IMCare obtains through its business or employment relationships;
- Proprietary information, including trade secrets, vendors and/or competitors; and
- Information about IMCare customers, employees, consultants, volunteers, contractors or participating providers that is not public knowledge.

We also may not acquire or use confidential or proprietary information (including technology) from other companies through improper means.

ACCOUNTING AND ACCURACY OF RECORDS

IMCare's reports and records made in the course of business must always be accurate, true and complete. No one may falsify, misrepresent or suppress any information contained in IMCare's records. IMCare will strictly adhere to the generally accepted accounting principles or statutory accounting principles as required. For example:

- All transactions and payments must be promptly and accurately reflected;
- No secret or unrecorded funds or assets may be created or maintained for any purposes;
- All invoices must accurately reflect the terms and services being purchased or sold and the price paid; and
- No person may make false entries, inappropriately amend entries, or fail to correct inaccurate entries.

We maintain, support and follow internal controls designed to provide reasonable assurance that transactions are authorized, and that transactions and other data are recorded and presented in a manner that is accurate, complete, current and not misleading. We charge all items to the appropriate account, regardless of the financial status of the line of business or contract.

IMCare is committed to the creation and submission of only true and accurate reports by its employees and any third parties who create or update IMCare records. We must create or submit false or misleading reports of operating statistics or measurements, such as performance data and utilization date. If we are unsure of the accuracy of any information that is to be submitted, we must take all necessary steps to verify the accuracy or raise our concerns to appropriate management. We all share the responsibility to ensure the careful and accurate document submission.

Your duties for IMCare reporting:

- Ensure that all IMCare records are accurate and complete
- Do not make false or misleading entries
- Promptly report any good faith belief of a violation
- Follow the principles of the *Standards of Conduct*

IMCare retains all documents for the appropriate period of time in accordance with IMCare's documentation retention policies as required by applicable laws and government program contractual requirements. We must not improperly destroy any records or other official IMCare documents. If litigation, a government audit or investigation is anticipated or ongoing, IMCare documents and records must be retained in their proper form until we are advised that the matter has been concluded.

OFFICE PROTOCOL/WORK ENVIRONMENT

IMCare is committed to maintaining a work environment that is safe and secure and where we treat each other with honesty, dignity and respect. We have the right to an environment free from harassment, retaliation, discrimination, violence, threats of violence, illegal drugs, and the influence of alcohol, where privacy and dignity are respected and all are protected from offensive, obscene, or threatening behavior. We strictly prohibit discrimination regarding employment.

Employees and IMCare representatives are responsible for adhering to all IMCare and Itasca County policies and procedures related to workplace safety and security, as well as federal, state and local laws and regulations governing workplace safety, employee health, and environmental protection. While on premises, employees, representatives, and visiting individuals must always wear a county-issued identification badge.

IMCare assets are to be used only for lawful, business-related purposes of IMCare. Assets include, but are not limited to entity data, business opportunities, strategies and plans, financial data, and other proprietary or confidential information about IMCare's business or its employees, equipment, credit cards, and computer supplies and software. We have the responsibility to protect these assets and to ensure that they are used for valid IMCare purposes and guarded against misuse, waste, abuse, loss, and theft. Incidental personal use of equipment and software must follow Itasca County's technology policy and any other related policies and procedures.

CONCLUSION

This *Standards of Conduct* reflects IMCare's commitment to the highest standards of legal and ethical business conduct. The *Standards of Conduct* does not contain all IMCare's policies or include all details regarding any policy. Rather, it sets for the fundamental legal and ethical principles for conducting all aspects of IMCare business. Detailed policies and procedures for conducting IMCare business are contained in Compliance 360.

Please take a few minutes to complete the attached Certification and Acknowledgement to indicate your acceptance of the *Standards of Conduct*.

In addition, you received a copy of IMCare's Conflict of Interest policy. You are obligated to review the policy and sign your acceptance and indicated any potential conflicts. Your signed acknowledgement will be reviewed to identify and address any potential conflicts.

Thank you.

CERTIFICATION AND ACKNOWLEDGEMENT

I have received and I have read, the Itasca Medical Care *Standards of Conduct*. I understand that the *Standards of Conduct* apply to my employment and that following all laws, regulations, policies, and the *Standards of Conduct* is a condition of my employment. I will seek advice from my supervisor, IMCare Director, or the Compliance Officer with any compliance questions or issues.

My signature means that I have received the Itasca Medical Care *Standards of Conduct* on _____, and that I acknowledge that it is my responsibility to read and comply with the procedures and policies set forth in the *Standards*.

Employee Partner Signature

Employee Partner Printed Name

Position

Date

By attesting at the conclusion of the electronic training module on the *Standards of Conduct*, you are completing the "Certification and Acknowledgement".

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Auditing and Monitoring Program	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.01
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

Internal auditing and monitoring standards are integral to the Compliance Plan. Data will be collected and analyzed on a regular basis to assess compliance with Medicare and Medicaid regulations, sub-regulatory guidance, contractual agreements, and all applicable Federal and State laws, as well as internal policies and procedures and established standards of practice to protect against Medicare and Medicaid noncompliance and potential fraud, waste, and abuse (FWA).

Monitoring activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An audit is a formal review of compliance with a particular set of standards (e.g., policies and procedures, business processes, laws, and regulations).

Routine chart review will be conducted to assess compliance with the established standards of practice and billing guidelines.

- Concurrent and retrospective reviews of both billing and medical records will be conducted.
- Reviews of policies, practices, procedures, documentation, transactions, and systems covered by HIPAA and the Privacy and Security regulations promulgated thereunder will be conducted.

Review Procedures for Providers:

- Reviewers selected and trained by the Contract Compliance Officer, Medical Director and/or Quality Improvement/Utilization Management (QI/UM) Director shall conduct routine random reviews from a representative sample of medical and billing records for a designated billing period ("Audit Period"). HIPAA review requirements are not limited to medical record review; thus, the reviewers shall conduct such policy, practice, procedure, document, transaction, and facility and system reviews as are deemed necessary to ensure that HIPAA requirements are met. Reviews may be both concurrent and retrospective.
- The medical records will be drawn at random by the IMCare Data/Project Coordinator from patient encounters occurring within a specified Audit Period.
 - A minimum of 10 records will be reviewed annually per randomly selected network provider; however, additional records may be reviewed at the discretion of the Contract Compliance Officer, Health Plan Compliance Coordinator, Medical Director, Pharmacy Director and/or QI/UM Director.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

- If a randomly selected network provider has less than 10 encounter records during an Audit Period, then all the providers' records for that Audit Period will be reviewed.
 - The Audit Period shall be determined by the Contract Compliance Officer, Medical Director, Pharmacy Director and/or QI/UM Director.
- The reviewer will examine the records for compliance with the applicable standards of coding/documentations practice; specifically, compliance with billing-related statutes, regulations, and guidelines.
- The reviewer will review a representative sample of each identified billing record for the Audit Period and compare charges found in those records with the documentation entered into the medical record. Each medical record will be reviewed and graded according to the point system developed. The point system will include, but is not limited to:
 - Support for the level of service and type of service billed.
 - Key element of the services provided.
 - Documentation reflecting the provider's participation in the service.
 - Where the services were provided.
 - Unbundling.
 - Services provided but not billed.
 - Legibility of medical record.
 - Proper use of modifiers.
 - Other aspects as determined by the Contract Compliance Officer or matters related to HIPAA as determined by the Itasca County Privacy Officer and Itasca County Security Officer.
- For tracking and educational purposes, a point value will be assigned to each review area to determine non-compliance. The Contract Compliance Officer, Medical Director, Pharmacy Director and/or QI/UM Director will amend the elements and subsequent point values based on national trends and issues.
- Reviews will be conducted of billings and medical records of all providers, regardless of practice or payor mix.
- Reviewers are expected to maintain medical records and other patient information confidentially. All reviewers shall be required to sign a confidentiality statement upon employment.

The IMCare Data/Project Coordinator will prepare a preliminary report detailing: the total number of billable encounters reviewed, the number of random charges reviewed as selected from the billing records, the number of compliant and non-compliant records, the leading reasons for non-compliance, and the total points accumulated.

The preliminary report will be reviewed by the Medical Director, Pharmacy Director and/or QI/UM Director who may direct additional reviews at his/her discretion.

A final report will be prepared by the Data/Project Coordinator and Contract Compliance Officer/Health Plan Compliance Coordinator indicating each reviewed provider's compliance and overall compliance. A determination of whether the provider is compliant will be made. The final report will include reasons for non-compliance.

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The final report will be provided to the provider. The provider will have the opportunity to object to findings in the report.

Any reviews done for the purpose of evaluating a provider's compliance with the HIPAA regulations will be presented to the County Privacy Officer and County Security Officer who may direct additional reviews at his/her discretion.

Review procedures for paid claims:

- The IMCare Controller, Claims Supervisor, and/or Data/Project Coordinator shall conduct routine random reviews from a representative sample of claims for a designated payment period ("Audit Period").
- The claims will be drawn at random by the Data/Project Coordinator from patient encounters occurring within the specified Audit Period.
 - A minimum of ten records will be reviewed per month per processor; however, additional records may be reviewed at the discretion of the Compliance Officer, Health Plan Compliance Coordinator, Controller and/or Claims Supervisor.
 - The sample drawn will include claims for:
 - High dollar claims
 - Targeted Case Management (TCM) – MH
 - Personal Care Assistance (PCA)
 - Elderly Waiver (EW) Services
 - Medicare
 - Medicare Secondary
 - Anesthesia
 - Ambulance
 - Vision
 - Durable Medical Equipment (DME)
 - Dental
 - Skilled Nursing Facility (SNF)
 - Emergency Room (ER)
 - Inpatient
 - Home Care
 - Laboratory Charges
 - Denied Claims
 - Reversed/Reprocessed Claims
 - Ambulatory Payment Classification (APCs)
- The reviewer will examine the records for compliance with the applicable billing standards; specifically, compliance with billing-related statutes, regulations, and guidelines.
- The reviewer will review a representative sample of each identified claim record for the Audit Period and compare charges paid to determine if the claim was processed and paid correctly. Each claim will be reviewed and graded according to the point system developed. The point system will include, but is not limited to:
 - Correct Fee Schedule usage.
 - Appropriate pricing/re-pricing.
 - Coordination of Benefits, when appropriate.

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- Overpayment/Underpayment.
 - Overrides/Hold Codes.
 - Timeliness of processing.
 - Other aspects as determined.
- For tracking and education purposes, a point value will be assigned to each review area to determine non-compliance. The Contract Compliance Officer, Medical Director and/or QI/UM Director will amend the elements and subsequent point values based on national trends and issues.
- Reviewers are expected to maintain medical records and other patient information confidentiality. All reviewers shall be required to sign a confidentiality statement upon employment.

The Data/Project Coordinator will prepare a preliminary report detailing: the total number of payment encounters reviewed, the number of random charges reviewed as selected from the claims record, the number of compliant and non-compliant records, the leading reasons for non-compliance, and the total points accumulated.

The preliminary report will be reviewed by the Medical Director, Pharmacy Director, and/or QI/UM Director who may direct additional reviews at his/her discretion.

A final report will be prepared by the Data/Project Coordinator and Contract Compliance Officer/Health Plan Compliance Coordinator indicating each reviewed processor's compliance and overall compliance. A determination of whether the processor is compliant will be made. The final report will include reasons for non-compliance.

The final report will be provided to the Claims Supervisor for discussion with the individual processors. Appropriate corrective action will be implemented to remedy the non-compliance.

The appropriate department supervisor will analyze the data to determine compliance trends. The results of this analysis will be reported to the Contract Compliance Officer and/or Compliance Committee.

Provider Objections to Review Report:

A provider may object to any final review report by submitting objections to the Contract Compliance Officer.

Objections must be made within 15 business days of receipt of the final review report, must be in writing, and state with particularity the reason for objection.

Objections to the law or billing guidelines will not be considered.

The Contract Compliance Officer, Health Plan Compliance Coordinator, Medical Director, Pharmacy Director and/or QI/UM Director, along with the Data/Project Coordinator will consider and rule on all objections in a timely manner. This group may request additional information supporting the objection from the aggrieved provider.

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- If the group agrees with the objection, then the matter is concluded, and the report shall reflect the changes. The report shall be amended with the reasons for the change, with citations of appropriate billing regulations, Medicare notices or bulletins, or other supporting documentation.
- If the group disagrees with the aggrieved provider, it will advise the provider of that decision and his/her appeal rights. The record shall state the reasons, with citations of appropriate billing regulation, Medicare notices or bulletins, or other supporting documentation. Written notice of disagreement shall be provided to the provider. If the provider fails to take a timely appeal, the review record shall stand, and corrective action may be implemented as required.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Compliance Plan	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.02
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

Itasca Medical Care (IMCare) provides an environment in which all employees, either direct or indirect, adhere to a high standard of ethical and legal conduct. IMCare requires employees and contractors to carry out their duties in an ethical and legal manner. To assure that IMCare and its staff adhere to these standards, IMCare maintains a Compliance Plan. The Plan focuses on compliance with laws pertaining to managed care organizations, privacy, and security. The Plan will seek first to prevent misconduct but is also designed for early detection of violations that will be addressed in a forthright and remedial fashion.

The goals of IMCare regarding compliance are:

- to establish policies and procedures and standards of conduct
- to designate a compliance officer and a compliance committee
- to conduct effective training and education
- to develop effective lines of communication
- to maintain an effective system for routine monitoring and identification of compliance issues enforcing standards through well-publicized disciplinary guidelines and policies and procedures that address dealing with sanctioned individuals
- to conduct internal monitoring and auditing
- to report promptly to detected offenses, investigate, develop corrective action, and report to the Government as necessary
- to conduct regular risk assessments to identify potential non-compliance

The Plan is founded on principles that assure that the Plan goals will be realized:

- **Proactivity:** High-risk areas will be identified, standards of conduct developed and maintained, and procedures will be implemented and reviewed for compliance. Risk identification will be an ongoing process.
- **Commitment:** IMCare is committed to accomplishing the goals and objectives of the Plan.
- **Education and Communication:** IMCare advocates ongoing identification of high-risk activity that creates legal risks and the adoption of procedures designed to minimize such risk.

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- Self-Assessment: Periodic self-review is a core requirement for an effective Plan. Whenever possible, self-assessment will be undertaken by an objective third party reviewer to assure the Plan is a valid and effective program.

PROCEDURE:

- 1. The IMCare Director/CEO, Quality Improvement/Utilization Management (QI/UM) Director, Controller/CFO, Medical Director, Pharmacy Director, Claims Supervisor and Contract Compliance Officer will:**
 - a. Carry out the Plan in accordance with the goals and principles identified herein.
 - b. Periodically report the results of the self-review of the Plan, and, depending on the results of those reviews, require amendment of the Plan accordingly.
- 2. The IMCare Contract Compliance Officer and Director will:**
 - a. Take steps to ensure that provider contracts, and other pertinent agreements are amended and updated as appropriate to include compliance with the Plan as a term of performance.
- 3. The IMCare Subcommittee to the Itasca County Board of Commissioners will:**
 - a. Monitor performance to determine whether each of the duties are being discharged in conformity with the goals and principles established for the Plan.
 - b. Take steps to assure the overall objectives of the Plan are being carried out.

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Title: Compliance Plan Elements	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.03
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

An effective Compliance Plan contains the following elements:

- Establishing policies and procedures and standards of conduct
- Designating a compliance officer and a compliance committee
- Conducting effective training and education
- Developing effective lines of communication
- Maintaining an effective system for routine monitoring and identification of compliance issues enforcing standards through well-publicized disciplinary guidelines and policies and procedures that address dealing with sanctioned individuals
- Conducting internal monitoring and auditing
- Reporting promptly to detected offenses, investigating, developing corrective action, and reporting to the Government
- Conducting regular risk assessments to identify potential non-compliance
- Remediation
- Assessment

The IMCare Compliance Plan will contain these elements as defined below:

1. **Establishing Policies and Procedures and Standards of Conduct:** IMCare will document all aspects of compliance with legal and regulatory requirements (includes operational policies), review and update for changes in regulations and guidance, distribute standards of conduct, and relevant policies to employees, first tier, downstream and related entities (FDRs), establish a top-down culture of compliance.
2. **Designating a Compliance Officer and a Compliance Committee:** The IMCare Compliance Officer must be an employee of Itasca County Health and Human Services and must report to senior management and the Board of Commissioners, the Compliance Officer will not hold roles that could lead to self-policing, and the Itasca County Board of Commissioners and senior management must be engaged in the program. The Contract Compliance Officer, along with the IMCare Director, Quality Improvement/Utilization Management (QI/UM) Directors, Medical Director, Pharmacy Director, Claims Supervisor and Controller, along with other key IMCare partners, are the make-up of the Compliance Committee.
3. **Conducting Effective Training and Education:** IMCare will conduct orientation and annual general compliance training for employees, senior management, board members, and FDRs (first tier, downstream, and related entities). Orientation and ongoing training must include fraud, waste, and abuse laws, and IMCare must provide specialized training by job function. Upon identifying and ranking risk, the Contract Compliance Officer and Compliance Committee, as applicable, will educate staff and contractors about the standards of practice and educate them in methods of compliance.
4. **Developing Effective Lines of Communication:** IMCare must establish effective lines of communication between the compliance officer, compliance committee, managers, the

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- Board, and contractors; and establish a hotline that is communicated and accessible to all (including providers and FDRs) and available anonymously.
5. Enforcing county standards through well publicized disciplinary standards and procedures encouraging program participation: IMCare must communicate and enforce expectations of compliance, reporting and assisting with resolution of issues, non-retaliation, and non-intimidation.
 6. Conducting Internal Monitoring and Auditing: Upon the identification and prioritization of risk, review procedures will be developed and implemented to determine compliance with the Standards of Conduct. The process of monitoring and auditing shall be designed by the Contract Compliance Officer, County Privacy Officer, and County Security Officer, as applicable and approved by the Compliance Committee. The process may give priority to review of activity of higher risk. It shall include proper controls and oversight of internal operations and contractors. It shall measure compliance program effectiveness with routine data collection and audits.
 7. Effective System for Prompt Response, Investigation, and Correction: IMCare shall maintain a means by which individuals may report violations of the Standards of Conduct or requirements of the Compliance Plan. No individual shall be subject to retribution for good faith reporting and the confidentiality of reports shall be protected when possible without compromising the achievement of the Compliance Program purposes. There must be prompt response to issues raised. Investigations shall be focused on root cause. Corrective action, or other appropriate action shall be taken (disciplinary action, repayment of overpayment) to correct problems at root cause level to reduce potential for recurrence. Investigation, documentation, and reporting shall be done in a manner to show correction to DHS and CMS with data.
 8. Conducting Regular Risk Assessments to Identify Non-Compliance: IMCare will conduct an annual risk assessment, using the Office of Inspector General (OIG) Work Plan as a tool to identify areas of concern for Federal and State governing agencies. Also, any finding in prior risk assessments will continue to be assessed for compliance.
 9. Remediation: Reasonable and prompt steps must be taken to respond to all incidents of non-compliance detected through audit and monitoring or reported by any individual. A corrective action plan will be implemented for each incident that is confirmed after any necessary investigation and required due process.
 10. Assessment: IMCare must assess and evaluate the effectiveness of the compliance program, identify opportunities, and implement changes as needed.

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Title: Compliance Investigations	Index: Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.04
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

The Contract Compliance Officer investigates compliance concerns to detect possible violations in applicable laws, regulations, and guidelines. The extent of the investigation will vary depending on the concern.

An effective reporting system makes the reporting individual feel comfortable in seeking guidance and disclosing information without threat of retribution. Reporting can be made in any of the following ways:

- A report to the Itasca County Fraud Prevention Hotline at 1-800-422-0312, ext. 2191
 - The Itasca County Fraud Prevention Investigator will forward any fraud, waste and abuse reports received on the Itasca County Fraud Prevention Hotline that pertain to IMCare to the IMCare Contract Compliance Officer for investigation.
- A report to the IMCare Compliance hotline at 1-866-269-0584 or imcarecompliance@co.itasca.mn.us
- Direct access to the Contract Compliance Officer, Privacy Officer and/or Security Officer by way of telephone, electronic mail, etc.
- Direct communication to the Contract Compliance Officer, Privacy Officer and/or Security Officer.

Reports of Questionable Practices

Reports and complaints of questionable practices may be made by anyone having knowledge or information about a known or suspected questionable practice. Reports may be made orally or in writing; however, all reports shall be received by the Contract Compliance Officer, who will coordinate a thorough and confidential investigation. Any oral, electronic, or written report should contain the following information.

- A factual, objective description of the questionable practice, including dates and times.
- The name of the individual or practice about which the report is being made.
- If the questionable practice involves inappropriate billing or charges:
 - When and if the claim was received and whether payment has been made.
 - If payment was made, what steps, if any, were taken to recoup the payment.
- The names of other individuals knowing about the questionable practices.
- Any other information deemed necessary to a thorough investigation.
- Reports may be made anonymously. If known, the investigator shall neither be required nor compelled to disclose the name of the reporting individual unless required by law or permitted by the reporting individual.

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Investigation

Upon receipt of an oral, electronic, or written report of questionable practice, the Contract Compliance Officer shall act promptly to conduct a confidential investigation. In addition to the information described above, the Contract Compliance Officer may obtain further information necessary to corroborate or dispute the report.

PROCEDURE:

The IMCare Contract Compliance Officer will:

1. Begin investigating all compliance-related concerns within seven days following receipt of the report.
2. In instances where concern was previously investigated, reviews the details of the previous investigation and actions taken.
3. Develop a written plan of investigation. The plan may be revised as the investigation proceeds. The investigation may include, but is not limited to:
 - a. Gathering relevant documents and facts
 - b. Reviewing documents
 - c. Interviewing appropriate individuals
 - d. Reviewing policies and researching procedures
 - e. Collaborating with an internal oversight authority
 - f. Contracting with an external authority
4. Document investigation methods and findings carefully and in an objective manner. Copies of supporting documents should be attached.
 - a. If the investigation does not substantiate the concern, documentation regarding the investigation is still filed. Once complete, documentation is maintained for a minimum of ten years.
 - b. When a compliance violation is found to exist, all documentation related to the investigation is kept in an “open” file until a remediation plan and any related monitoring are complete.
5. Provide feedback to the source regarding the investigation, providing the issue was not reported anonymously. Sources who report anonymously may call to receive feedback. Responses should be general in nature and not reveal information of a confidential nature such as an individual’s name or corrective action taken because of the investigation.
6. Document investigations conducted and a brief description of the results in the Compliance Issue Log. Compliance information is reported quarterly to the IMCare Subcommittee of the Itasca County Board of Commissioners.
7. Ensure that under no circumstances is retaliation for discussing a concern acceptable. This includes questions and concerns an employee discusses with an immediate supervisor, oversight authority, or the Contract Compliance Officer.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Measuring Compliance Program Effectiveness	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.05
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

The Contract Compliance Officer has been assigned the task of overseeing the monitoring of various activities and operations of Itasca Medical Care (IMCare), providing an assessment of the effectiveness of the Compliance Plan and related documents, and indicating the areas where the Compliance Plan may need to be revised or improved. To the extent that the monitoring activities reveal conduct which could potentially constitute violations of the Compliance Plan, failure to comply with applicable state and federal laws, and other types of misconduct, IMCare has an obligation to investigate the conduct in question immediately to determine whether any such violation occurred, take action to discipline the person or persons involved, and correct the problem.

IMCare believes that a thorough and ongoing evaluation of the various aspects of the Compliance Plan is crucial to its success. In order to evaluate the effectiveness of the Compliance Plan, IMCare will employ a variety of monitoring techniques, including but not limited to, one or more of the following:

- Periodic interviews with management personnel regarding their perceived levels of compliance within their areas of responsibility.
- Questionnaires developed to poll personnel regarding compliance matters including the effectiveness of individual training/educational techniques.
- Periodic written reports of personnel utilizing assessment tools developed to track specific areas of compliance risk.
- Audits designed and performed by internal and/or external auditors utilizing guidelines.
- Investigations of alleged non-compliance reported through the Reporting Policy or other means.
- Exit interview for departing employees.

Information obtained through monitoring efforts will be retained in written format and provided to the Contract Compliance Officer and, if necessary, the Compliance Committee.

PROCEDURE:

The IMCare Contract Compliance Officer will:

1. Evaluate the effectiveness of the Code of Conduct and other compliance policies and provide the results of such evaluation to the Compliance Committee and IMCare subcommittee to the Itasca County Board of Commissioners, at least annually.

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The IMCare Compliance Committee will:

1. Review, revise, and issue modifications and/or updates to the Compliance Plan based on the results of the evaluation.

The IMCare Contract Compliance Officer will:

1. Distribute any changes to the Compliance Plan to the employees.
2. Initially assess any reports received either through a Reporting Policy mechanism or through some other monitoring mechanism.
3. If the initial assessment indicates there is a basis for believing that the conduct reported constitutes non-compliance with the Compliance Plan, applicable state or federal law, or other policy, the matter shall be referred to the Compliance Committee for review and investigation.
4. Be responsible for directing the investigation and may solicit the support of internal or external resources to conduct the investigation.
5. Notify the IMCare Director regarding the nature of the complaint.
6. Commence the investigation as soon as reasonably possible, but in no event more than 30 days following the receipt of the report, information, or complaint regarding the potential non-compliance.
7. Interview the person or persons involved in or having knowledge of the potential non-compliance.
8. Review the statutes, regulations, and policies involved.
9. Prepare a summary report with recommendations on corrective actions and provide to the Director of IMCare and/or the Quality Improvement/Utilization Management Director to recommended disciplinary measures to be taken against the person or persons whose activities or conduct is the subject of the investigation.
10. Correct the problem and document disciplinary action and initiate education/training to prevent recurrence of the problem.
11. Recoup any overpayments uncovered during an investigation (with interest, if appropriate).
12. Report any viable fraud to the appropriate government agency within 60 days of the discovery of the credible evidence of fraud.
 - a. In some situations, if violations of the False Claims Act are reported to the Office of the Inspector General (OIG) within 30 days of learning of credible evidences, fines may be double instead of tripling the amount of damages.
 - b. Refer to the OIG Provider Self-Disclosure Protocol.
13. Track activities using the MEG Tool for Measuring Compliance Program Effectiveness.
 - a. Share MEG Tool with the Compliance Committee on a quarterly basis.

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Title: Compliance Oversight	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.06
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

The Compliance Committee, Contract Compliance Officer, County Privacy Officer and County Security Officer will provide Compliance Plan oversight.

Compliance Committee:

1. Purpose: The purpose of the Compliance Committee is to oversee the implementation and operation of the Compliance Plan. The Compliance Committee will review reports and recommendations of the Contract Compliance Officer regarding Compliance Plan activities, including data regarding compliance generated through audit, monitoring, and individual reporting. Based on these reports, the Compliance Committee will make recommendations to the IMCare Subcommittee to the Board of Commissioners as requested and will report to individual departments regarding compliance with the Plan. The Compliance Committee shall carry out other duties as described in this Compliance Plan.
2. Composition and Chair: The Compliance Committee shall be comprised of the IMCare Director (Chair)/CEO, IMCare Quality Improvement/Utilization Management (QI/UM) Director (Quality), IMCare QI/UM Director (Utilization), Medical Director, Dental Director, Pharmacy Director, Contract Compliance Officer, Claims Supervisor and Controller/CFO, the Itasca County Administrator, the Itasca County Health and Human Services Director/Privacy Officer, and the Itasca County MIS Director/Security Officer. If a committee member is no longer affiliated (either through employment, election, or contract) with IMCare, then his/her membership on the Compliance Committee will end immediately. A simple majority shall serve as a quorum. The Compliance Committee reports to the IMCare Subcommittee to the Itasca County Board of Commissioners.
 - a. The Compliance Committee shall meet at least quarterly at predetermined times and dates, and at any time a meeting is needed.
 - b. A summary of the items addressed, or actions taken at each meeting shall be made and retained by the Contract Compliance Officer.
3. Duties: The duties of the Compliance Committee shall include, but are not limited to:
 - a. Overseeing the implementation and operation of the Compliance Plan.
 - b. Reviewing and giving final approval of the Plan, Standards of Conduct, and policies and procedures, and any amendments thereto, related to compliance.
 - c. Furnishing adequate resources for and support of the Plan.
 - d. Reviewing and evaluating risk assessments prepared by the Contract Compliance Officer and approve compliance monitoring plans.

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- e. Reviewing confidential final investigative compliance reports presented to verify that findings of non-compliance are addressed through appropriate corrective action plans and/or disciplinary action to assist in reducing the risk of similar non-compliance in the future.
 - f. Enforcing consistent application of compliance standards, including fair, equitable and consistent disciplinary action of individuals identified as responsible for confirmed non-compliance.
 - g. Providing guidance to the Contract Compliance Officer in the development of policies and standards related to compliance awareness, training, monitoring, and response (including corrective action, sanctions and enforcement) to identify, avoid and/or minimize non-compliance with applicable laws, regulation and policies.
 - h. Receiving and acting upon reports and recommendations from the Contract Compliance Officer and IMCare Director.
 - i. Serve as appellate body for employees contesting compliance reports.
 - j. Evaluating the performance of the Compliance Plan and making recommendations accordingly.
 - k. Evaluating the performance of the Contract Compliance Officer and the overall operation of the Compliance Program.
 - l. Reporting actions and making recommendations to the appropriate officials, regarding employee performance.
 - m. Performing other functions that may be reasonably necessary to fulfill the Compliance Committee's responsibilities and purpose.
4. Committee Member Responsibilities:
- a. Compliance committee members are expected to regularly attend the scheduled and called Compliance Committee meetings.
 - b. Any sensitive information regarding employees, or information identified as confidential or proprietary learned by a member during his/her tenure on the Compliance Committee shall be considered confidential and the Compliance Committee members shall not disclose such information unless otherwise directed.
5. Subcommittees: Subcommittees may be formed from the Compliance Committee's membership to address specified issues.

Contract Compliance Officer:

- 1. Purpose: The Contract Compliance Officer is responsible for the implementation, administration, and oversight of the Compliance Plan. The Contract Compliance Officer is the lead administrator of the Compliance Plan and reports to the IMCare Director.
- 2. Duties:
 - a. Develop and implement the IMCare Compliance Plan, including providing oversight and monitoring of its implementation and periodic review.
 - b. Monitor and oversee the Compliance Plan in conjunction with the County Privacy Officer and County Security Officer relating to HIPAA.
 - c. Develop policies and procedures for implementation and operation of the Compliance Plan.
 - d. Maintain, distribute, and promote IMCare's Standards of Conduct.

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- e. Maintain, distribute, and promote IMCare's Conflict of Interest policies and procedures.
 - f. Maintain current knowledge of laws and regulations, keeping abreast of recent changes that may affect IMCare policies, procedures, and processes through personal research, seminars, peer contact, and bench-marking compliance monitoring practices and implementation strategies.
 - g. Coordinate efforts of staff, delegates, and providers to implement the Plan.
 - h. Encourage awareness among employees, delegates, and contractors about compliance matters and the importance of adherence to the Standards of Conduct by developing, coordinating, and participating in a training program that focuses on compliance-related issues.
 - i. Provide guidance to administration, governing body, and staff to facilitate compliance with statutory, regulatory, and IMCare requirements.
 - j. Oversee monitoring, auditing, and reporting of activity within the scope of the Compliance Plan.
 - k. Investigate possible non-compliance.
 - l. Maintain a retribution-free system for reporting of non-compliance or concerns about Compliance Plan matters, which includes implementing and publicizing a "Compliance Hotline".
 - m. Ensure that a compliance risk assessment is completed by IMCare at least annually and report results and recommend areas of focus to control or manage the identified risks.
 - n. Assist in development of corrective action plans.
 - o. Report any violations of HIPAA requirements to the County Privacy Officer and/or County Security Officer, as applicable.
 - p. Serve on the Compliance Committee.
 - q. Routinely report results of monitoring, auditing, and reporting activity to the Compliance Committee.
 - r. Provide leadership for IMCare's compliance efforts.
 - s. Ensure that the HHS-OIG's list of excluded individuals, SDN, and related entities and the General Services Administration's list of parties debarred from federal programs have been checked with respect to physicians, staff, contractors, and vendors.
 - t. Work with all departments/areas of IMCare to identify high risk compliance areas.
3. Specific Authority: The Contract Compliance Officer shall have the authority to carry out the above-mentioned duties.

Senior Management:

- 1. Role: Senior Management plays an important role in the Compliance Plan:
 - a. Work with the Contract Compliance Officer, County Privacy Officer, County Security Officer, and Compliance Committee to assure compliance with the Compliance Plan in their departments, and otherwise oversee departmental compliance and encourage a culture of compliance throughout their departments.
 - b. Implement corrective/disciplinary action as necessary to assure compliance, and as recommended.

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- c. Cause their department to develop and adopt departmental policies and procedures to enable their departments to adhere to the Compliance Plan.
- d. Review departmental policies, at least annually, to assure that they conform with the Compliance Plan.
- e. Provide information to the Contract Compliance Officer, County Privacy Officer, County Security Officer, and Compliance Committee, as necessary, regarding their departments and their compliance efforts.
- f. Apprise employees of the results of monitoring, auditing, and reporting of activities of the Compliance Plan.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Compliance Reporting to the Board	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.07
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

The quarterly compliance report is intended to keep the Itasca County Board of Commissioners informed of how the compliance program is operating, to ensure the Board that complaints or concerns are being addressed, and to ensure continued oversight and support from the Board in Itasca Medical Care's (IMCare) compliance program. The Director of IMCare will report to the IMCare Subcommittee of the Board on a quarterly basis. If an issue is deemed to be of a serious nature, however, it will be reported to the Board at its next regularly scheduled meeting after the issue arises. During the quarterly report, the Director will inform the IMCare Subcommittee of the Board of any current compliance issues or investigations and inform them of compliance audits performed during the previous quarter.

PROCEDURE:

The IMCare Contract Compliance Officer will:

1. Perform complex audits in at least four areas.
2. Provide written information to the IMCare Director for reporting to the IMCare Subcommittee of the Board.

The IMCare Director will:

1. Present the audit results and other relative compliance information to the IMCare Subcommittee of the Board on a quarterly basis.
2. Ensure maximum confidentiality of the information conveyed to the IMCare Subcommittee of the Board.
3. Collect any written reports that were prepared for the quarterly presentation and return them to the Contract Compliance Officer.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Compliance Remediation	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.08
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

The Contract Compliance Officer develops a remediation plan when a compliance violation is detected. The plan is designed to prevent a recurrence of the violation and is a key factor in evaluating the success of the compliance plan.

PROCEDURE:

The IMCare Contract Compliance Officer will:

1. Develop remediation plans on a case-by-case basis, which may include:
 - a. Additional or modified education.
 - b. Corrective action.
 - c. Development of new policies and procedures.
 - d. Revision to existing policies and procedures.
 - e. Revision to the Compliance Plan.
 - f. Additional monitoring and auditing.
 - g. Reporting to outside agencies.
2. Ensure that corrective action resulting from a compliance investigation follows the Corrective Action Plans Policy and Procedure (1.05.09).
3. Coordinate reporting of issues, and monitoring settlement of issues, reported to outside authorities.
4. Prepare routine compliance status reports that include investigations conducted, a brief description of the results, including any corrective action, and general remediation plan information.
5. Maintain a compliance log of compliance issues received and the results of any investigation.
6. Document on, or attach to, the Compliance Issue Log any remediation plans, including any reporting to an external agency. Plans that require more monitoring are considered “open” and are not filed until the monitoring period is successfully completed. Once completed, all documentation related to the investigation and required remediation of a compliance concern is filed for a minimum of ten years.
7. Ensure that employees are not retaliated against for their participation in the reporting and/or investigation process. This includes questions or concerns an employee discusses with an immediate supervisor, oversight authority, or the Contract Compliance Officer.

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The IMCare Director will:

1. Report to the IMCare Subcommittee of the Itasca County Board of Commissioners investigations conducted, a brief description of the results, and general remediation plan information, including any reporting to outside agencies.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Corrective Action Plans	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.09
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

Corrective action shall be imposed as a means of facilitating the overall Compliance Plan goal of full compliance. Corrective action plans should assist staff and providers to understand specific issues and reduce the likelihood of future non-compliance. Corrective action, however, shall be sufficient to effectively address the instance of non-compliance and should reflect the severity of the non-compliance and staff and provider's past adherence to compliance standards.

Basis for Corrective Action: Internal review reports, consultants' reports, external audit reports, focused audits, and reports of questionable practices may be considered as the basis for imposing corrective action.

Elements of a Corrective Action Plan:

1. As appropriate given the nature of the noncompliance, a corrective action plan shall include:
 - a. A resolution of specific problems identified.
 - b. A recommendation to reprocess or not pay inappropriate claims.
 - c. A report to appropriate government authorities about the non-compliance, if required.
 - d. A recommended policy and/or procedure to modify practices to reduce the likelihood of recurrence and to monitor adoption of and compliance with the recommendations.
 - e. Additional mandatory education and training for staff and providers who are the subject of the corrective action.
 - f. Other corrective measures as required/recommended by the Compliance Committee.
 - g. Focused reviews of individual records for a defined period.
 - h. Other reasonable corrective action measures calculated to ensure adherence to the compliance plan.

Corrective actions shall be in response to non-compliance during a given audit period, but non-compliance in previous audit periods can be considered in deciding upon appropriate corrective action.

The failure of an individual or entity subject to a corrective action plan to adhere to the plan shall be grounds for further corrective action.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

PROCEDURE:

The IMCare Contract Compliance Officer will:

1. Use the information from compliance investigations to develop correction action plans when non-compliance issues are identified.
2. Propose the corrective action plan to the Compliance Committee (or the Director and Quality Improvement/Utilization Management (QI/UM) Director) for review and approval prior to presentation to the individual(s) involved in the non-compliance issue.
3. Follow up and audit corrective action plans to determine whether the corrective action plan is being followed and is effective. The failure of an individual or entity subject to a corrective action plan to adhere to the plan shall be grounds for further corrective action.

First Report of Noncompliance

The IMCare Contract Compliance Officer will:

1. Conduct remedial education, including determining the format to be used.
2. Within 90 days after the remedial education is completed, perform a follow-up audit for compliance.

Second Report of Noncompliance

The IMCare Director will:

1. Execute a letter of reprimand to the staff or provider.

The IMCare Contract Compliance Officer will:

1. Conduct remedial education, including determining the format to be used.
2. Perform concurrent review of issue for a 60-day period.
3. Within 90 days after the remedial education is completed, perform a follow-up audit for compliance.

Third Report of Noncompliance

The IMCare Contract Compliance Officer will:

1. Present the compliance investigation to the Compliance Committee for further review, actions, and recommendations.

The IMCare Compliance Committee will:

1. Review the results of the compliance investigation(s) and based on the seriousness of the non-compliance determine what action should be taken, including termination of the staff and/or provider. Only the IMCare Director has authority to terminate or recommend termination of an IMCare employee. The IMCare Director and/or QI/UM Director has the authority to terminate contracted individuals.
2. Implement any action as determined by the committee.
3. Prepare notice to the staff and/or provider regarding the results.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: False Claim Reporting	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: Deficit Reduction Act of 2005, Section 6032; 31 USC 3279-3133; 31 USC Chapter 38; MN Rule 9505.2160 to 9505.2245; 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 1/1/07	Policy Number: 1.05.10
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

DEFINITIONS:

Abuse means:

- In the case of a **vendor or provider**, a pattern of practices that are inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs to IMCare programs or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health services. The following practices are deemed to be abuse by a vendor:
 - Submitting repeated claims, or causing claims to be submitted, from which required information is missing or incorrect;
 - Submitting repeated claims, or causing claims to be submitted, using procedure codes which overstate the level or amount of services provided;
 - Submitting repeated claims, or causing claims to be submitted, for health services that are not reimbursable under IMCare;
 - Submitting repeated claims, or causing claims to be submitted, for health services that do not comply with Minnesota Rules Part 9505.0210, and if applicable, Minnesota Rules Part 9505.0215;
 - Submitting repeated duplicate claims, or causing claims to be submitted, for the same services provided to the same enrollee;
 - Repeated submission of claims, or causing claims to be submitted, for services that are not medically necessary;
 - Failing to develop and maintain health service records as required under Minnesota Rules Part 9505.2175;
 - Failing to use generally accepted accounting principles or other accounting methods which relate entries on an enrollee's health service record to corresponding entries on claims;
 - Failing to disclose or make available to the IMCare an enrollee's health service records or the vendor's financial records as required by Minnesota Rules Part 9505.2185;
 - Failing to properly report duplicate payments from third party payers for covered health services provided to an enrollee and billed to IMCare;
 - Failing to obtain information and assignment of benefits as specified in Minnesota Rules Part 9505.0070, subpart 3, or to bill Medicare as required by Minnesota Rules Part 9505.0440;
 - Failing to keep financial records as required under part 9505.2180;

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- Repeatedly submitting or causing false information to be submitted for the purpose of obtaining a service agreement, prior authorization, inpatient hospital admission certification under Minnesota Rules Parts 9505.0501 to 9505.0540, or a second surgical opinion as required under Minnesota Rules Part 9505.5035;
 - Submitting a false or fraudulent application to become an IMCare network provider;
 - Soliciting, charging, or receiving payments from IMCare enrollees or other non-medical assistance sources, in violation of CFR 42 § 447.15, or Minnesota Rules Part 9505.0225, for services for which a vendor or provider has received reimbursement from or should have billed to IMCare.
 - Payment by a vendor of program funds to another vendor whom the vendor knew or had reason to know was suspended or terminated from program participation;
 - Repeatedly billing IMCare for health services after entering into an agreement with a third-party payer to accept an amount in full satisfaction of the payer's liability;
 - Repeatedly failing to comply with the requirements of the IMCare provider participation agreement that relate to the programs covered by Minnesota Rules Parts 9505.2160 to 9505. 2245 (surveillance and integrity review requirements);
 - Failing to comply with the ownership and control information disclosure requirements of CFR 42 § 455;
 - Billing for services that were provided to an enrollee without the request or consent of the enrollee, the enrollee's guardian, or the enrollee's responsible party;
 - Billing for services that were outside of the vendor's license, or in the case of a vendor that is not required to hold a license, billing by a vendor for services that the vendor is not authorized to provide under applicable regulatory agency requirements; or
 - Billing for services in a manner that circumvents program spenddown requirements.
-
- In the case of an **Enrollee**, the use of health services that result in unnecessary costs, or in reimbursements for services that are not medically necessary. The following practices are deemed to be abuse by an enrollee:
 - Obtaining equipment, supplies, drugs, or health services that are in excess of limits or that are not medically necessary and that are paid for by IMCare;
 - Obtaining duplicate or comparable services for the same health condition from a multiple number of providers, such as going to multiple pharmacies or physicians. (Does not include a second opinion that is medically necessary.);
 - Continuing to engage in practices that are abusive after receiving written notice from IMCare warning that the conduct must cease;
 - Altering or duplicating their IMCare identification card for the purpose of obtaining additional health services or aiding another person to obtain such services;
 - Using an identification card that belongs to another person;

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- Using an identification card to assist an unauthorized individual to obtain health services for which IMCare is billed;
- Duplicating or altering prescriptions;
- Misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs;
- Furnishing incorrect eligibility status or information to a provider;
- Furnishing false information to a provider in connection with health services previously rendered to the enrollee which were billed to IMCare;
- Obtaining health services by false pretense;
- Repeatedly obtaining health services that are potentially harmful to the enrollee;
- Repeatedly obtaining emergency room health services for non-emergency care;
- Repeatedly using medical transportation to obtain health services from providers located outside the IMCare service area when health services appropriate to the enrollee's physical or behavioral health needs can be obtained inside the service area;
- Repeatedly arranging for services and then canceling services to circumvent the spenddown requirement; and
- In addition to the criteria listed above, the following are deemed to be abuse by an enrollee enrolled in the restricted recipient program:
 - Obtaining medical services from a physician without a referral from the enrollee's designated primary care provider;
 - Obtaining emergency room services for non-emergency care;
 - Obtaining prescriptions from a pharmacy other than the designated pharmacy; or
 - Obtaining health services from a non-designated provider when the enrollee has been required to designate a provider.

Fraud means an act which:

- Constitutes a crime, or attempts or conspiracies to commit those crimes, including theft, perjury, aggregated forgery or forgery, medical assistance fraud, or financial transaction card fraud;
- Constitutes a false statement, false claim, or false representation where the person knows, or should reasonably know the statement, claim or representation was false, including knowingly and willfully submitting a false or fraudulent application for provider status; and
- Is a felony.

Waste means:

- Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs.
- It is not generally considered to be caused by criminally negligent action, but by the misuse of resources.

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POLICY:

All employees read and sign IMCare's *Standards of Conduct*. The *Standards of Conduct* address the issue of false claims. All employees will also be provided a copy of the booklet entitled *An Overview of the False Claims Act and Federal Health Care Programs*, and a copy of this policy and procedure, with attachments.

Responsibility of non-management employees:

Anyone who has knowledge of a violation must report this information. If you report a violation, you will not experience retaliation. If you do not report a violation, you may be subject to disciplinary action even if you were not directly involved.

Responsibility of Management:

Management must demonstrate and promote a commitment to ethical and legal behavior that is consistent with Itasca Medical Care's mission and values. As a leader you have the obligation to ensure that IMCare employees under your supervision:

- Know about and follow all laws, regulations, and policies within the scope of their responsibilities.
- Know the procedure for reporting suspected or actual violations.
- Encourage others to ask questions and to report actual or suspected violations

PROCEDURE:

1. IMCare Staff will:

- a. Report incidences of suspected fraud, waste, and/or abuse to their supervisor, the IMCare Director, another member of management, or the Contract Compliance Officer.

2. The IMCare Supervisor/Director or other notified party will:

- a. Document report.

3. The Member of Management/Contract Compliance Officer will:

- a. Assure the staff that the issue will be addressed by the Compliance Committee.
- b. Forward the issue to the Compliance Committee.

4. The IMCare Compliance Committee will:

- a. Take steps to ensure that the staff does not experience retaliation.
- b. Maintain confidentiality.
- c. Investigate provider and/or enrollees based on information received, to monitor compliance with Medicaid and/or Medicare program requirements.
 - Review claims
 - Review DTR notices
 - Review relevant regulations, statutes, and rules
- d. Review service requests.

5. The Appropriate Staff will:

- a. Conduct interviews of all parties involved to ascertain facts and intent.
 - Examination of medical records and/or financial records.

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- Examination of equipment, materials, prescribed drugs, or other items used for services.
 - Examination of prescriptions for enrollees.
 - Verify credentials of providers, and provider employees.
 - Consult peer review.
- b. Report results of investigation to Compliance Committee.

6. The IMCare Compliance Committee will:

- a. Review and discuss the results of the investigation; determine whether:
- In compliance with the requirements of the Medicaid and/or Medicare Programs.
 - Insufficient evidence exists.
 - Evidence supports administrative, civil, or criminal action.
- b. Based upon the results of the review of the investigation, and determination, take one or more actions:
- Close the investigation when no further action is warranted.
 - Impose administrative remedies.
 - Refer the matter to the appropriate state regulatory agency.
 - Refer the matter to the State Attorney General or the County Attorney for appropriate criminal legal action.
- c. Issue a warning that states the practices/actions are potentially in violation of laws or regulations (see Restricted Recipient Policy and Procedure 02.06.16).
- d. Administrative Remedies for Providers:
- Referral to licensing board,
 - Suspend or terminate participation,
 - Require prior authorization of all services,
 - Restrict participation,
 - Require a provider agreement of limited duration,
 - Require a provider agreement which stipulates specific conditions of participation,
 - Review claims before payment,
 - Corrective Action Plan to monitor ongoing compliance.
- e. Administrative Remedies for Enrollees:
- Restriction of enrollee,
 - Referral to adult or child protection,
 - Reported restriction to MN Department of Human Services.
- f. Inform the staff that the Committee has followed through on his or her report.

7. IMCare Staff Reporting Incident will:

Pursue outside intervention per the Federal False Claims Act, if not satisfied with results of Compliance Committee investigation and subsequent action.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: FWA Training and Education for First Tier, Downstream and Related Entities	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR §§ 422. 503-504 ; 42 CFR §§ 423. 503-504	
Effective Date: 01/01/2009	Policy Number: 1.05.11
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

DEFINITIONS:

Plan Sponsor: An entity that has a contract with CMS to offer one or more of the following Medicare products: Medicare Advantage (MA) Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans (PDP) and 1876 Cost Plans.

First Tier Entity: A party that enters a written arrangement, acceptable to CMS, with a Plan Sponsor to provide administrative services or health care services for a Medicare eligible individual under the MA or Part D programs. Examples include: Pharmacy Benefits Manager (PBM), contracted hospitals, clinics and allied providers.

Downstream Entity: A party that enters into a written arrangement, acceptable to CMS, with persons or entities involved in the MA or Part D benefit, below the level of the arrangement between a Plan Sponsor and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Examples include: pharmacies, marketing firms, quality assurance companies, claims processing firms, and billing agencies.

Related Entity: An entity that is related to the Plan Sponsor by common ownership or control and performs some of the Plan Sponsor's management functions under contract or delegation; furnishes services to Medicare enrollees under an oral or written agreement; or leases real property or sells materials to the Plan Sponsor at a cost of more than \$2,500 during a contract period.

POLICY:

All Itasca Medical Care (IMCare) First Tier, Downstream and Related Entities are required to comply with applicable Federal and State laws and regulations to prevent, detect and correct fraud, waste and abuse and noncompliance in a timely and well-documented manner. Noncompliance may include inaccurate and untimely payment or delivery of items or medical services, complaints from members, illegal activities and unethical behavior. IMCare requires the implementation of a compliance program as a condition of contractual requirements. These requirements include the following:

- Distribute written compliance policies and procedures to workforce
- Distribute code of conduct to workforce
- Provide workforce with General Compliance Training and Fraud, Waste and Abuse training within 90 days of initial hire and annually thereafter

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- Maintain a system to receive, respond to and track questions or reports of suspected or detected noncompliance or potential fraud, waste and/or abuse from employees and to IMCare
- Completing Office of Inspector General (OIG) and General Services Administration's System for Award Management (SAM) exclusion screenings
- Reporting and requesting the use of offshore operations
- Monitoring and auditing First Tier, Downstream and related entities that provide administrative or health care services to IMCare members to ensure they comply with all requirements (e.g., training, exclusion screening, etc.) and any applicable laws, rules and regulations
- Operational oversight – conducting internal oversight of the services performed for IMCare to ensure that compliance is maintained with applicable laws, rules and regulations • Retain documentation of all compliance/training efforts

Administrative services include, but are not limited to, the following:

- Member and provider services
- Membership functions
- Utilization Management
- Claims Administration, processing and coverage adjudication
- Pharmacy benefits manager
- Hotline operations
- Bid preparation
- Licensing and credentialing

IMCare will ensure that an effective fraud, waste and abuse training and education program exists between the compliance officer and the organization's employees, managers and directors, and the organization's first tier, downstream and related entities, as required.

An authorized representative from a first tier, downstream or related entity organization must verify compliance with the requirements upon initial contracting (within 30 days) with IMCare and annually thereafter (by December 31st) by completing an Attestation of Compliance. The attestation allows the organization to attest that they will adopt the IMCare Compliance Plan, Standards of Conduct and related policies and procedures or have developed their own plan, standards or code of conduct and compliance policies and procedures that meet all requirements. First tier, downstream and related entities are required to meet the remaining requirements identified above.

First Tier, Downstream and Related Entities must immediately report compliance and fraud, waste, and abuse issues to the IMCare Contract Compliance Officer. This can be done via direct communication at 218-327-6769; via the confidential compliance hotline at 1-800-269-0584; via direct e-mail at laura.grover@co.itasca.mn.us; or, via confidential e-mail at imcarecompliance@co.itasca.mn.us.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

PROCEDURE:

1. All employees, managers, directors and board members of IMCare shall receive effective fraud, waste and abuse training to be completed annually by December 31.
2. All first tier, downstream and related entities of IMCare shall have a Compliance Plan, Standards or Code of Conduct and related compliance policies and procedures. The organization may adopt IMCare's Compliance Plan, Standards of Conduct and related policies and procedures rather than develop their own.
3. First tier, downstream and related entities must complete the IMCare Provider Compliance Attestation at initial contracting, and annually by December 31st. The attestation is located on the IMCare website:
<http://imcare.org/DocumentCenter/View/5255/Requirement-for-First-Tier-and-Downstream-Entities-PDF>
 - a. In the event IMCare does not receive the required completed attestation and accompanying documents from the first tier, downstream and related entities at initial contracting, the contract will not be executed.
 - b. IMCare will remind first tier, downstream and related entity organizations of the annual reporting requirement by newsletter or mailing. In the event IMCare does not receive the required completed attestation and accompanying documents from the first tier, downstream and related entities annually, IMCare will send a reminder letter to applicable first tier, downstream and related entities. The reminder letter will include much the same information sent in the original notification letter. Non-compliance with this requirement may result in contract termination.
4. The Contract Compliance Officer will track and maintain Provider Compliance Attestations.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Maintaining Compliance Program and Policies and Procedures	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.12
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

It is the policy of IMCare to maintain a Compliance Plan, which is a proactive effort to incorporate contemporaneous changes to the plan. Consistent with this ideal, it may be necessary from time to time to amend the overall structure of the Compliance Plan, as well as to amend various procedural and technical components therein. To ensure that the Compliance Plan remains a viable plan geared at maintaining maximum compliance, the following procedures are necessary and shall be followed with respect to Compliance Plan changes, modifications, revisions, and amendments.

PROCEDURE:

The IMCare Compliance Committee will:

1. Make technical changes to the Compliance Plan, including any component therein, which technical changes would not reduce, enlarge, and materially modify the authority of the Compliance Committee or the Contract Compliance Officer.
 - a. A technical change is one which is procedural in nature and has the effect of improving the overall operational aspects of the Plan. Examples include, but are not limited to, increasing or decreasing the number of charts reviewed, increasing or decreasing the number of training sessions, changing the manner of providing training, topics addressed at training sessions, amending monitoring/auditing criteria. A technical amendment to the Compliance Plan shall be effective upon resolution of the majority of the Compliance Committee.
 - b. All technical changes will be provided to the Itasca County Board of Commissioners for information purposes only, and to ensure that the Board has the most current version of the Compliance Plan.
2. Make recommendations to the Itasca County Board of Commissioners of substantive changes to the Compliance Plan which may affect the overall integrity of the Plan or add, delete or materially modify any policy or policies therein.

The IMCare Director will:

1. Request resolution from the Board, on behalf of the Compliance Committee, for amendments, modification, changes, or revision to the Compliance Plan that are not technical in nature.
2. Present changes to the Board.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

The Itasca County Board of Commissioners will:

1. Have exclusive authority for approving any changes to the Compliance Plan which would substantively affect the integrity of the plan or would constitute a material change to the overall plan, or to any policy or policies comprising the plan.
2. Upon recommendation of the Compliance Committee, shall be authorized to make amendments, modifications, changes or revisions to the plan.
3. Make a final resolution approving and supporting the Compliance Plan.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Monitoring of Providers/Vendors for Fraud, Waste and Abuse	Index: 1.05 - Compliance
NCQA Standard #: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Statute/CFR#: 42 CFR § 422.503; 42 CFR § 423.504; Minnesota Rule 9505 §§ 2160 through 2245	
Effective Date: 01/01/2004	Policy Number: 1.05.13
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY/PROCEDURE:

To identify providers and/or vendors providing services at a frequency or amount not medically necessary or resulting in unnecessary cost to the program.

In the case of a provider/vendor, abuse means a pattern of practices that are inconsistent with sound fiscal, business, or health services practices, and that result in unnecessary costs to the programs or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health service.

The following are deemed abuse by a provider/vendor:

- Submitting repeated claims, or causing claims to be submitted, from which required information is missing or incorrect.
- Submitting repeated claims, or causing claims to be submitted, using procedure codes which overstate the level or number of services provided.
- Submitting repeated claims, or causing claims to be submitted, for health services that are not reimbursable under IMCare.
- Submitting repeated claims, or causing claims to be submitted, for health services that do not comply with Minnesota Rules Part 9505.0210, and if applicable, Minnesota Rules Part 9505.0215.
- Submitting repeated duplicate claims, or causing claims to be submitted, for the same services provided to the same enrollee.
- Repeated submission of claims, or causing claims to be submitted, for services that are not medically necessary.
- Failing to develop and maintain health service records as required under Minnesota Rules Part 9505.2175.
- Failing to use generally accepted accounting principles or other accounting methods which relate entries on an enrollee's health service record to corresponding entries on claims.
- Failing to disclose or make available to the IMCare an enrollee's health service records or the vendor's financial records as required by Minnesota Rules Part 9505.2185.
- Failing to properly report duplicate payments from third party payers for covered health services provided to an enrollee and billed to IMCare.

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- Failing to obtain information and assignment of benefits as specified in Minnesota Rules Part 9505.0070, subpart 3, or to bill Medicare as required by Minnesota Rules Part 9505.0440.
- Failing to keep financial records as required under Minnesota Rules Part 9505.2180.
- Repeatedly submitting or causing false information to be submitted for the purpose of obtaining a service agreement, prior authorization, inpatient hospital admission certification under Minnesota Rules Parts 9505.0501 to 9505.0540, or a second surgical opinion as required under Minnesota Rules Part 9505.5035;
- Submitting a false or fraudulent application to become an IMCare network provider.
- Soliciting, charging, or receiving payments from IMCare enrollees or other non-medical assistance sources, in violation of 42 CFR § 447.15, or Minnesota Rules Part 9505.0225, for services for which a vendor or provider has received reimbursement from or should have been billed to IMCare.
- Payment by a vendor of program funds to another vendor whom the vendor knew or had reason to know was suspended or terminated from program participation.
- Repeatedly billing IMCare for health services after entering into an agreement with a third-party payer to accept an amount in full satisfaction of the payer's liability.
- Repeatedly failing to comply with the requirements of the IMCare provider participation agreement that relate to the programs covered by Minnesota Rules Parts 9505.2160 to 9505.2245 (surveillance and integrity review requirements).
- Failing to comply with the ownership and control information disclosure requirements of 42 CFR § 455.
- Billing for services that were provided to an enrollee without the request or consent of the enrollee, the enrollee's guardian, or the enrollee's responsible party.
- Billing for services that were outside of the vendor's license, or in the case of a vendor that is not required to hold a license, billing by a vendor for services that the vendor is not authorized to provide under applicable regulatory agency requirements; or
- Billing for services in a manner that circumvents program spenddown requirements.

Fraud is:

- An act which constitutes a crime against any program, or attempts or conspiracies to commit those crimes, including theft, perjury, aggravated forgery or forgery, and Medical Assistance fraud.
- Making a false statement, false claim, or false representation to program where the person knows or should reasonably know the statement, claim, or representation is false, including knowingly and willfully submitting false or fraudulent application for provider status.
- A felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D), subject to any safe harbors established in Code of Federal Regulations, title 42, Part 1001, Section 952.

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IMCare performs monthly claims audits, post utilization reviews, chart audits in conjunction with HEDIS, review of high dollar cases on a monthly basis, review of multiple ER visits within a quarter, focus audits (PCA, DME, etc.), and maintains a fraud hotline to report potential fraud, waste and abuse. IMCare follows up on all calls from enrollees regarding questionable services on DTRs and Prescription Drug EOBs. Employees are encouraged to report any suspected fraud to their immediate supervisor, the Director, or the Contract Compliance Officer. All information obtained regarding potential fraud, waste and/or abuse is forwarded to the Contract Compliance Officer for investigation and follow up. Caremark provides a list of excluded prescribers on a monthly basis, our credentialing process compares new and re-credentialing providers to the Administrative Services Agency SAM/EPLS and OIG Exclusion list on a monthly basis, PrimeWest Health queries the provider database from the claims system via StreamlineVerify and the Contract Compliance Officer queries IMCare managers and clinical staff via StreamlineVerify.

IMCare will investigate providers/vendors to monitor compliance with program requirements for the purposes of identifying fraud, theft, abuse, or error in administration of the programs.

Among the activities that IMCare's investigation may include are:

- Examination of health service or financial records.
- Examination of equipment, materials, prescribed drugs, or other items used in or for a recipient's health service under a program.
- Examination of prescriptions for recipients.
- Interviews of related parties (recipients and their responsible relatives, providers and persons employed by or under contract to providers, etc.).
- Verification of the professional credentials of a provider/vendor, the provider/vendor's employees, and entities under contract with the provider/vendor to provide health services or maintain health service and financial records related to a program.
- Consultation with IMCare's peer review mechanisms; and
- Determination of whether a health service provided to a recipient meets the criteria.

After completing its investigation, IMCare must determine whether:

- A. The provider/vendor is compliant with the requirements of a program and program payments were properly made.
- B. Insufficient evidence exists that fraud, theft, abuse, or error has occurred; or
- C. The evidence of fraud, theft, abuse, or error supports administrative, civil, or criminal action.

After determining the extent of fraud, theft, abuse, or error, IMCare will take one or more of the following actions:

1. Close the investigation when no further action is warranted.
2. Impose sanctions (restriction, suspension, termination).
3. Seek monetary recovery.
4. Implement a corrective action plan.
5. Refer the investigation to the appropriate state regulatory agency, peer review mechanism, or licensing board.

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6. Refer the investigation to CMS, DHS SIRS Unit, and/or attorney general (Medicaid Fraud Control Unit) or, if appropriate, to a county attorney for possible civil or criminal legal action.
7. Issue a warning that states the practices are potentially in violation of program laws and regulations.

If sanctions are imposed, they become effective immediately (the date of restriction, suspension, or termination).

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Non-Retaliation/Non-Retribution Policy	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.14
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

Itasca Medical Care (IMCare) is responsible for proper use of its resources. IMCare is committed to conducting its business in full compliance with the law and with its own policies and procedures. Such adherence strengthens and promotes ethical and fair practices and treatment of all employees of IMCare and those who conduct business with us. All employees and any other individuals holding a position of fiduciary duty with IMCare are obligated to perform these duties in compliance with all applicable laws and IMCare policies and procedures.

The purpose of this policy is to encourage and enable good-faith reports by IMCare employees of observed or suspected misconduct or non-compliance with law or IMCare policies and procedures without fear of retaliation or retribution.

Knowledge of suspicion of misconduct, violations of law, or other wrongdoing must be immediately reported to IMCare management, the Compliance Officer, or the IMCare Fraud Hotline.

No employee is permitted to engage in retaliation, retribution, or any form of harassment against another employee for reporting compliance-related concerns.

Employees cannot exempt themselves from the consequences of wrongdoing by self-reporting, although self-reporting may be considered in determining the appropriate course of action.

Any employee who violates this policy will be subject to disciplinary action(s).

PROCEDURE:

All IMCare management will:

1. Maintain an open-door policy and assure their staff that the system truly encourages the reporting of problems and that there will be no retaliation, retribution, or harassment for doing so.

All IMCare employees will:

1. Report any concerns directly to the Compliance Officer if he/she believes that he/she has been subject to conduct in violation of this policy.

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The IMCare Contract Compliance Officer will:

1. Begin investigations on all reported concerns of violation of this policy within 30 days.
2. Maintain confidentiality of employer concerns, as legal and practical.
3. Ensure that only personnel who have a need to know will be informed.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Reporting Non-compliance to Director	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.15
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

The Contract Compliance Officer will notify the Itasca Medical Care (IMCare) Director about all complaints and the results of all investigations. The Director, as senior executive, must be informed of all compliance efforts to ensure support for the program and to ensure that adequate measures are being taken to resolve compliance issues. The Contract Compliance Officer will inform the IMCare Director of the results of all audits for presentation to the IMCare Subcommittee of the Itasca County Board of Commissioners.

PROCEDURE:

The IMCare Contract Compliance Officer will:

1. Complete the investigation, and report directly to the Itasca County Board of Commissioners if there is evidence substantiating the complaint, if the complaint raises allegations of wrongdoing by the IMCare Director.
2. Immediately notify the IMCare Director upon receiving a compliance complaint. After formulating the initial investigation plan, the Contract Compliance Officer will discuss the plan with the IMCare Director.
3. Give the IMCare Director the results of quarterly compliance audits at least seven days prior to the meeting of the IMCare Subcommittee of the Itasca County Board of Commissioners, to ensure that she is aware of the audits and results and has the opportunity to request clarification, if necessary, prior to the meeting.

The IMCare Director will:

1. Decide whether to contact legal counsel regarding the matter, if the complaint is of a nature that raises the possibility of wrongdoing that poses immediate physical or financial harm to IMCare.
2. Receive a copy of the final compliance report, which contains a summary of the investigation and its resolution. This copy should be treated as confidential and should be returned to the Contract Compliance Officer to be kept in confidential compliance files.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Response to Government Investigations	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.16
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

Government investigators may arrive unannounced at Itasca Medical Care (IMCare) or the homes of present or former employees and seek interviews and documentation. IMCare will cooperate with any appropriately authorized government investigation or audit; however, IMCare will assert all protections afforded it by law in any such investigation or audit. The purpose of this policy is to establish a mechanism for the orderly response to government investigations to enable IMCare to protect its interests as well as appropriately cooperate with the investigation.

PROCEDURE:

Request for Interview

IMCare staff members will:

1. When government investigators request an interview, there is no obligation to consent to an interview, although anyone may volunteer to do so. One may require that the interview be conducted during normal business hours, at IMCare or another location.
2. Always be polite and should obtain the following information:
 - a. The name, agency affiliation, business telephone number, and address of all investigators.
 - b. The reason for the visit.
3. Ask if there is a subpoena or warrant to be served, and request a copy of the subpoena or warrant, when the investigator arrives.
4. Stop the interview at any time, with a request that the investigator return when counsel can be present. IMCare will be represented by the Itasca County Attorney's Office or outside contracted counsel; staff members have the right to their own individual legal counsel. Local counsel should be present for interviews whenever possible.
5. Potentially choose not to respond to the investigator's questions. The investigator has the authority to subpoena the staff member to appear before a grand jury.
6. Immediately notify his or her supervisor when contacted by an investigator. Provide this individual with as much information and documentation about the investigation as is known. Ultimately the request should be reported to the Contract Compliance Officer.

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The Search

IMCare staff members will:

1. Request an investigator on IMCare's premises to wait until the Contract Compliance Officer, counsel, the IMCare Director, Quality Improvement/Utilization Management (QI/UM) Director, Claims Supervisor or Controller arrives.
2. Not alter, remove or destroy permanent documents or records of IMCare. All records are subject to state or nationally recognized retention guidelines and may be disposed of only in accordance with those guidelines. Once there has been notice of an investigation, the destruction portion of any policy on record retention is suspended.
3. Potentially refrain from speaking to the investigators. If the investigators present a search warrant or warrant, the investigators have the authority to enter private premises, search for evidence of criminal activity, and seize those documents listed in the warrant. No IMCare staff member must speak to the investigators but must provide the documents requested in the warrant.
4. Request copies of the warrant and the affidavit providing reasons for issuance of the warrant.
5. Request an opportunity to consult with IMCare's counsel before the search commences. Provide counsel with a copy of the warrant immediately. If counsel can be reached by phone, put counsel directly in touch with the lead investigator.
6. Cooperate with the investigators, but do not consent to the search.
 - a. The Contract Compliance Officer, IMCare Director, QI/UM Director, Claims Supervisor or Controller should instruct the lead investigator that:
 - i. IMCare objects to the search.
 - ii. The search is unjustified because IMCare is willing to voluntarily cooperate with the government.
 - iii. The search will violate the rights of IMCare and its employees.
 - b. Under no circumstances should staff obstruct or interfere with the search. Although they should cooperate, an employee should clearly state that this does not constitute consent to the search.
 - c. Whenever possible, keep track of all documents and what information the documents contain given to the investigators.

The Contract Compliance Officer, IMCare Director, QI/UM Director, Claims Supervisor or Controller will:

1. Contact the prosecutor immediately and request that the search be stopped if local counsel is not available. One can negotiate alternatives to the search and seizure, including provisions to ensure that all existing evidence will be preserved undisturbed. If the prosecutor refuses to stop the search, request agreement to delay the search to enable IMCare to obtain a hearing on the warrant.
2. Attempt to negotiate an acceptable methodology with the investigators to minimize disruptions and keep track of the process. Considerations include the sequence of the search; whether investigators are willing to accept copies in place of originals; and if so, who will make the copies and how; whether IMCare will be permitted to make its own set of copies; and arrangements for access to records seized.

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3. Point out limitations on the premises to be searched and on the property to be seized.
 - a. Avoid expansion beyond the proper scope of the search from confusion or overreaching.
 - b. Never consent to an expansion of the search.
 - c. Disputes regarding the scope must be brought to the attention of the prosecutor of the court to be settled. IMCare staff members should not prevent the investigators from searching areas they claim to have the right to search.
 - d. Investigators generally have the right to seize evidence of crimes that is in their “plain view” during a search regardless of whether such evidence is described in the warrant.
4. Take steps to protect other IMCare staff members.
 - a. IMCare should send all but essential personnel home or temporarily reassign them to other areas when a warrant is served.
 - b. Selected employees should remain along with the Contract Compliance Officer, IMCare Director, QI/UM Director, Claims Supervisor or Controller and/or IMCare counsel to monitor the search.
 - c. Investigators should never be left alone on IMCare’s premises, and no employee should be left alone with the investigators.
5. Object to any search of privileged documents.
 - a. If there is a possibility that the search will compromise privileged information, IMCare should object on that basis, and raise the issue with the court if necessary.
 - b. Negotiate a methodology to protect the confidentiality of any privileged information pending a resolution of these objections. For example, segregate the privileged documents from other files, and investigators will not read the documents until the court has made a decision or the investigators will seize the documents, but place them unread in sealed envelopes until the matter is resolved.
6. Keep a record regarding the search.
 - a. Ask investigators for proper identification, including their business cards.
 - b. List the names and positions of all the investigators with the date and time.
 - c. Verify the list with the lead agent and request he or she sign it.
 - d. Monitor and record the way the search is conducted. Note in detail the precise areas and files searched, the time periods when each of them was searched, the way the search was conducted, the agents who participated, and which files were seized.
 - e. Several individuals probably will be needed to monitor the different areas being searched simultaneously.
 - f. If the monitor is ordered to leave, contact the lead investigator. A person should only be ordered to move if they are in the way, not to avoid being observed. Never provoke a confrontation with an agent.
7. If possible, do not release a document to the investigators unless it has been reviewed by counsel. This is not possible under a search warrant.
8. Keep all privileged and confidential documents separate and labeled accordingly. If seized, the documents should be protected from disclosure if labeled properly.
9. Make a record and copy of all records seized.
 - a. If this is not possible, before the agents leave IMCare’s premises, request an inventory of the documents seized.

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- b. Request the lead agent to note the date and time the search was completed as well as sign the inventory with the agent's full title, address and telephone number.
 - c. When documents are seized, the investigators are required to give the occupant a copy of the warrant.
 - d. Copies of the seized documents should be requested as well, especially medical records, as this is the most efficient way to inventory documents seized.
 - e. Create a parallel inventory of the documents seized.
 - f. Download copies of files from hard drives of computers, and copy diskettes, especially if the material is essential to the ongoing operations of IMCare.
10. Videotape the search, if possible.
- a. A videotape may provide evidence of undue disruption or misconduct on the part of the investigators.
 - b. If the investigators claim the taping interferes with the search, the Contract Compliance Officer, IMCare Director, QI/UM, Claims Supervisor or Controller should make a record of the refusal. Do not persist if the agents have warned that they regard the taping as interference.

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Title: Response to Search Warrants	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.17
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

In the event a search warrant is served on any employee or IMCare, we want to fully comply with the warrant and cooperate with the agents serving the warrant. We also want to exercise and preserve all our rights afforded by the search warrant process.

A search warrant is a written document giving legal authorization to specific law enforcement officers to search a specified area and to seize specific material. To be valid, a search warrant must:

1. Describe the material that can be seized and the places that may be searched.
2. Be signed by, or on behalf of, a judge or magistrate with jurisdiction over the area to be searched.

PROCEDURE:

1. If agents of the federal or state government present any employee with a search warrant seeking access to company material, cooperate with the agents and immediately contact legal.
2. The highest-ranking employee within the department should become the contact person for the agents. When possible, non-essential employees should be sent home until the search is completed.
3. Ask for identification from the agent in charge of executing the warrant and ask for a copy of both the search warrant and the affidavit submitted to the court in order to obtain the warrant. Fax or send this information to legal as soon as possible.
4. Cooperate fully with the agents. It is critical that no employees interfere with the agents in any way during their search or prevent them from accessing anything listed in the search warrant. To do so could constitute obstruction of justice.
5. The contact person should accompany the agents during the search and take notes of what they take, what they look at, to whom they talk, and what questions they ask.
6. The agents may ask employees questions during the search. Agents may present themselves at the home of an employee. Employees have the right to either talk to the agents or not talk to them, except to the extent that it is necessary to talk to them to comply with the search warrant. Employees have the right to consult with counsel when making that decision and to have counsel present if they decide to talk to the agents.
7. The search warrant will include an attachment listing items that can be seized and places that may be searched. If the agents try to go into areas that are not listed in the warrant, ask them to wait until legal counsel arrives. If they refuse, do not interfere, but note

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which agents went into areas not specified in the warrant, when this occurred, and whether they seized anything from the area.

8. Agents may take original documents. You should ask for a detailed inventory of the material the agents are taking. They are required to provide a receipt for the articles taken.
9. If the agent takes documents (including computer files), ask to make copies of those documents. They are not required to allow copies to be made and may refuse to do so.
10. If the agents are looking for a document housed in a place other than those specific places listed on the warrant, let the agent know we will comply once the search warrant has been updated. While you should not block access to any area, never give agents permission to search an area that is not listed on the warrant.

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Title: Training and Education	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2004	Policy Number: 1.05.18
Written by: Contract Compliance Officer	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

An effective education program ensures communication and understanding of the Compliance Plan, as well as the standards and procedures to be followed. The intent of the education and training program is to instruct enrollees about the Compliance Plan and the standards of practice, particularly the laws governing managed care. Mandatory, on-going training and education is integral to a Compliance Plan.

1. Role of Contract Compliance Officer, Privacy and Security Officer: The Contract Compliance Officer, in conjunction with, when applicable, the County Privacy Officer, and County Security Officer shall be responsible for coordinating, developing, and implementing training and education policies, procedure, and programs to ensure appropriate education and training for all levels of staff and other applicable individuals.
2. Scope: The training and education program will focus on standards of practice created by the rules applying to managed care organizations as well as, ethics, patient privacy rights, information security practices and HIPAA requirements. The scope may be expanded to include additional standards created by laws and rules regulating the industry. These programs are directed to all employees and associated individuals.
3. Training and Education:
 - a. Training will be conducted on identified issues and compliance issues designated by the Contract Compliance Officer, and County Privacy and County Security Officers.
 - b. Training content will include:
 - i. Identification and explanation of acceptable standards of practice as such standards are defined by regulation, the Centers for Medicare, and Medicaid Services (CMS) interpretation, and/or any managed care specific guidelines.
 - ii. Identification and explanation of unacceptable practices and improper activities.
 - iii. Explanation of the legal penalties for improper activities and the institutional penalties for failure to comply, and
 - iv. Explanation of the Compliance Plan, its elements, the auditing guidelines, Compliance Plan investigation protocols, and reporting procedures.
 - c. Periodic compliance-related courses will be scheduled for employees who have completed the initial training courses.
 - d. Periodic updates will be supplied to notify employees about the Compliance Plan, as well as important changes to policy, procedure, or law.

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- e. Methods of implementation:
 - i. In-service training.
 - ii. Live or video seminars.
 - iii. Computer-based training.
 - iv. Periodic electronic mail, newsletters, or other like means of communication.
- f. Annual compliance training, as well as new employee training, is mandatory. The Contract Compliance Officer or the IMCare CEO/Director will certify completion of these training courses.
 - i. Attendance lists shall be maintained for each training and/or compliance-related course given.
 - ii. Attendees are required to sign in and remain for the entire course. Computer-based training requires completion of an electronic attestation statement.
 - iii. Signing the attendance list and taking course materials, without remaining for the course, are not considered attendance unless otherwise expressly stated on the course notice or materials.
 - iv. Course completion/non-completion shall be reported to the Compliance Committee and the direct supervisor.

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Title: Fraud and Abuse Plan	Index: 1.05 - Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 438.604; 42 CFR § 455.1(a)(2); 42 CFR § 455.15(b); 42 CFR § 455.106; 42 CFR § 1001.1001; 42 CFR § 1001.1901; 42 CFR § 1002.3(b); MN Statutes § 363A.36; US Sentencing Guidelines – USSG § 8B2.1; Social Security Act of 1935, §§ 1128, 1128A, 1902(a)(68)(A); 18 USC § 874; 31 USC § 3801, et seq.; False Claims Act – 31 USC §§ 3729-3733; Fraud Enforcement & Recovery Act of 2009, Pub. L. 111-21, 123 Stat. 1617; Minnesota Rules 9505.2160 – 9505.2245	
Effective Date: 01/01/2006	Policy Number: 1.05.19
Written by: Contract Compliance Officer/Health Plan Compliance Coordinator	Reviewed/Revised Date: 04/27/2022
Attachments:	

DEFINITIONS

Abuse (for Medicaid programs) means a pattern of practices that are inconsistent with sound fiscal, business or health service practices, and that result in unnecessary costs to the programs or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health service.

The following practices are deemed to be abuse by a provider:

- 1) Submitting repeated claims, or causing claims to be submitted, from which required information is missing or incorrect;
- 2) Submitting repeated claims, or causing claims to be submitted, using procedure codes that overstate the level or amount of health service provided;
- 3) Submitting repeated claims, or causing claims to be submitted, for health services which are not reimbursable under the programs;
- 4) Submitting repeated claims, or causing claims to be submitted, for the same services provided to the same recipient;
- 5) Submitting repeated claims, or causing claims to be submitted, for health services that do not comply with part 9505.0210 and, if applicable, part 9505.0215;
- 6) Submitting repeated claims, or causing claims to be submitted, for health services that are not medically necessary;
- 7) Failing to develop and maintain health service records as required under part 9505.2175;
- 8) Failing to use generally accepting accounting principles or other accounting methods which relate entries on the recipient's health service record to corresponding entries on the billing invoice, unless another accounting method or principle is required by federal or state law or rule;
- 9) Failing to disclose or make available the recipient's health service records or the provider's financial records as required under part 9505.2185;
- 10) Repeatedly failing to properly report duplicate payments from third party payers for covered health services provided to a recipient under a program and billed to IMCare;
- 11) Failing to obtain information and assignment of benefits as specified in part 9505.0070, subpart 3, or to Medicare as required by part 9505.0440;

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- 12) Failing to keep financial records as required under part 9505.2180;
- 13) Repeatedly submitting or causing false information to be submitted for the purpose of obtaining a service agreement, prior authorization, inpatient hospital admission certification under parts 9505.0501 to 9505.0540, or a second surgical opinion as required under part 9505.5035;
- 14) Submitting a false or fraudulent application for provider status;
- 15) Soliciting, charging, or receiving payments from recipients or nonmedical assistance sources in violation of Code of Federal Regulations, title 42, section 447.15, or part 9505.0225, for services for which the provider has received reimbursement from or should have billed the program;
- 16) Payment by a provider of program funds to another provider whom the provider knew or had reason to know was suspended or terminated from program participation;
- 17) Repeatedly billing a program for health services after entering into an agreement with a third-party payer to accept an amount in full satisfaction of the payer's liability;
- 18) Repeatedly failing to comply with the requirements of the provider participation agreement that relate to the programs covered by parts 9505.2160 to 9505.2245;
- 19) Failing to comply with the ownership and control information disclosure requirements of Code of Federal Regulations, title 42, section 455;
- 20) Billing for services that were provided to a recipient without the request or consent of the recipient, the recipient's guardian, or the recipient's responsible party;
- 21) Billing for services that were outside of the scope of the provider's license, or for services that a provider is not authorized to provide under applicable regulatory agency requirements;
- 22) Billing for services in a manner that circumvents the program's spenddown requirement.

The following practices are deemed to be abuse by a recipient:

- 1) Obtaining equipment, supplies, drugs, or health services that are in excess of program limitations or that are not medically necessary and that are paid for through a program;
- 2) Obtaining duplicate or comparable services for the same health condition from a multiple number of vendors, such as going to multiple pharmacies or physicians. Duplicate or comparable services do not include an additional opinion that is medically necessary for the diagnosis, evaluation or assessment of the recipient's condition or required under program rules, or a service provided by a school district as specified in the recipient's individualized education program under Minnesota Statutes, section 256B.0625, subdivision 26;
- 3) Continuing to engage in practices that are abusive of the program after receiving the department's written warning that the conduct must cease;
- 4) Altering or duplicating the medical identification card for the purpose of obtaining additional health services billed to the program or aiding another person to obtain such services;
- 5) Using a medical identification card that belongs to another person;
- 6) Using the medical identification card to assist an unauthorized individual in obtaining a health service for which a program is billed;
- 7) Duplicating or altering prescriptions;

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- 8) Misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs;
- 9) Furnishing incorrect eligibility status or information to a provider;
- 10) Furnishing false information to a provider in connecting with health services previously rendered to the recipient which were billed to a program.
- 11) Obtaining health services by false pretenses;
- 12) Repeatedly obtaining health services that are potentially harmful to the recipient;
- 13) Repeatedly obtaining emergency room health services for nonemergency care;
- 14) Repeatedly using medical transportation to obtain health services from providers located outside the local trade area when health services appropriate to the recipient's physical or mental health needs can be obtained inside the local trade area;
- 15) Repeatedly arranging for services and then canceling services to circumvent the spenddown requirement.

In addition, the following practices are deemed to be abuse by a recipient enrolled in the restricted recipient program:

- 1) Obtaining medical services from a physician without a referral from the recipient's designated primary care provider;
- 2) Obtaining emergency room services for nonemergency care;
- 3) Obtaining prescriptions from a pharmacy other than the designated pharmacy; or
- 4) Obtaining health services from a non-designated provider when the recipient has been required to designate a provider.

Abuse (for Medicare programs) includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Fraud (for Medicaid programs) means:

- 1) Acts which constitute a crime against any program, or attempts or conspires to commit those crimes, including the following:
 - a. Theft in violation of Minnesota Statutes, section 609.52;
 - b. Perjury in violation of Minnesota Statutes, section 609.48;
 - c. Aggravated forgery and forgery in violation of Minnesota Statutes, sections 609.625 and 609.63;
 - d. Medical assistance fraud in violation of Minnesota Statutes, section 609.466; and
 - e. Financial transaction card fraud in violation of Minnesota Statutes, section 609.821
- 2) Making a false statement, false claim, or false representation to a program where the person knows or should reasonably know the statement, claim, or representation is false,

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including knowingly and willfully submitting a false or fraudulent application for provider status; and

- 3) A felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D), subject to any safe harbors established in Code of Federal Regulations, title 42, section 952.

Fraud (for Medicare programs) is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Improper Payment means any payment that should not have been made or was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes, but is not limited to:

- 1) Any payment for an ineligible recipient;
- 2) Any duplicate payment;
- 3) Any payment for services not received;
- 4) Any payment incorrectly denied; and
- 5) Any payment that does not account for credits or applicable discounts.

Medically Necessary or Medical Necessity is a health services that is, pursuant to Minnesota Rules, Part 9505.0175 subp (25):

- 1) Consistent with the enrollee's diagnosis or condition;
- 2) Is recognized as the prevailing standard or current practice by the Provider's peer group; and
- 3) Is rendered:
 - a. In response to a life-threatening condition or pain; or
 - b. To treat an injury, illness, or infection; or
 - c. To care for the mother and child through the maternity period; or
 - d. To achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or
 - e. As a preventative health service defined under Minnesota Rules, Part 9505.0335.

Restricted recipient program means a program for recipients who have failed to comply with the requirements of the program. Placement in the restricted recipient program does not include long-term care facilities. Placement in the program means:

- 1) Requiring the recipient for a period of 24 or 36 months of eligibility to obtain health services from a designated primary care provider, hospital, pharmacy, or other designated health service provider located in the recipient's local trade area; or
- 2) Prohibiting the recipient from using the personal care assistant choice or consumer-directed services for a period of 24 months of eligibility.

Suspending participation or suspension means making a provider ineligible for reimbursement through program funds for a stated period of time.

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Suspending payments means stopping any or all program payment for health services billed by a provider pending resolution of the matter in dispute between the provider and IMCare.

Termination participation or termination means making a vendor ineligible for reimbursement through program funds.

Waste means overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Withholding payments means reducing or adjusting the amounts paid to a provider to offset overpayments previously made to the provider.

POLICY:

All employees, agents or entities performing services on behalf of Itasca Medical Care (IMCare) must comply with fraud and abuse prevention and detection requirements.

Integrity Program

IMCare will have administrative and management arrangements or procedures, including a mandatory compliance plan and a Special Investigations Unit (SIU), whose responsibilities include the detection and investigation of fraud and abuse by its enrollees and providers, that are designed to guard against fraud, abuse, and improper payments.

All activities and corrective actions taken under the integrity program, will be documented. In addition, the Minnesota Department of Human Services (DHS) and other applicable regulatory agencies will be informed of the names of our integrity program officials.

A report will be submitted to DHS by April 30th of the current year, detailing the integrity program and include investigative activities, corrective actions, fraud, and abuse prevention efforts, and results consistent with DHS guidelines. The report details implementation of DHS Integrity Program requirements, and specifically describes the activities IMCare has undertaken to safeguard against fraud and abuse.

IMCare will establish and adhere to a process for reporting to the State, Medicaid Fraud Control Unit (MFCU), the State's Office of Inspector General (OIG)/Surveillance and Integrity Review Services (SIRS), Centers for Medicaid and Medicare Services (CMS), the OIG for the U.S. Department of Health and Human Services, and the appropriate law enforcement agency credible information of violations of law by the State, IMCare, Network Providers, subcontractors, or enrollees for a determination as to whether criminal, civil or administrative action may be appropriate. If IMCare has reason to believe that an enrollee has defrauded the program, IMCare will refer the case to an appropriate law enforcement agency as mandated in 42 CFR § 455.15(b).

A report that includes the name, specialty, address, and reason for adverse provider action of providers whose participation has been denied at enrollment, credentialing or recredentialing,

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and provider whose active participation status IMCare has taken action to terminate or not renew during the previous month, will be submitted to the state monthly.

The Compliance Officer and Health Plan Compliance Coordinator (and others as deemed necessary) will meet with the State's SIRS periodically, when specifically requested by the State, to discuss IMCare's anti-fraud and abuse activities.

A breach of this policy may result in noncompliance with regulatory requirements and potential penalty to IMCare. IMCare will investigate alleged violations and take disciplinary action or other appropriate corrective action.

PROCEDURE:

IMCare's integrity program requirements include administrative and management procedures, including a board-approved compliance plan and Special Investigations Unit (Program Integrity Team) whose responsibilities include the detection and investigation of fraud and abuse by its enrollees and providers that are designed to guard against fraud, abuse and improper payments that are reviewed and updated, at least annually. The procedures of IMCare's Program Integrity Team relative to fraud, waste and abuse shall include the following elements:

1. Effective training and education for IMCare employees and partners, to enhance information sharing and referrals to the Compliance Officer or Compliance Coordinator regarding fraud, waste, and abuse.
 - a. New employee and annual compliance training and education is required for all employees and partners. IMCare maintains records of training and education of employees and partners and reports regularly to the Compliance Committee.
2. Maintaining open and effective lines of communication between the Contract Compliance Officer, Health Plan Compliance Coordinator, employees, and partners concerning the reporting of fraud waste and abuse issues or incidents.
 - a. Any employee who makes a good faith report of a known or suspected instance of wrongdoing will not be subject to disciplinary action or punished for making the report. IMCare also has an absolute policy against retaliation for bringing forward a good faith concern. Reports may be made in writing, in person, via telephone, or by mail or e-mail. Reports may also be made through the IMCare compliance hotline, or via the compliance-specific e-mail, and may remain anonymous.
3. Maintaining procedures for routine internal monitoring and auditing including pre-payment review of network providers and contracted services to detect fraud waste and abuse and improper payments.
 - a. IMCare has multiple EDI edits in place to identify claims that have invalid or missing information. Claims are rejected at the clearinghouse level, so they do not require processor review.
 - b. A function of the pre-payment process is to review monitoring workflows to help identify potential fraud, waste, and abuse. Identified issues are resolved prior to

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- the payment process. This may include provider outreach, potentially voiding or denying claims and/or a referral to the Compliance Coordinator.
4. Maintaining procedures for prompt response in detecting offenses, and for the development of corrective action initiatives. This includes provisions for identifying, investigating, and taking corrective action against fraudulent and abusive practices by providers, subcontractor, enrollees, IMCare employees, board members and partners.
 - a. IMCare has established internal controls to ensure that potential fraudulent and abusive practices are identified and investigated in a timely manner. The Director approves all payments made by IMCare. The accountant and an outside firm regularly review revenues and expenses and watch for trends in each area. The Contract Compliance Officer monitors for potential conflicts of interest and any ownership or control interests that appear suspect.
 - b. IMCare staff regularly discusses fraudulent, wasteful, and abusive activity and issues. New regulations are reviewed and discussed to determine how best to meet industry standards.
 - c. IMCare maintains awareness of current efforts in the state to reduce fraud, waste, and abuse.
 - d. IMCare requires timely investigation of fraud, waste and abuse when detected, through resolution and reporting.
 - e. A corrective action plan may be developed that includes, but is not limited to, training, policy revisions, operational changes and/or discipline.
 5. Maintaining procedures for post payment edit and audits, including profiling provider services and enrollee utilization that identifies aberrant behavior and/or outliers.
 - a. Claims data and certain utilization reports are reviewed to identify trends in costs and other possible anomalies. This information is also used to identify enrollees who may need case management or restriction.
 - b. A variety of retrospective reviews are also utilized to detect potential fraud, waste, and abuse.
 - i. Data analysis, including both random and focused audits;
 - ii. Complaints from enrollees, employers and others;
 - iii. Third party review of claims and billing practices; and
 - iv. Post-payment review edits – procedure to procedure, procedure to provider, procedure to gender, frequency to time, diagnosis to procedure and others.
 6. Maintaining policies and procedures that safeguard against unnecessary or inappropriate use of services and against excess payments for services.
 - a. IMCare employs a wide variety of procedures to address over- and under-utilization and overpayments.
 - b. The Provider Advisory Committee and Quality Improvement/Utilization Management Committee reviews case management and utilization reports on a regular basis, monitors trends, and recommends action for areas of concern.
 - c. IMCare also identifies persons for possible restriction in the Restricted Recipient Program (RRP) to ensure that enrollees are receiving services appropriately.

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- d. IMCare and county staff are trained to identify and report enrollee communication that may be related to provider services that were perceived to be inappropriate or inadequate.
- 7. Maintaining policies and procedures that safeguard against failure by subcontractors or Participating Providers to render medically necessary items or services that are required to be provided to an enrollee covered under IMCare contracts.
 - a. IMCare performs prior authorization reviews for the determination of medical necessity for services and drugs.
 - b. IMCare's Quality Director and/or Pharmacy Director ensure that enrollees receive eligible services through delegated entities.
- 8. Maintaining a method to verify whether services paid for by IMCare were furnished to the enrollee as required in 42 CFR §455.1(a)(2). These methods are described in the Annual Integrity Program Report.
 - a. Transportation – IMCare will query the claims system for transportation dates of service that match a medical/dental/chiropractic appointment for enrollees. A random review of claims will be done. If the random sample reveals a potential issue, and audit of services will occur. Findings will be brought to the Utilization Review Committee for recommended action. IMCare will monitor for patterns of issues, and the appropriate fraud and abuse actions will be initiated.
 - b. Pharmaceutical – IMCare's contracted Pharmacy Benefit Manager (PBM) contracts with participating pharmacies which provides regular education as well as audits network pharmacies. Results of audits are provided to IMCare if compliance or fraud issues are discovered.
 - c. Extended Diagnostic Assessments – IMCare will review potential multiple visits/assessments billed on Extended Diagnostic Assessments.
 - d. Behavioral Health & Medical Records Audit – IMCare's QI/UM Director will have chart abstractors randomly audit records to identify discrepancies between billed vs. documented. Findings will be reported back to The Program Integrity Team to determine appropriate action.
 - e. Enrollee Surveys – IMCare will initiate enrollee surveys to be sent to a random selection of enrollees for which IMCare was billed for a DME or home care service (and other identified service issue areas). Survey questions will be included that ask the enrollee to confirm the equipment or home care service received as well as their satisfaction with the service/equipment. Returned surveys will be documented in a spreadsheet and analyzed to determine outliers. Appropriate fraud and abuse actions will be initiated, as necessary.
 - f. Verification of Service – IMCare Care Coordinator/Case Managers will verify services with the enrollee or the enrollee's representative through the assessment, re-assessment, and transition process.
 - g. DME Verification – IMCare Claims staff and Care Coordinators/Case Managers will verify services by linking authorization and payment amount on DME providers billing rental versus purchase.

The annual integrity report provided to DHS will:

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1. Detail implementation processes, investigate activity, corrective actions, fraud and abuse prevention efforts, and results designed to meet the requirements of the DHS Contract.
2. The report must detail implementation of DHS requirements and must specifically describe the activities it has undertaken to safeguard against Fraud and Abuse.
3. The report must describe the activities of the previous calendar year.
4. The report will provide the following summary information about reports of provider fraud and abuse of investigated by IMCare:
 - a. Direct methods and results for verification of services.
 - b. Description of pre-payment and post-payment edits used to identify potential fraud and abuse.
 - c. Number of reports, by provider type and by enrollees.
 - d. Number of opened cases, number of cases resolved, and number remaining open.
 - e. Number and types of penalties or sanctions imposed;
 - f. Dollar amounts recovered which had been paid on behalf of enrollees; and
 - g. Number of referrals to the Medicaid Fraud Control Unit (MFCU).

For reporting of credible information of violations of law by the State, IMCare, participating providers, subcontractors, or enrollees, IMCare will:

1. Have a process for reporting to the State, MFCU, CMS, National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) and/or the OIG, for a determination as to whether criminal, civil, or administrative action may be appropriate.
 - a. If IMCare has reason to believe that an enrollee has defrauded one of the programs, IMCare shall refer the case to the State, MFCU, CMS, NBI MEDIC and/or the OIG, and other appropriate law enforcement agencies, as necessary.
 - b. IMCare investigates vendors or providers to monitor compliance with program requirements for the purposes of identifying fraud, abuse, theft, or error in the administration of the programs.
 - c. IMCare's fraud, waste and abuse investigations include but are not limited to the following:
 - i. Contacting the person(s) making the fraud or abuse allegations, where appropriate;
 - ii. Contacting appropriate agencies to assist in the investigation process;
 - iii. Retrieving and comparing prescription drug records to claims where appropriate;
 - iv. Contacting the credentialed/contracted provider at issue, where appropriate;
 - v. Internal meeting(s) to discuss results, next steps.
 - d. After completing of an investigation, IMCare determines whether:
 - i. The vendor/provider is in compliance with the requirements of a program and program payments were properly made;
 - ii. Insufficient evidence exists that fraud, abuse, theft, or error has occurred; or
 - iii. The evidence of fraud, abuse, theft, or error supports administrative, civil or criminal action.
 - e. Upon determination, IMCare takes one or more of the following actions:

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- i. Close the investigation when no further action is warranted;
- ii. Impose administrative sanctions as appropriate – including suspension, termination, debarment, re-training, corrective action plans, lockouts;
- iii. Seek monetary recovery as appropriate;
- iv. Refer/report the investigation findings to the appropriate state and federal regulatory agency, peer review mechanism or licensing board;
- v. Refer the investigation to law enforcement or other attorney for violation of program laws or regulation;
- vi. Issue a warning letter to the enrollee;
- vii. Issue a warning that states that practices are potentially in violation of program laws or regulation;
- viii. Send a letter stating the review has been completed and indicating there were no findings; or
- ix. Refer the investigation to another appropriate agency.

IMCare reports Adverse Actions:

1. The Provider Advisory Sub-committee may take adverse action while reviewing unclean credentialing and recredentialing files. Adverse actions are reported to the Compliance Officer.
2. IMCare receives referrals from DHS SIRS when an adverse action is taken against a provider at the state level. IMCare determines the action to be taken with the referral. If adverse action is needed all systems are updated accordingly. IMCare actions are reported back to SIRS on the response form.
3. IMCare receives referrals from Caremark when they have taken an adverse action against a pharmacy or pharmacist.
4. IMCare receives memos from CMS when they have taken an adverse action. IMCare determines the action to be taken with the referral. If adverse action is needed all systems are updated accordingly.
5. Report quarterly to the State the name, specialty, address, and reason for adverse action of Providers whose participation has been denied at enrollment, credentialing or re-credentialing, and providers whose active participation status IMCare has taken action to terminate or not renew during the previous quarter.

Upon request from the MFCU and other required agencies for administrative, financial medical or any other records that relate to the delivery of items or services under the contract, IMCare will:

1. Report to the State agency in writing any fraud that IMCare knows or has reason to believe has been committed by a provider, vendor, IMCare employee, subcontractor, or enrollee within 5 business days after IMCare learns of or has reason to believe that such fraud has been committed. IMCare will cooperate fully in any investigation of the fraud by the state and MFCU and in any subsequent legal action that may result from those investigations.
2. IMCare shall maintain a detailed log of all reports of provider and enrollee fraud and abuse investigated by IMCare or its subcontractors which shall be submitted to the State quarterly. The report includes investigations that are opened or closed in that quarter.

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3. IMCare shall report in writing to the State any abusive billing by Providers that warrant investigation within 90 days of identification of the problem.

Except when IMCare has good cause, IMCare will:

1. Suspend all Medicaid payments to a Provider after the following:
 - a. The State has notified IMCare that it has suspended all Medicaid payments to the provider based on determination there is credible allegation of Fraud against the provider for which an investigation of payments made under the Medicaid program is pending; or
 - b. IMCare determines there is a credible allegation of fraud against the provider for which an investigation is pending under the Medicaid program.
2. Discontinue the temporary suspension of payments described above as after either of the following:
 - a. The State or IMCare or the prosecuting authorities determine there is insufficient evidence of fraud by the provider and the State or IMCare has notified the other party of the lack of evidence; or
 - b. Legal proceedings related to the provider's alleged fraud are completed.
3. Find good cause exists not to suspend payments, not to continue a payment suspension previously imposed, or suspend payment only in part if any of the provisions of 42 CFR § 455.23(e) or (f) are applicable. For purposes of implementing a good cause under this provision, "IMCare" determinations shall be substituted for "State" determinations. IMCare will notify the State in writing of the basis for any good cause determination to not suspend payments, not continue a payment suspension, or to suspend only part. Wherever an IMCare investigation leads to the initiation of a payment suspension by IMCare, IMCare shall notify the State within 24 hours after the imposition of the suspension. IMCare must make a written fraud referral to the state and MFCU no later than the next business day after the suspension is imposed.
4. Review all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis, to determine whether there is a credible allegation of fraud. For purposes of a payment withholding, credible allegation of fraud means an allegation, which has been verified by the State or IMCare from any source, and which has indicia of reliability.

For any suspected fraud or patterns of abuse by its recipients, IMCare will report in writing via email to the state.

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Title: Exclusions and Convictions	Index: 1.05 - Compliance
NCQA Standard #: 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Statute/CFR#: 42 CFR Part 1001; 42 USC § 1320a-7; 42 USC § 1320a-7a; 42 USC 1396u-2 (Sec 4707 of the Balanced Budget Act of 1997); 42 CFR § 455.106	
Effective Date: 01/01/2006	Policy Number: 1.05.22
Written by: Compliance	Reviewed/Revised Date: 06/15/2022
Attachments:	

DEFENITIONS:

Convicted means that:

- 1) A judgement of conviction has been entered against an individual by a Federal, State, or local court, regardless of whether:
 - a. The judgement of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.
 - b. A Federal, State, or local court has made a finding of guilt against an individual or entity.
 - c. A Federal, State, or local court has accepted a plea of guilty by an individual or entity; or
 - d. An individual or entity has entered participation in a first defender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

Immediate family member means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent; stepchild; stepbrother or stepsister; father-, mother-, daughter-, son-, brother-, sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

Incarceration means imprisonment or any type of confinement with or without supervised release, including, but not limited to, community confinement, house arrest or home detention.

Indirect ownership interest includes an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue.

Managing employee means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity or part thereof or directly or indirectly conducts the day-to-day operations of the entity or part thereof.

Member of Household means, with respect to a person, any individual with whom the person is sharing a common abode as part of a single-family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of a household.

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Ownership Interest means an interest in: (1) the capital, the stock, or the profits of the entity; or (2) any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.

Ownership or control interest means, with respect to an entity, a person who: (1) Has a direct or an indirect ownership interest (or any combination thereof) of five percent or more in the entity; (2) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity of any of the property assets thereof, if such interest is equal to or exceeds five percent of the total property and assets of the entity; (3) is an officer or a director of the entity; (4) is a partner in the entity if the entity is organized as a partnership; (5) is an agent of the entity; or (6) is a managing employee of the entity.

POLICY:

IMCare must ensure that items or services furnished, ordered, or prescribed by excluded individuals or entities are not paid for.

IMCare will not include a director, officer, partner or person with an ownership or control interest, nor subcontractor in its business entity who is excluded from participation in federal or state health care programs. This includes entities owned or controlled by a sanctioned person.

IMCare will not make an employment, consulting, or other agreement with an individual or entity for the provision of items or services that are significant and material to IMCare's obligations where the individual or entity is excluded from participation in federal or state health care programs. Significant and material services include, but are not limited to health care, utilization review, medical social work, or administrative services.

IMCare will not have any agents, managing employees, or persons with an ownership or control interest who have been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid.

Amisys providers maintained by PrimeWest Health (PWH) are queried as they are added to the system and monthly by PrimeWest Health using StreamlineVerify. PWH notifies IMCare of any potential matches that need resolution or reporting.

Pharmacies and pharmacists maintained by CVS|Caremark are queried as they are added to the system and monthly by CVS|Caremark. CVS|Caremark notifies IMCare of any potential matches that need resolution or reporting.

IMCare will report to the State, within seven days of receipt of the following:

- 1) Any information regarding excluded or convicted individuals or entities, including agents, managing employees, or persons with an ownership or control interest; and
- 2) Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a provider.

IMCare will promptly notify the State of any administrative action it takes to limit participation of a provider in the Medicaid program.

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PROCEDURE:

- 1. The IMCare Medical Support Specialist responsible for credentialing/re-credentialing support will:**
 - a. Query the necessary lists/databases for Medicaid/Medicare sanctions for initial credentialing applications for practitioners/organizations seeking participation, and applications for re-credentialing practitioners/organizations seeking ongoing participation (following credentialing P&P 1.08.07 Medicare/Medicaid Sanctions):
 - i. National Practitioner Data Bank (NPDB)
 - ii. Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) Database
 - iii. Excluded Parties List System (EPLS)
 - iv. Minnesota Medicaid Exclusions Lists
 - v. Social Security Death Master File
- 2. The IMCare Contract Compliance Officer will:**
 - a. Collect disclosure of ownership and control interest from contractors and subcontractors at the time of contracting and re-contracting.
 - b. Collect disclosure of ownership and control interest from managing employees and board members.
 - c. Maintain a list for monthly querying provided to StreamlineVerify.
 - d. Query StreamlineVerify to check for excluded individuals reported through disclosures.
 - e. Resolve and address any potential matches.
- 3. The Health Plan Compliance Coordinator will:**
 - a. Investigate any potential exact matches to determine required action.
 - b. Based on required action, notify appropriate parties of action (i.e., Credentialing, Claims, Compliance).
 - c. Track to ensure compliance with laws and regulations, and for reporting purposes.
 - d. Notify the State within the required timeframes.

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Title: Referral to Law Enforcement	Index: 1.05 Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 455.15(b); 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 01/01/2006	Policy Number: 1.05.24
Written by: Compliance	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

Itasca Medical Care (IMCare) must establish and adhere to a process for credible information of violations of law by the state, IMCare, network providers, subcontractors, or enrollees to law enforcement for a determination as to whether civil, criminal, or administrative action may be appropriate.

Furthermore, if the findings of a preliminary investigation give IMCare reason to believe that an incident of fraud or abuse has occurred by an enrollee in the Medicaid and/or Medicare program, IMCare must take the following action, as appropriate:

- If there is reason to believe that an enrollee has abused the Medicaid and/or Medicare program, IMCare must conduct a full investigation of the abuse.
- If there is reason to believe that an enrollee has defrauded the Medicaid and/or Medicare program, IMCare must refer the case to an appropriate law enforcement agency.

IMCare may collaborate with the Itasca County Health and Human Services (ICHHS) Fraud Investigator in cases where an enrollee has been alleged to have abused the Medicaid program.

IMCare will formulate partnerships with area law enforcement agencies, including state and federal authorities to facilitate referrals by IMCare.

PROCEDURE:

1. The IMCare Health Plan Compliance Coordinator will:
 - a. Conduct a full investigation on referrals regarding credible information of violations by any IMCare partners or enrollees.
 - b. Determine the extent of the violation.
 - c. Determine if collaboration with the ICHHS Fraud Investigator is warranted.
 - d. Contact law enforcement (MN Department of Human Services Surveillance and Integrity Review Services (SIRS)/Medicaid Fraud Control Unit (MFCU)) and refer incidences as necessary.
 - e. Refer to the appropriate Medicare Fraud Contractor if Medicare enrollee.
 - f. Document and follow any recommendations.
 - g. Monitor the case and take any appropriate action.

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Title: Disclosure by Providers: Information Related to Business Transactions	Index: Compliance
NCQA Standard #:	
Statute/CFR#: 42 CFR § 455.105	
Effective Date: 01/01/2007	Policy Number: 1.05.29
Written by: Compliance	Reviewed/Revised Date: 06/15/2022
Attachments:	

POLICY:

IMCare Provider Participation Agreements include the requirements of information related to business transactions.

Information that must be submitted

Within 35 days of the date on a request by the Secretary or Minnesota Department of Human Services (DHS) (State) or Centers for Medicaid and Medicare Services (CMS), full and complete information about:

- 1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- 2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

In addition, DHS may request information related to business transactions. Providers must be able to submit this information the IMCare within 15 days of the date of the written request from the State or CMS. IMCare must report the information to the State within 10 days of receipt from the providers.

Denial of Federal Financial Participation (FFP)

Pursuant to 42 CFR § 455.105, FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or DHS. FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or DHS and ending on the day before the date on which the information was supplied.

Denial of FFP is cause for termination of the IMCare Provider Participation Agreement.

PROCEDURE:

1. The IMCare Compliance Officer will:
 - a. Ensure that IMCare Provider Participation Agreements contain language pertaining to disclosure of transactions.
 - b. Upon receipt of a request for business transaction, notify providers of request and requirement for information within 15 days.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

- c. Upon receipt of information from providers, report to the State within 10 days of IMCare's receipt.
- d. Report non-compliance with providers who do not comply with a request for disclosures.
- e. Consider termination of the IMCare Provider Participation Agreement for providers who do not comply with a request for disclosures.
- f. Notify IMCare Claims Department of non-FFP for the period of the requested disclosure to pursue takeback of claims and collection.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

Title: Conflict of Interest	Index: 1.05 - Compliance
NCQA Standard #: N/A	
Statute/CFR#: 42 CFR § 438.58 and 42 CFR § 421; 42 CFR § 438.608 (Medicaid); 42 CFR § 422.503 (Medicare Part C); 42 CFR § 423.504 (Medicare Part D)	
Effective Date: 03/03/2004	Policy Number: 1.05.31
Written by: Compliance	Reviewed/Revised Date: 06/15/2022
Attachments:	

DEFINITIONS:

Family Member: is a spouse, domestic partner, ancestors, parent, brothers and sisters, in-laws, children, grandchildren, great grandchildren, and spouses of children, of a Responsible Person.

Financial Interest: a person has a financial interest if the person has directly or indirectly, through business, investment, or family:

- A. An ownership or investment interest in any entity that has a transaction or arrangement with IMCare; or
- B. A compensation arrangement with IMCare or with any entity or individual that has a transaction or arrangement with IMCare; or
- C. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual which is negotiating a transaction or arrangement with IMCare.

Compensation includes direct and indirect remuneration as well as gifts or favors that are substantial in nature.

Responsible Person: any person in a position to exercise substantial influence over the affairs of IMCare at any time during the five-year period **ending** on the date of the transaction. A responsible person includes a Family Member.

Substantial Influence: means having powers or responsibilities or holding types of interests as found in people who serve on the governing body and who are entitle to vote, such as Itasca County Board members, chief executive officer, chief operation officers, treasurers and chief financial officers and persons with a material financial interest in IMCare.

POLICY:

This policy is designed to protect IMCare's interest when it is contemplating entering a transaction or arrangement that might benefit the private interest of a responsible person of IMCare. IMCare must ensure compliance with Medicare and Medicaid regulations relative to Managed Care; help directors, officers, and employees of IMCare identify situations that represent potential conflicts of interest; and provide IMCare with a procedure that, if observed, will allow a transaction to be treated as valid and binding even though a director, officer, or employee has or may have a conflict of interest with respect to the transaction. In the event that there is an inconsistency between the requirements and the procedures described herein and those in federal or state law, the law shall control.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

The provision of this policy shall, regarding any public officer, county official or deputy or clerk or employee of such official, be supplemented by the requirements and penalties of Minnesota Statutes §§ 382.18, 471.87, and 471.88 to the extent that either this policy or the enumerated statutes restrict the conduct of an individual the most restrictive shall prevail.

PROCEDURE:

1. The Responsible Person will:

- a. Disclose the existence of a financial interest and all material facts to the County Board, treasurers, and members of committees with Board delegated powers considering the proposed transaction or arrangement.
- b. Leave the board or committee meeting while the determination of conflict of interest is discussed after disclosure of the financial interest and all material facts, and after any discussion by the Board or committee members with the Responsible Person. The remaining Board or committee members shall decide if a conflict of interest exists.

2. The Board or Committee will:

- a. Appoint a disinterested person or committee to investigate alternative to the proposed transaction or arrangement, if appropriate.
- b. Determine whether IMCare can obtain a more advantageous transaction or arrangement with reasonable efforts from a person or entity that would not give rise to a conflict of interest after discussion.
- c. Determine by a majority vote whether the transaction or arrangement is in IMCare's best interest and for its own benefit and whether the transaction is fair and reasonable to IMCare and shall make its decision as to whether to enter the transaction or arrangement in conformity with such determination, if a more advantageous transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest.
- d. Inform the member of the basis for such belief and afford the member an opportunity to explain the alleged failure to disclose if the Board or committee has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest.
- e. Take appropriate disciplinary and corrective action if, after hearing the response of the member and making such further investigation as may be warranted by the circumstances, and the Board or committee determines the member has failed to disclose an actual or possible conflict of interest.
- f. Ensure that a voting member on any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from IMCare is precluded from voting on matters pertaining to that member's compensation.
- g. Ensure that physicians who receive compensation, directly or indirectly, from IMCare whether as employees or independent contractors, are precluded from membership on any committee whose jurisdiction includes compensation matters. However, no physician, either individually or collectively, is prohibited from providing information to any committee regarding physician compensation.

ITASCA MEDICAL CARE (IMCare) POLICY AND PROCEDURE

3. Each County Board member and principal officer, committee member, and employee of IMCare will:

- a. Annually sign a statement (located at the end of this policy or via computer-based training) that affirms such person:
 - i. Received a copy of the Conflict of Interest Policy.
 - ii. Read and understands the Policy.
 - iii. Agreed to comply with the Policy.
 - iv. Understands IMCare is a governmental organization and to comply with statute must engage primarily in activities that accomplish its governmental purposes.

4. The Board will:

- a. Conduct periodic reviews to ensure that IMCare operates in a manner consistent with its governmental purposes and that it does not engage in activities that are not acknowledged by statute. The periodic review shall be conducted annually by the IMCare Contract Compliance Officer and, at minimum, include the following:
 - i. Whether compensation arrangements and benefits are reasonable and are the result of arm's-length bargaining.
 - ii. Whether acquisitions of physician practices and other provider services result in inurement or impermissible private benefit.
 - iii. Whether partnership and joint venture arrangements and arrangements with management service organization and physician hospital organizations conform to written policies, are properly recorded, reflect reasonable payments for goods and services, further IMCare's governmental purposes and do not result in inurement or other impermissible private benefit.
 - iv. Whether arrangements to provide health care and agreements with other health care providers, employees, and third-party payers further IMCare's governmental purposes and do not result in inurement or impermissible private benefit.

**ITASCA MEDICAL CARE (IMCare)
POLICY AND PROCEDURE**

STATEMENT PERTAINING TO THE CONFLICT OF INTEREST POLICY

I have received a copy of the IMCare Conflict of Interest Policy. I have read and understand the Conflict of Interest Policy and, in signing this statement, I hereby agree to comply with the policy's literal expression and also with what I believe to be its intent. I understand IMCare is a governmental organization and that to maintain its nonprofit status it must engage primarily in activities that accomplish one or more of its governmental purposes.

I may have certain financial interests that may give rise to a conflict of interest or the appearance of a conflict of interest as set forth below. The nature of those financial interests, the specific transactions, and arrangements with respect to which such conflict of interest or the appearance thereof may exist and the reasons why such financial interests may give rise to a conflict of interest, or the appearance thereof are as follows:

(Please write "NONE" if applicable. Please attach additional sheets if more space is needed.)

I also certify if any possible transaction or arrangement is considered in the future about which I may have a conflict of interest or that has the appearance of creating a conflict of interest, I will promptly disclose the circumstances to the Board and to the members of any committees with Board-delegated powers considering the proposed transaction or arrangement and comply with the Conflict of Interest Policy in all regards with respect to such transaction or arrangement, including leaving any meeting during the discussion thereof and the vote thereon.

Name (Printed or Typed)

Signature

Date

By attesting at the conclusion of the electronic training module on *Conflict of Interest*, you are completing the "Statement Pertaining to the Conflict of Interest Policy".



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2504

DEPARTMENT: Transportation
PRESENTER: Ryan Sutherland

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:

Bid Award for Contract 59201 - Harris Township Sunny Beach Road Project

BOARD ACTION REQUESTED:

Award contract 59201 for Harris Township, Sunny Beach Road Project to the lowest responsible bidder, Hawkinson Construction, in the amount of \$1,731,486.25 and authorize the required signatures on the contract documents.

BACKGROUND:

This project is a Harris Township project funded by a Local Road Improvement Project grant and local Township dollars. Bids were opened on June 21, 2022 at 11:00 a.m. Results of that bid are as follows:

Engineer's Estimate \$1,981,854.62
Hawkinson Construction \$1,731,486.25

Although only one bid was received, it was a competitive bid. The Township reviewed the bids and approved the award at their June 22, 2022 meeting.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

07/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 07/26/2022 2:30 PM
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RESULT:	APPROVED (5 TO 0)
MOVER:	Commissioner Leo Trunt
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2520

DEPARTMENT: Land Department

TIME REQUESTED: < 5 Minutes

PRESENTER: Michael Gibbons

AGENDA ITEM:

Application for Repurchase of Tax Forfeited Parcel by John Valentine

BOARD ACTION REQUESTED:

Adopt the Resolution Re: Repurchase of South 197' Lot 8, BLK 8 1st Add Cohasset by John Valentine.

BACKGROUND:

This property forfeited on October 31, 2021 for non-payment of property taxes. Itasca County has received payment for all delinquent taxes, penalties, interest and associated costs.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:

1. Application_signed
2. Map

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



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

RESOLUTION 2022-49

RE: REPURCHASE OF SOUTH 197' LOT 8, BLK 8 1ST ADD COHASSET

WHEREAS, Minn. Statute 282.141 provides that the State of Minnesota held in trust for the taxing districts may be repurchased by the owner at the time of forfeiture, or the owner's heir, devisee, or representative, or any person to whom the right to pay taxes was given by statute, mortgage, or other agreement, subject to adoption of a resolution the County Board any payment of the sum of all delinquent taxes, penalties, interest and associated costs, and

WHEREAS, the applicant, John Valentine, has applied to repurchase State of Minnesota land held in trust for the taxing districts legally described as: South 197' Lot 8, BLK 8 1st Add Cohasset, Cohasset, MN, and

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

WHEREAS, approving the repurchase will promote the use of land that best serves the public interest.

NOW THEREFORE BE IT RESOLVED, that the Itasca County Board approves the repurchase application by John Valentine, subject to payment including taxes, penalties and interest of \$1,905.47; deed tax \$1.65; deed fee \$25.00; recording fee \$46.00; repurchase application fee \$300.00 for a total of \$2,278.12.

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

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

I, BRETT SKYLES, Administrator of the County of Itasca, do hereby certify that I have compared the foregoing with the original resolution filed in my office on the 26th day of July 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 July A.D. 2022.

Administrator

APPLICATION FOR REPURCHASE OF FORFEITED LANDS
Pursuant to Minnesota, Statutes Section 282.241

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

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

**South One hundred Ninety-seven feet (S 197') of Lot Eight (8), Block Eight (8) FIRST
ADDITION TO COHASSET**

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

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

That such taxes became delinquent 2017 and remained delinquent

and unpaid for the subsequent years of 2017 thru 2021

That the aggregate of all delinquent taxes and assessments, with penalties, costs and interest, exclusive of taxes and assessments to be reinstated as provided by Minnesota Statutes, Section 282.

251, is the sum of **Two Thousand Two Hundred Seventy-eight and 12/100ths Dollars (\$2,278.12)**, which includes (taxes, penalties & interest \$1,905.47; plus deed tax \$1.65; deed issuance fee \$25.00; recording fee \$46.00; application fee \$300.00)

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

For Resale *22294 Co Rd 70 Boyer* *55709*

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

Dated 7-15, 2022

Applicant

Applicant

**State of Minnesota, } ss.
County of Itasca**

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

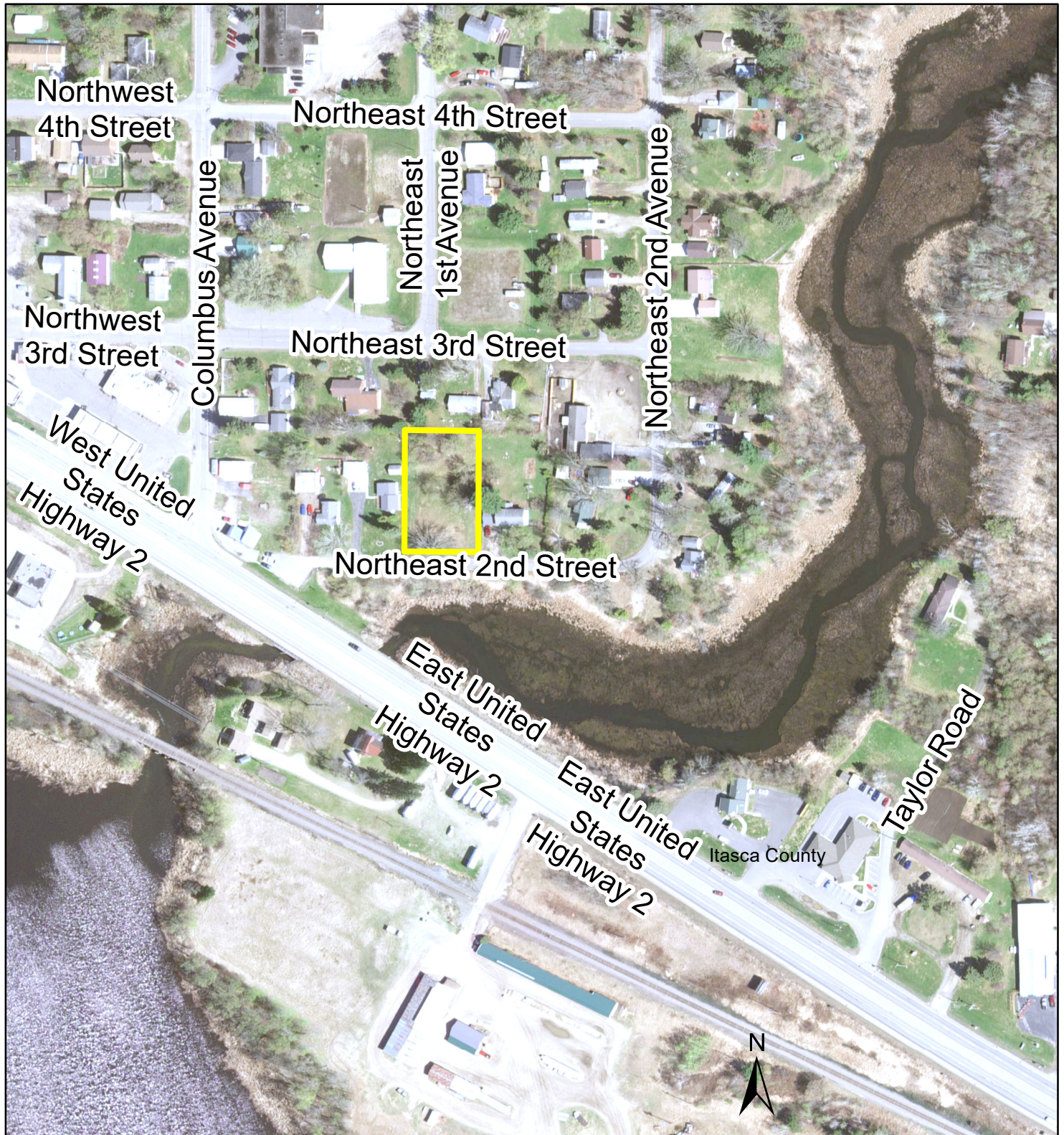
Subscribed and sworn to before me this

15th day of July, 2022

Austin Rohling



**Application to Repurcahase of 05-445-0860
South 197' Lot 8, BLK 8 1st Add Cohasset**



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

Itasca Geographic Information System
"Decision support through automation"

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Feet



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2498

DEPARTMENT: Sheriff

TIME REQUESTED: 5 Minutes

PRESENTER: Tabbatha Litchke

AGENDA ITEM:

Stepping Up Initiative Resolution

BOARD ACTION REQUESTED:

Adopt the Resolution Re: Stepping Up Initiative to Reduce the Number of People with Mental Illnesses in Jails.

BACKGROUND:

Stepping Up is a national initiative to reduce the number of people who have mental illnesses in jails. Counties that have joined Stepping Up are using the initiative's framework document, Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask (Six Questions), to guide them in creating collaborative partnerships in their jurisdictions, systematically identifying people who have mental illnesses in their jails, and using data to inform systems-level changes and strategic plans to track progress over time.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:

1. Stepping up
2. Stepping up 2
3. Stepping up 3

07/19/2022

RESULT:	RECOMMENDED FOR CONSENT	NEXT: 07/26/2022 2:30 PM
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RESULT:	APPROVED (5 TO 0)
MOVER:	Commissioner Leo Trunt
SECONDER:	Commissioner Davin Tinquist
AYES:	Davin Tinquist, Terry Snyder, Leo Trunt, Burl Ives, Ben DeNucci



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

RESOLUTION 2022-45

RE: STEPPING UP INITIATIVE TO REDUCE THE NUMBER OF PEOPLE WITH MENTAL ILLNESSES IN JAILS

WHEREAS, counties routinely provide treatment services to the estimated 2 million people with serious mental illnesses booked into jail each year; and

WHEREAS, prevalence rates of serious mental illnesses in jails are three to six times higher than for the general population; and

WHEREAS, almost three-quarters of adults with serious mental illnesses in jails have co-occurring substance use disorders; and

WHEREAS, adults with mental illnesses tend to stay longer in jail and upon release are at a higher risk of recidivism than people without these disorders; and

WHEREAS, county jails spend two to three times more on adults with mental illnesses that require interventions compared to those without these treatment needs; and

WHEREAS, without the appropriate treatment and services, people with mental illnesses continue to cycle through the criminal justice system, often resulting in tragic outcomes for these individuals and their families; and

WHEREAS, Itasca County and all counties take pride in their responsibility to protect and enhance the health, welfare and safety of its residents in efficient and cost-effective ways; and

WHEREAS, Itasca County Jail division has hired a mental health professional, implemented a Release Advanced Planning Program, cognitive programming, mental health services tracking system, designed a mental health unit in the new jail facility; and

WHEREAS, through *Stepping Up*, the National Association of Counties, the Council of State Governments Justice Center and the American Psychiatric Association Foundation are encouraging public, private and nonprofit partners to reduce the number of people with mental illnesses in jails;

NOW THEREFORE BE IT RESOLVED, THAT Victor Williams, Itasca County Sheriff, will hereby sign on to the Call to Action to reduce the number of people with mental illnesses in our county jail, commit to sharing lessons learned with other counties in the state and across the country to support a national initiative and encourage all county officials, employees and residents to participate in *Stepping Up* and Itasca County resolves to utilize the comprehensive resources available through *Stepping Up* to:

* Convene or draw on a diverse team of leaders and decision makers from multiple agencies

committed to safely reducing the number of people with mental illnesses in jails.

- * Collect and review prevalence numbers and assess individuals' needs to better identify adults entering jails with mental illnesses and their recidivism risk, and use that baseline information to guide decision making at the system, program, and case levels.
- * Examine treatment and service capacity to determine which programs and services are available in the county for people with mental illnesses and co-occurring substance use disorders, and identify state and local policy and funding barriers to minimizing contact with the justice system and providing treatment and supports in the community.
- * Develop a plan with measurable outcomes that draws on the jail assessment and prevalence data and the examination of available treatment and service capacity, while considering identified barriers.
- * Implement research-based approaches that advance the plan.
- * Create a process to track progress using data and information systems, and to report on successes.

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

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

I, BRETT SKYLES, Administrator of the County of Itasca, do hereby certify that I have compared the foregoing with the original resolution filed in my office on the 26th day of June 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 June A.D. 2022.



Administrator

How Counties Are Keeping People with Mental Illnesses Out of Jails and Improving Public Safety

What is Stepping Up?

Stepping Up works to address the overincarceration of people with mental illnesses and substance use disorders. This national initiative gives county leaders the resources and tools they need to meet this challenge in their community by

- Increasing collaboration among behavioral health, criminal justice, homelessness and other systems to develop shared solutions;
- Using data to inform effective policy decisions; and
- Implementing high-impact strategies, with a particular focus on diversion.

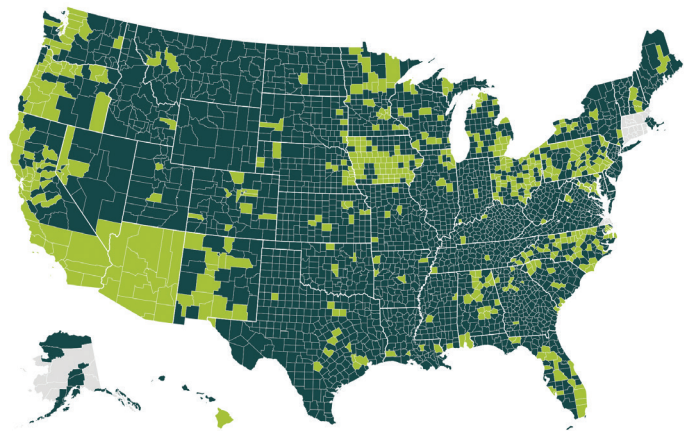
Why is it important?

Committing to the principles of Stepping Up can ultimately lead to

- Fewer people with behavioral health needs entering the justice system when they can be safely served in the community;
- Enhanced community capacity to serve people diverted from the justice system;
- Greater public safety;
- Better health outcomes; and
- Improved access to treatment and other support services.

How far does Stepping Up reach?

There are 520 counties across 43 states in the network—47 percent of the U.S. population resides in a Stepping Up county.



■ Participating Counties

“Stepping Up helped us kick off a conversation that is continuing to this day about the importance of collecting data and collaborating across organizations to improve outcomes for people with mental illnesses, as well as reduce their risk of coming back into the system.”

Mike Brouwer, Douglas County, Kansas, Criminal Justice Coordinator

What have Stepping Up sites accomplished?

Since the initiative launched in 2015, Stepping Up counties across the country have made significant strides. Here are a few examples of the many successes we've seen:

Alabama became the first state to pass a statewide Stepping Up resolution and provides grants to localities to expand diversion interventions.

Berks County, Pennsylvania, implemented a sophisticated data system to identify people who have frequent contact with the health and criminal justice systems and tailor policy solutions to connect them to community-based supports.

Fairfax County, Virginia, expanded crisis response center services, resulting in over 1,800 diversions from potential arrest.

Fulton County, Georgia, invested \$500,000 in improved data systems and analysis; \$800,000 in diversion initiatives; \$100,000 in Crisis Intervention Team, Mental Health First Aid, and trauma training coordination; and \$370,000 in screening and reentry services to establish baseline data and increase connections to care.

Douglas County, Kansas, safely decreased its jail population with serious mental illnesses by 50 percent and has maintained that reduction for three consecutive years.

Yolo County, California, opened a mental health urgent care facility and developed an integrated data-sharing system across criminal justice and health agencies.

What can my county get out of the Stepping Up initiative?

Tailored Resources

The Stepping Up website has a library of free reports, tools, webinars, guides, and handbooks, all of which were designed for county leaders like you. Access the full set of resources at StepUpTogether.org.

Peer Learning

The Stepping Up partners have identified Innovator counties that offer real-world experience and expertise. Each of these counties has demonstrated the ability to accurately assess and track the prevalence of serious mental illness in jail and enact high-impact improvements across systems. Innovators play an essential role in Stepping Up through peer coaching, guidance on the overall direction of the initiative, and more.

Direct Assistance

The Stepping Up partners provide various levels of one-on-one technical assistance to help jurisdictions meet their goals. If you are interested in receiving direct assistance from Stepping Up, email us at info@stepuptogether.org.

How can I get started?

1.

Visit StepUpTogether.org.

2.

Pass a resolution to join the initiative.

3.

Subscribe to receive the latest information about Stepping Up at StepUpTogether.org/Take-Action.

4.

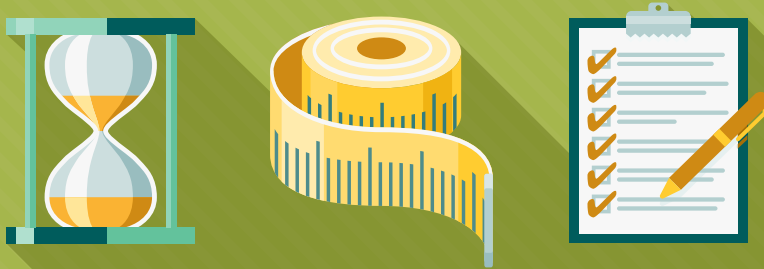
Reach out to info@stepuptogether.org if you have any questions.

Stepping Up is a national initiative to reduce the number of people with mental illnesses in jails and is the result of a partnership between The Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation.

This project was supported by Grant No. 2019-MO-BX-K002 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Set, Measure, Achieve

Stepping Up Guidance to Reach Prevalence Reduction Targets



Stepping Up is a national initiative to reduce the number of people with serious mental illnesses (SMI) in jails. Launched in May 2015, Stepping Up is a partnership between The Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation. More than 500 counties have joined the initiative over the past five years. During that time, we've seen many successes—but we've also seen how difficult it can be to establish and meet measurable goals to reduce the prevalence of SMI in jails.

Although 4 percent of adults in the U.S. general population experience SMI, studies estimate that 17 percent of people in jails have SMI.¹

The following guidance supports counties in setting targets for reducing the number of people with SMI in their jails, measuring progress toward meeting these targets, and achieving results.

1. Set your targets

The first step in setting targets is establishing baselines for the goals you want to achieve. Stepping Up recommends that you set baselines for each of the *four key measures*: (1) the number of jail bookings of people with SMI, (2) their length of stay in jail, (3) connections to treatment for this population, and (4) their rates of recidivism.

In addition to these measures, Stepping Up recommends establishing an overall baseline prevalence rate. The baseline prevalence rate is the overall percentage of your jail population² that has an SMI. Counties that have implemented Stepping Up's recommended *three-step approach* to having accurate, accessible data on the prevalence of SMI in jail (see text box) and have set a baseline prevalence rate can use this rate to help set their targets. Counties that are still in the process of setting their baseline can use an average daily population (ADP) count and/or point-in-time count of the number and percentage of people with SMI in their jail.

Once your county has a baseline prevalence rate and baselines for some or all of the four key measures, you are ready to set reduction targets. Counties can be as ambitious or conservative with their targets as they choose, and they can set targets for any or all of these measures depending on their local priorities and efforts. Stepping Up suggests the following minimum targets for each measure:

Three steps to accurate, accessible data on the prevalence of SMI in jail

1.

Establish a shared definition of SMI for your Stepping Up efforts that is used throughout local criminal justice and behavioral health systems;

2.

Use a validated mental health screening tool on every person booked into the jail and refer people who screen positive for symptoms of SMI to a follow-up clinical assessment by a licensed mental health professional;

3.

Record clinical assessment results and regularly report on this population.

Average Daily Population (ADP): 5-percent reduction per year

Example:

Starting measure: ADP of people with SMI in the jail is 100 in 2020

Target: Reduce the ADP of people with SMI to 95 people in 2021

Key Measure 1. Jail Bookings/Admissions: 10-percent reduction per year

Example:

Starting measure: 100 admissions involving people with SMI in 2020

Target: Reduce the number of admissions to 90 in 2021

Key Measure 2. Average Length of Stay (ALOS): 5-percent reduction per year

Example:

Starting measure: ALOS for people with SMI in the jail is 40 days in 2020

Target: Reduce to an ALOS of 38 days for people with SMI in 2021

Key Measure 3. Connections to Care: 10-percent increase per year

Example:

Starting measure: 50 percent of people with SMI in the jail are connected to care in 2020

Target: Increase that share to 55 percent in 2021

Key Measure 4. Recidivism: 5-percent reduction per year

Example:

Starting measure: Recidivism rate for people with SMI is 50 percent in 2020

Target: Reduce the rate to 48 percent in 2021

² Set, Measure, Achieve: Stepping Up Guidance to Reach Prevalence Reduction Targets

2. Measure your progress

To see how your county is performing in relation to reduction targets, you will need to monitor each measure consistently. The chart below provides detailed guidance for how to calculate your progress.

Calculating Progress			
Measure	Definition	Tips	Formula
Average daily population (ADP)	The average number of people in the jail over the reporting period. Calculate this figure for people with and without SMI. Also report metrics by race/ethnicity/age/sex for people with and without SMI.	Use reported measures to calculate ADP.	$= (\text{bookings during reporting period} \times \text{ALOS during reporting period}) / (\text{days in reporting period})$
Key Measure 1: Bookings/admissions	The number of admissions into jail over the reporting period. Calculate this figure for people with and without SMI. Also report metrics by race/ethnicity/age/sex for people with and without SMI.	Do not count “turn-around admissions,” meaning when someone is discharged from the jail to go to court or to the hospital but is still in custody. People who have multiple admissions within the period count multiple times toward the overall admissions number.	= total # of admissions in the reporting period Required data elements <i>Individual ID</i> <i>Booking ID</i> <i>Admission date(s)</i> <i>SMI status</i> <i>Race/ethnicity/age/sex</i> Optional data element <i>Most serious charge per booking</i>
Key Measure 2: Average length of stay (ALOS)	The average length of stay (in number of days) for people released from jail over the reporting period. Calculate this figure for people with and without SMI. Also report metrics by race/ethnicity/age/sex for people with and without SMI.	For people who are booked and released on the same day, the length of stay (LOS) is 1. For people who are released during the reporting period, their total LOS is counted in the average. For people with multiple stays during the reporting period, each release is counted as a separate release event.	$= (\text{sum of the total lengths of stay}) / (\text{total number of release events during the reporting period})$ Required data elements <i>Individual ID</i> <i>Booking ID</i> <i>Admission date(s)</i> <i>Release date(s)</i> <i>SMI status</i> <i>Race/ethnicity/age/sex</i>

Calculating Progress (continued)

Measure	Definition	Tips	Formula
Key Measure 3: Connections to care	The percentage of people identified with SMI who are referred to community-based behavioral health treatment at release over the reporting period. Also report metric by race/ethnicity/age/sex for people with and without SMI.	A referral to post-release treatment is the minimum measure constituting a connection to care. Counties may identify and include other measures of connection to care (e.g., scheduling a first post-release appointment, physically driving a person to their first post-release appointment).	= (# identified with SMI who are released and referred to community-based behavioral health treatment at release during the reporting period) / (# of people with SMI released during the reporting period) Required data elements <i>Individual ID</i> <i>Booking ID</i> <i>Release date(s)</i> <i>SMI status</i> <i>Referral to care (Y/N)</i> <i>Race/ethnicity/age/sex</i> Optional data elements <i>Other measures of connection to care</i>
Key Measure 4: Recidivism	The percentage of people admitted to jail during the reporting period who have a prior jail admission in the past year. Calculate this figure for people with and without SMI. Also report metrics by race/ethnicity/age/sex for people with and without SMI.	If possible, account for the different pathways to re-booking, such as pretrial, sentence, and revocation bookings.	= (# admitted who have a prior jail admission in your county jail in the past year) / (total admissions during the reporting period) Required data elements <i>Individual ID</i> <i>Booking ID</i> <i>Admission date(s)</i> <i>SMI status</i> <i>Race/ethnicity/age/sex</i> Optional data elements <i>Admission type or reason</i>

Notes on Reporting Data

Reporting by Diagnosis: Some counties may not be able to distinguish between people with only SMI and people with both SMI and co-occurring substance use disorders. While recent studies show as low as 24–34 percent of women and 12 to 15 percent of men in the criminal justice system have both mental illnesses and substance use disorders, others indicate that as high as 60–87 percent of people with SMI have a co-occurring disorder as well.³

Analyzing Demographics: Counties should disaggregate data on each of the measures by self-identified race, ethnicity, age, and sex. Other demographic data to consider collecting and analyzing include sexual orientation and gender identity. Having this information will allow counties to identify if particular populations are overrepresented in the jail's SMI population. If the data do reveal overrepresentation of a specific group(s), the planning team should identify possible causes for the disproportionality and determine policy and program responses specific to the population(s).

3. Achieve results

By setting targets and measuring progress, counties will be better positioned to identify high-impact strategies they can implement or expand to reach reduction goals. It will also allow county leaders to prepare specific, data-driven requests for local, state, federal, and philanthropic support. More broadly, setting prevalence reduction targets will amplify counties' transparency efforts and ensure coordinated cross-systems work toward common goals. The Stepping Up website offers webinars, case studies, reports, assessment tools, and other resources to help counties identify strategies to reach their targets. Stepping Up understands that being able to show meaningful reductions in the prevalence of SMI in jails can take time. We will continue to share ways to measure interim progress and celebrate your successes along the way to achieving results.

Endnotes

1 Henry J. Steadman et al., "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 6, no. 60 (2009): 761–765; Center for Behavioral Health Statistics and Quality, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (Washington, DC: U.S. Department of Health and Human Services, 2019), <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf>; Karen M. Abram and Linda A. Teplin, "Co-occurring Disorders among Mentally Ill Jail Detainees," *American Psychologist* 46, no. 10 (1991): 1036–1045.

2 Counties should track the jail population for which their county is "responsible" (i.e., excluding federal holds; people detained on behalf of other jurisdictions, including municipal holds; and cases that will be transferred to other jurisdictions for case processing/supervision via change of venue/interstate compact). Counties should track cases that are held for civil case processing, including incompetency proceedings, and are encouraged to track the average length of stay for this population separately, if possible, to inform case processing decisions and capacity needs.

3 Substance Abuse and Mental Health Services Administration, *Screening and Assessment of Co-occurring Disorders in the Justice System* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015), 6, <https://store.samhsa.gov/product/Screening-and-Assessment-of-Co-Occurring-Disorders-in-the-Justice-System/PEP19-SCREEN-CODJS>.

Stepping Up is a national initiative to reduce the number of people with mental illnesses in jails and is the result of a partnership between The Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation. For more information, visit StepUpTogether.org or contact us at info@stepuptogether.org. This project was supported by Grant No. 2019-MO-BX-K002 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

IN FOCUS CONDUCTING A COMPREHENSIVE PROCESS ANALYSIS

This brief focuses on conducting a comprehensive process analysis, or a step-by-step examination of how people who have serious mental illnesses (SMI¹) move through a county's criminal justice and behavioral health systems. A process analysis can help counties determine appropriate pathways for people with SMI, which may include diversion from jail to treatment in the community, a clinical assessment by a licensed mental health professional during or shortly after jail booking, pretrial supervision conditions, post-sentence supervision conditions, and more. The process analysis will also help counties identify what resources currently exist at the point of law enforcement contact, in jails, and in the community, and identify where there may be treatment and service gaps across systems.

Additionally, conducting this analysis will help counties uncover how much relevant data is available and where more data is needed to track Stepping Up's four key measures: (1) the number of people booked into jail who have SMI; (2) their average length of stay in jail; (3) how many are connected to treatment; and (4) their recidivism rates. Review [In Focus: Collecting and Analyzing Baseline Data](#) for more information about the four key measures.

WHY IT'S IMPORTANT

To reduce the number of people in jails who have SMI, it is important for counties to pinpoint interventions that are available in the jail and the community. With this knowledge, counties can appropriately place people who have SMI in diversion programs or move them through the criminal justice system in a timely manner, including through connections to treatment and services in the community. To make the best use of limited county resources, it is important to target supervision and services to people with SMI who are assessed as having a high risk of recidivating and high needs based on a validated criminogenic risk and needs assessment.²

Stepping Up is a national initiative to reduce the number of people who have mental illnesses in jails. Counties that have joined Stepping Up are using the initiative's framework document, [Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask \(Six Questions\)](#), to guide them in creating collaborative partnerships in their jurisdictions, systematically identifying people who have mental illnesses in their jails, and using data to inform systems-level changes and strategic plans to track progress over time. This brief is one of a series of companion products designed to provide counties with further guidance on how to apply the *Six Questions* framework. For key resources related to Stepping Up, including case studies, webinars, and network calls, visit the [Stepping Up Toolkit](#).

1. The abbreviation "SMI" is used to denote both singular and plural forms of "serious mental illness."

2. Criminogenic risk and needs assessments are designed to estimate the likelihood that a person will come in contact with the criminal justice system again, either as a result of a new arrest and conviction or reincarceration for violating the conditions of supervision. For additional information, refer to Osher et al., *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery* (New York: The Council of State Governments [CSG] Justice Center, 2012), <https://csgjusticecenter.org/mental-health-projects/behavioral-health-framework/>.

In addition to identifying and quantifying system gaps, conducting a comprehensive process analysis will enable counties to streamline current operations, eliminate duplicative efforts, and increase efficiency. Without a comprehensive process analysis, there are likely missed opportunities for improving public health and safety and providing the most appropriate responses to people who have SMI.

WHY IT'S CHALLENGING

Conducting a comprehensive process analysis can prove difficult because county systems are complex, county departments and community-based agencies providing support to this population tend to work in silos, and, across the many county systems, technology is rarely in place to track data electronically. Due to these complexities, there is no one-size-fits-all approach to reducing the number of people who have SMI in jails. Every county must develop policies and practices that adhere to local, state, and federal laws, such as privacy laws, which regulate how systems operate.

In their efforts to track the four key measures, information technology (IT) staff and other key stakeholders may struggle to reach consensus on developing an integrated data system, establishing mechanisms to share information, prioritizing policies and target populations, and using resources. Counties that tackle these challenges and complete the process analysis are in a better position to apply their local data to decision making and fill treatment and service gaps. See [In Focus: Collecting and Analyzing Baseline Data](#) for more on privacy rules and information sharing.

WHAT COUNTIES SHOULD DO

In order to conduct a comprehensive process analysis, counties should do the following:

- **Map the county's criminal justice and behavioral health systems.**

Using input from front-line staff about day-to-day system operations, this map should clearly demonstrate how people who have SMI move through the criminal justice and behavioral health systems. The map should start with the first point of criminal justice contact, such as the 911 call for service or when law enforcement responds to people who are experiencing a mental health crisis in public.³ Other parts of the map could cover processes related to pre-booking diversion opportunities, time in jail during the pretrial stage, time in jail during the post-conviction stage, and returning to the community after a period of incarceration. Some counties may even consider how people who have SMI fare prior to any criminal justice involvement, what drives initial law enforcement contact with that population, and whether there are crisis lines or other mechanisms in place to respond to people who have urgent mental health needs. All available details about the county's criminal justice and behavioral health functions—including the number of mobile crisis responders, the size of the county jail population identified as having SMI, and the number of participants served by a specialty treatment court, for example—should be represented on the system map. See Figure 1 for an example of a system map from Scotts Bluff County, Nebraska, that follows the Sequential Intercept Model.⁴

3. For more information about collaboration between law enforcement and mental health entities, read the CSG Justice Center, *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs* (New York: CSG Justice Center, 2019), <https://csjusticecenter.org/law-enforcement/publications/police-mental-health-collaborations-a-framework-for-implementing-effective-law-enforcement-responses-for-people-who-have-mental-health-needs/>.

4. Some counties choose to map their criminal justice and behavioral health systems using the Sequential Intercept Model. See the text box on page 5 for more information.

- **Identify opportunities for policy and process improvement.**

System mapping discussions can highlight ways to eliminate duplicative processes or programs and adjust policies and practices to better serve people who have SMI. This effort often leads to sharing information and resources across agencies and improving access to care.

- **Develop and analyze a list of existing evidence-based programs and services.⁵**

This list, which could be developed within the system map, should include programs and services that are currently available in the jail and community, with details about each program and service, such as eligibility criteria, waitlists, and cost. Programs and services could include behavioral health treatment, cognitive behavioral therapy, psychiatric services, supportive housing, supportive employment, and facilitated support groups. These interventions are provided by various people—including licensed mental health professionals, community supervision officers, faith-based groups, advocates, and volunteers—who may work together to provide collaborative case management.⁶ The list should indicate whether program or service matches and referrals are based on criminogenic risk as well as needs, including SMI. Compiling this list of interventions will help reveal any gaps that need to be filled either by adjusting how existing programs and services are provided or by investing additional resources to supply new programs.

- **Conduct a qualitative analysis for a fuller picture.**

Counties should make systems-level, data-driven decisions that also include a qualitative analysis because numbers may not tell the whole story. There are different mechanisms to collect qualitative data, including focus groups, one-on-one interviews, and surveys. A priority should be placed on interviewing people in the criminal justice system who have SMI and/or their family members because of their direct contact with the systems. This information will help county leaders articulate problems and proposed policy and practice recommendations for decision makers to consider. Because it presents an opportunity to talk with various stakeholders, collecting qualitative data may also help county leaders develop stronger relationships within and across agencies.

- **Review relevant statutes, standard operating procedures, and other policies.**

County leaders should flag policies and practices that are not in compliance with laws, are outdated, do not align with evidence-based practices, and/or disproportionately impact people who have SMI. After determining if the flagged policies and practices should be amended or eliminated, county leaders should present proposed changes to local decision makers with rationale for why those changes would help reduce the number of people in jails who have SMI. Note that some policy changes may require state administrative or legislative measures. Local champions of criminal justice and behavioral health system improvements may advocate for such changes at the state level.

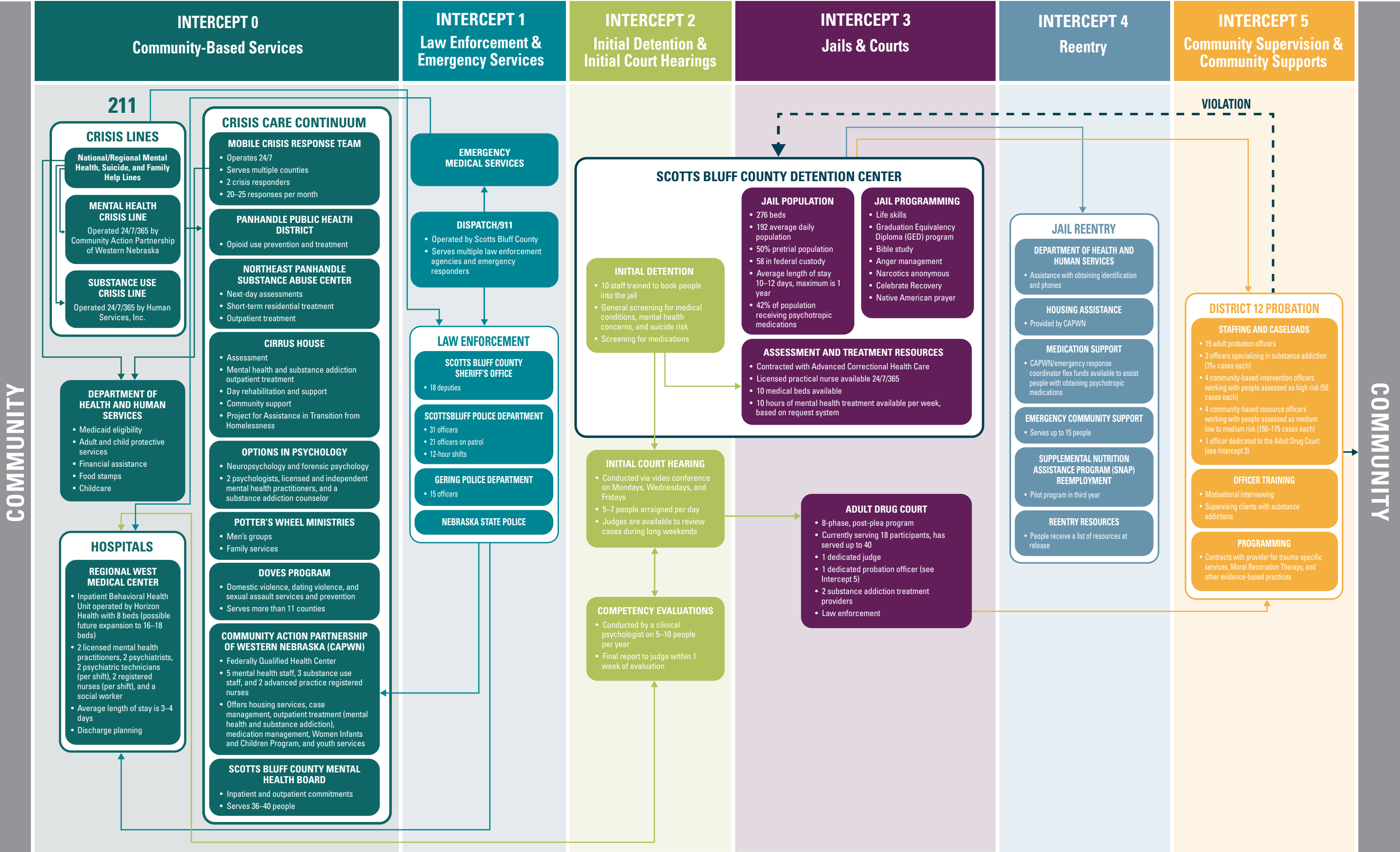
- **Take jail tours and observe programs.**

With permission from the appropriate stakeholders, county leaders should take tours of jails and treatment facilities to better understand how the criminal justice and behavioral health systems interact. These officials should also consider observing group programs run by behavioral health experts and community supervision officers and work with providers to ensure that programming in jails and treatment facilities is evidence based.

5. Programs and services are considered evidence based when they have demonstrated effectiveness through scientific research and evaluation. Both research and field experience show that implementing evidence-based programs and services with fidelity correlates to reduced recidivism rates and improved outcomes for people in the criminal justice system. For more information on evidence-based practices, visit <https://www.samhsa.gov/ebp-resource-center>.

6. See the CSG Justice Center, “Collaborative Comprehensive Case Plans,” accessed April 10, 2019, <https://csgjusticecenter.org/nrrc/collaborative-comprehensive-case-plans/>.

FIGURE 1: SCOTTS BLUFF COUNTY, NEBRASKA, SYSTEM MAP



To Get Started, Consider Hosting a Sequential Intercept Mapping Workshop

The purpose of the Sequential Intercept Model (SIM) is to help counties develop a strategic, systems-level plan that will improve responses for people in the criminal justice system who have mental illnesses and co-occurring substance addictions. The SIM Workshop requires system-wide participation, including criminal justice and behavioral health stakeholders, such as people who have had personal experience with these systems. The workshop is best conducted by a trained, neutral facilitator.

The final product of the workshop should illustrate how a person who has SMI moves through the criminal justice system, identify opportunities and resources for diverting people from jail to appropriate responses in the community, and indicate gaps in services. After completion of the SIM Workshop, the next step is to prioritize the needed interventions and resources that will impact one or more of the four key measures.

The U.S. Department of Justice's Bureau of Justice Assistance has supported the SIM Workshop by including it as a priority for Justice and Mental Health Collaboration Program grants. Policy Research Associates Inc. is the developer of the SIM process and facilitates mapping workshops. For more information about the history of the model or hosting a SIM Workshop, visit <https://www.prainc.com/sim/>.

To learn more about other counties that have conducted a comprehensive process analysis, read the National Association of Counties' [Chester County, Pennsylvania, and Franklin County, Ohio](#), case studies.



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2183

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:

1. Citizen Input Sign-up Sheet 07-26-2022

RESULT:	INFORMATIONAL - NO ACTION TAKEN
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**CITIZEN INPUT
SIGN-UP SHEET**

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.

By signing, you agree that you have read and agree to the terms set forth above.

Doug Carpenter Payment of Bills



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2150

DEPARTMENT: Auditor / Treasurer

PRESENTER: Gail Guck

TIME REQUESTED: < 5 Minutes

AGENDA ITEM:

Commissioner Warrants

BOARD ACTION REQUESTED:

Approve Commissioner Warrants with a check date of July 29, 2022, in the amount of \$2,367,835.78.

BACKGROUND:

N/A

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

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



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2125

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 July 2022.

BACKGROUND:

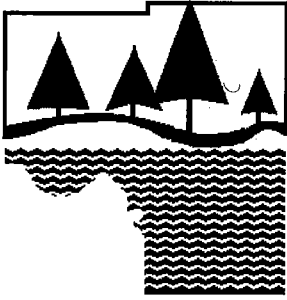
N/A

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:

1. ICHHS Warrants - July 2022

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



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

July 2022

Income Maint/Admin Payments	\$ 133,528.56
Social Services - Waivers	\$ 27,788.95
Social Services - Non-Waivers	\$ 527,306.11
Foster Care/Out of Home/FamilySupport	\$ 89,536.95
Relative Custoday/Preventive Placement Costs/Incidentals	\$ 400,212.87
Public Health	\$ 11,249.65
Community Health Board	\$ 293,477.08
Total	\$ 1,483,100.17

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.

July 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	487,698.28	435,540.15	533,038.47	431,360.66	326,329.84
June	585,853.92	453,742.31	382,221.73	511,262.03	511,990.80
July	400,212.87	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	3,198,560.59	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	56	35	63%	8	23%
June	53	19	36%	3	16%
July	47	20	43%	12	60%
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!
	350	175	#DIV/0!	55	#DIV/0!
	average			average	

July 2022
Out of Home Placement Payments by Vendor

		Rate	Invoices Paid
Northwestern MN Juvenile	-	\$200-\$340/day	\$ 97,221
The Bridge Residential Facility	-	\$250/day	\$ 48,341
Mille Lacs Academy	-	\$334 - \$403/day	\$ 41,567
Snyders/Foundation for Life	-	\$122/day	\$ 30,209
Northwood	-	\$294-\$331/day	\$ 29,593
MCF - Redwing	-	\$215/day	\$ 14,945
Go Forward Group Home	-	\$245/day	\$ 14,700
Heartland Girls Ranch	-	\$249 - \$316/day	\$ 8,937
Little Sand Group Home	-	\$240/day	\$ 8,597
Evergreen Shelter	-		\$ 7,520
Village Ranch	-	\$175 - \$231/day	\$ 5,870
Northstar	-	\$128/day	\$ 4,792
Lutheran Social Services	-	\$148-\$194/day	\$ 3,806
Volunteers of America	-		\$ 2,800
North Homes	-	\$175 - \$365/day	\$ 2,626
Anoka County Juvenile Center	-	\$226 - \$282/day	\$ -
Arrowhead Juvenile Center	-	\$250/day	\$ -
Bar None	-	\$475/day	\$ -
Dakota County Juvenile Serv	-	\$325 - \$340/day	\$ -
Itaskin Juvenile Center	-	\$175 - \$328/day	\$ -
Kidspeace Corp	-	\$266/day	\$ -
Kindred Family Focus	-		\$ -
Lighthouse	-	\$128/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	\$ -
West Central Juvenile Center	-	\$334/day	\$ -
Woodland Hills	-	\$152 - \$331/day	\$ -
Individuals*	-	\$21 - \$121/day	\$ 78,689
Total			\$ 400,213

*Individuals : Includes Foster Care & Family Support Programs



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2426

DEPARTMENT: University of Minnesota Extension **TIME REQUESTED:** 10 Minutes
PRESENTER: Conley Janssen

AGENDA ITEM:

Itasca County Farm Family of the Year

BOARD ACTION REQUESTED:

Honor Shady Oaks Red Angus as the 2022 Itasca County Farm Family.

BACKGROUND:

Jack and Mary Burt

Eric and Alaina Mousel

The Burt family farm began when George and Ella Burt, along with their two sons, Don and Roy, purchased 120 acres of land in 1911. They moved to Itasca County from Iowa and began a small farm and logging operation. In the 1930s, the family started a small dairy herd. After World War II, Don came home and purchased another 120 acres increasing the farm size to 320 acres. By the early 1960s, Don upgraded the dairy farm from hand milking and expanded to 25 cows.

In the 1970s, Don transitioned the farm to a beef cow/calf operation. During this time, Don's nephew, Jack Burt and his wife, Mary, started investing time and resources into the farm. In 1986, Jack and Mary moved their growing family to the farm and became the third generation of the family to farm. Jack and Mary expanded the beef herd.

When Jack and Mary's kids got involved in 4-H they purchased registered Red Angus breeding females, which would later grow into a registered Red Angus seedstock operation. Jack and Mary's daughter, Alaina, took interest in the cow business and learned to artificially inseminate cattle and to manage data necessary to organize a registered cow herd.

In 2011, the Burt Family Farm was recognized as a Century Farm and two years later Alaina, along with her husband, Eric, returned to the farm with their growing family.

The family currently raises registered Red Angus cattle and sells breeding stock. In addition to the beef herd the farm is home to a roadside pumpkin stand in the fall selling pie, coffee and pumpkins. Jack and Mary Burt are co-owners of the farm. Jack handles day-to-day operations. Mary helps put up hay, babysits her grandchildren, and quilts. Eric and Alaina are part owners of the operation. Eric

oversees the herd's nutrition, breeding selection and takes care of fencing. Alaina manages data, artificially inseminates the cows, and is an occasional equipment operator. Eric and Alaina's children Katie, Jack and June, participate in 4-H. They also harvest and help sell pumpkins.

The Burts and Mousels have invested in their local communities. Jack, a retired teacher and coach, served on the local Farm Service Co-op board and continues to invest in youth through mentoring and coaching engineering design and robotics Mary served as secretary of the Minnesota Red Angus Association and as Splithand Township supervisor and currently volunteers with Lutheran Social Services. Eric is a past president of the Arrowhead Regional Farm Bureau and a member of the St. Louis Valley and MN State Cattlemen's Associations. He is also an UMN Livestock Extension Educator. Alaina is a 4-H volunteer and past secretary of the Minnesota Red Angus Association.

COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION: None

RESULT:	INFORMATIONAL - NO ACTION TAKEN
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**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2518

DEPARTMENT: Health & Human Services

TIME REQUESTED: < 5 Minutes

PRESENTER: Becky Lauer

AGENDA ITEM:

HHS Family & Child Services Update

BOARD ACTION REQUESTED:

Informational

BACKGROUND:

Family & Child Services Division Update January - June 2022

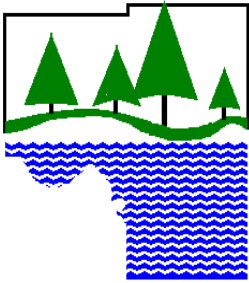
COUNTY ATTORNEY REVIEW: N/A

SUPPORTING DOCUMENTATION:

1. 2022 Jan-June Report to Board

RESULT:

PULLED FROM AGENDA



ITASCA COUNTY HEALTH AND HUMAN SERVICES

ITASCA RESOURCE CENTER

1209 SE 2nd Avenue, Grand Rapids, Minnesota 55744-3983

Hearing Impaired Number TDD: 218-327-5549

(218) 327-2941

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

July 20, 2022

CHILD PROTECTION

TYPES OF CPS CASES OPENED

Jan-Dec	Family Assessment	Investigation	Facility Investigation	PSOP/CW	Total	Average/month
2018	254	158	31	91	534	44.5
2019	209	155	23	110	497	41.3
2020	196	96	14	73	379	31.6
2021	212	127	14	99	452	37.7
2022 (Jan-June)	85	57	8	33	183	30.5

2022 January – June summary

- 183 new cases have been opened thus far from January – June 2022 and included 409 children.
- Out of home placement occurred in 21 of the 183 cases (11% of total cases) and included 35 children. Probation arranged for 14 children to be placed in shelter care.
- 41% of the children were placed due to parental drug use
- 33% of the children were placed due to their own behaviors/delinquency
- 12% of the children were placed due to their own mental health concerns
- 12% of the children were placed due to physical abuse, neglect, abandonment
- 2% of the children were placed in extended foster care upon reaching the age of 18

2021 MN PERFORMANCE REPORT- CHILD SAFETY AND PERMANENCY (published July 2022)

- % of children with a substantiated maltreatment report who do not experience a repeat substantiated maltreatment report within 12 months. (Threshold = to or above 90.9%)
Itasca performance: 100%
- % of children discharged from out-of-home placement to permanency in less than 12 months. (Threshold = to or above 40.5%)
Itasca performance: 55.8%
- % of days children in family foster care spent with a relative. (Threshold = to or above 35.7%)
Itasca Performance: 46.6%

ICWA: (Indian Child Welfare Act)

In 2017 DHS began an audit process of cases involving Native American children. These cases are referred to as ICWA cases and have stringent requirements per the Federal law. Our agency has worked diligently to be in compliance with ICWA requirements, which are tied to funding from DHS. Our 2022 audit (case from 2021) was completed in June and the results are listed in the chart below. The fact that Itasca County obtained 100% compliance in this audit is a result of collaboration amongst staff at several levels and they should be commended on this success.

Year	Itasca Ranking	Compliance Expected	Itasca County %
2017	5 th	Baseline year	72%
2018	12 th	80%	77%
2019	33 rd	90%	71%
2020	8 th	100%	93%
2021	1 st	100%	100%

ADULT PROTECTION AND MENTAL HEALTH

	Adult Protection Cases opened	Commitment Cases opened
2018	64	63
2019	71	56
2020	69	50
2021	66	77
2022	27	23

Prior to July 2022, our agency had one Adult Protection social worker who was responsible for all the cases. Due to the volume of cases, we will be reassigning another social worker to adult protection to assist with the caseload. As our community ages, the need for services will continue to increase and with 2 APS Investigators, we will be able to attend to the communities' increasing needs. The MN Legislature made significant changes to the laws and rules governing Adult Protection Services implemented on August 1, 2022.

The collaboration with the Community Paramedic program operated by Meds One has proven to be an invaluable partnership. The staff from this program partner with APS and

PH staff to address challenges of people living in their homes to identify supports and services that are needed to keep that person in their home.

Respectfully submitted,

Becky Lauer

Family & Child Services Division Manager



**ITASCA COUNTY
BOARD OF COMMISSIONERS**

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

Tuesday, July 26, 2022

REQUEST FOR BOARD ACTION: RBA-2022-2471

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: None

RESULT:

PULLED FROM AGENDA