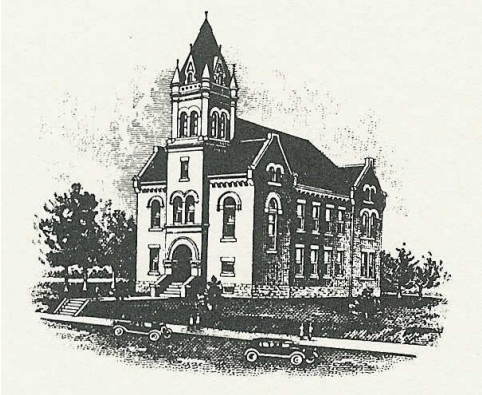
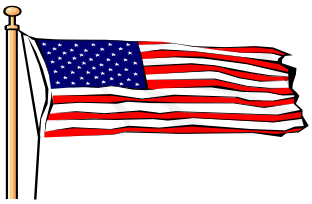


Kanabec County Board of Commissioners

Regular Meeting Agenda

The Meeting of November 15, 2022

- Due to COVID-19 safety protocol, this meeting will be in-person and via WebEx (video/phone conference)
- The public may join the meeting via WebEx or in-person at the meeting room.
- If attending the meeting in-person, the total number of persons (including commissioners) will be limited and social distancing/safety protocol may be in effect.



To be held via WebEx telephone call or video meeting:
Telephone call-in number for public access: 1-408-418-9388
Access Code: 2492 019 1782

Video Meeting link:
https://kanabeccounty.webex.com/kanabeccounty/j.php?MTID=mc2b8336515fc91e79f185b326dad6375
Meeting number: 2492 019 1782
Password: TrNfETQs594 (87633877 from video systems)

To be held at: **Kanabec County Courthouse**
Boardroom #164
18 North Vine Street
Mora, MN 55051

Please use the Maple Ave Entrance.

Scheduled Appointments: **Times are approximate and time allotted to each subject will vary. Appointment times may be changed at the discretion of the board.**

The audience is invited to join the board in pledging allegiance:

I pledge allegiance to the flag of the United States of America, and to the Republic for which it stands: one nation under God, indivisible with Liberty and Justice for all

9:00am a. Call to Order
b. Pledge of Allegiance
c. Agenda approval

9:05am Recess county board to a time immediately following the FSB.

Family Services Board

9:25am Renee Peterson, Kanabec County Community Health & Family Services Administrative Assistant- Public Programs Health Plans approval

9:30am Susanne Hinrichs, Regional Director Northeast Region and Jan Derdowski, Program Leader for the Northeast Region for the Center for Youth Development, Jean Mattson, Chair of the Kanabec Extension Committee- University of Minnesota Extension Presentation

10:00am Brian Smith, Sheriff –
a. Request to Approve Renewal of Medical Examiner Contract for 2023

b. Request to Approve Agreement with a Local Vendor for Animal Control Services in 2023
c. Request to Implement a Temporary Dispatch Sergeant Position
d. Quarterly Report

10:20am Chad Gramentz, Public Works- Safety Plan Update

10:30am Public Comment

Telephone call-in number for public access: 1-408-418-9388
Access Code: 2492 019 1782

10:45am Recess county board to a time immediately following the Drainage Authority Board.

Drainage Authority Board

Other business to be conducted as time is available:

1. Minutes
2. Paid Bills
3. Regular Bills
    a. Revenue Fund
    b. Road & Bridge
4. Snake River 1W1P Comprehensive Watershed Management Plan Update
5. Discuss Address Change for Kanabec Courthouse
6. Discuss Existing Travel Reimbursement Policy
7. Discuss 2023 Final Budget & Levy
8. Future Agenda Items
9. Discuss any other matters that may come before the County Board

ADJOURN

Kanabec County Family Services

905 East Forest Avenue, Suite 150
Mora, MN 55051
Phone: 320-679-6350
Fax: 320-679-6351

Kanabec County Family Services Board
Agenda
November 15, 2022
9:05 a.m.

1. **Agenda Approval** **Pg. 1**

2. **Tim Dahlberg & Katie Heacock : Presentation on Adult Protection and Child Support Performance Report**
   -See attached report **Pg. 2-18**

3. **Director's Report** **Pg. 19**
   - **Staffing**
   - **Purchase of electronic equipment when on sale**
     - **Action requested**
     - **See attached resolution** **Pg. 20**
   - **Ongoing Number of Children in Placement**

4. **Health Plans Care Coordination Agreements**
   - **Action requested**
   - **See attached resolution** **Pg. 21-127**

5. **Annual Agency Contracts Consent Agenda**
   -Action requested
   -See attached consent agenda and resolutions **Pg. 128-132**

6. **3rd Quarter report**
   -See attached report **Pg. 133-145**

7. **Welfare Fund Report**
   -See attached report **Pg. 146**

8. **Financial Report**
   -See attached report **Pg. 147-148**

9. **Abstract Approval**
   -See attached abstract and board vendor paid list **Pg. 149-151**

10. **Other Business**

11. **Adjourn**

Kanabec County
Performance Report

Adult Protection and Child Support
Performance Report
October 2022

Reporting Periods:
Adult Protection July 1, 2021 – June 30, 2022
Child Support Oct. 1, 2021 – Sept. 30, 2022

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

For more information contact:
Minnesota Department of Human Services
Human Services Performance Management System
DHS.HSPM@state.mn.us | (651) 431-5780

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

Performance Report Overview

About this Report

The purpose of this report is to share county performance data on the Adult Protection and Child Support measures as they relate to the Human Services Performance Management system (referred to as the Performance Management system).

This report contains data on four measures and includes:

- State fiscal year (July 1, 2021 – June 30, 2022) performance data for the Adult Protection measure
- Federal fiscal year (Oct. 1, 2021 – Sept. 30, 2022) performance data for the three Child Support measures
- Performance data trends for recent years
- A performance comparison to other counties in the same Minnesota Association of County Social Services Administrators (MACSSA) region

This report compares county performance to the thresholds established for the Performance Management system. The Performance Management system defines a threshold as the minimum level of acceptable performance, below which counties will need to complete a Performance Improvement Plan (PIP) as defined in Minnesota Statutes Chapter 402A. For counties below the threshold, an official PIP notification—with instructions for accessing PIP forms, PIP completion directions, and available technical assistance—will be sent in addition to this report.

After an unprecedented statewide decline in performance on the Percent of Current Child Support Paid measure, the Human Services Performance System suspended 2022 PIPs for this measure. See page 14 for additional details.

Additional Information

Supplemental and background information about the Performance Management System can be found on CountyLink: **www.dhs.state.mn.us/HSPM.**

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

Updated Small Numbers Policy

Small Numbers Policy Update

The policy for assessing performance in counties with small numbers was updated and a policy update bulletin issued in 2022: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs-337635

The policy overview below reflects the updated assessment method.

- If a county has a denominator of 20 or fewer and is meeting the threshold for a measure, the county is performing to expectations and no further assessment will take place.
- If a county has no people in a measure, it will be considered to be meeting the threshold.
- If a county has a denominator of 20 or fewer and is not meeting the threshold for a measure, performance will be reviewed across two years of data. Two years below the performance threshold for any one measure will trigger the PIP process.
- Measures using a regression threshold model, such as the Self-Support Index, will not be subject to the small numbers policy. The reason for this is that the regression models account for a variety of factors outside of county control, including caseload size.

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

Discontinuation of Adult Repeat Maltreatment Measure

Background:

Changes enacted by the 2022 legislature and signed by Governor Walz changed the way counties will offer services to vulnerable adults in Minnesota. The list of changes can be found in Laws of Minnesota 2022, chapter 98, article 8, sections 37-49. Based on the legislative changes, counties will no longer make investigation determinations for adults referred to the agency for self-neglect. Instead, all adults who are vulnerable and accepted by the agency as self-neglecting will be engaged in assessment, service planning and interventions with no determination of maltreatment. The Adult Repeat Maltreatment measure was dependent on determinations as criteria for the measure and has been discontinued since it is no longer relevant.

Discontinued measure details:

Percent of vulnerable adults with a maltreatment determination without a repeat determination within six months.

Percent of vulnerable adults subject to a repeat allegation of suspected maltreatment reported to the statewide Common Entry Point, the Minnesota Adult Abuse Reporting Center (MAARC), determined to be substantiated or inconclusive within six months of an initial allegation, of the same incident type, determined to be substantiated or inconclusive.

Additional information:

https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs-339388

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

New Adult Protection Measure Initial Disposition

Background:

The Performance Management and Adult Protective Services teams from DHS hosted a stakeholder engagement event on Nov. 9, 2020 to discuss two proposed Adult Protection measures and respective thresholds. More than 40 representatives from counties and the provider community attended the virtual event.

During the meeting there were breakout sessions where groups of county and stakeholder participants provided feedback on the proposal to add a second Adult Protection measure, Initial Dispositions Made within Five Days. After the conversations exploring questions, benefits and concerns, the group voiced their overall approval of the measure and threshold.

The Human Services Performance Council adopted the additional measure in Feb. 2021 and an initial baseline report was provided in Oct. 2021. Due to the timing of this measure, this report includes a second baseline. Counties will be held accountable to the threshold beginning in 2023.

Measure details:

Percent of vulnerable adults reported as maltreated with initial disposition for response made within five working days.
The measure is calculated based upon the difference between the date a report was received by a county that a vulnerable adult was suspected of experiencing maltreatment and the date of the county's decision to offer adult protective services to the vulnerable adult. The measure compares the total number of reports received during the state fiscal year with an initial disposition date within five business days.

- Count is for reports where a county was the lead investigative agency (LIA) responsible for a response.
- The date received is the date a report of suspected maltreatment is received from the Minnesota Adult Abuse Reporting Center (MAARC).
- Initial disposition is defined as the LIA's determination if the report from MAARC will be assigned for investigation of allegation and protective services to safeguard and prevent harm to the vulnerable adult from maltreatment. See also the definition of initial disposition as defined in
- statute: https://www.revisor.mn.gov/statutes/cite/626.5572

Measure Threshold

This report displays county performance results compared to a threshold of 90%.

About the Measure

Outcome: Adults and children are safe and secure.

Percent of vulnerable adults reported as maltreated with initial disposition for response made within five working days.

What is this measure?
The measure is calculated based upon the difference between the date a report was received by a county that a vulnerable adult was suspected of experiencing maltreatment and the date of the county's decision to offer adult protective services to the vulnerable adult. The measure compares the total number of reports received during the state fiscal year with an initial disposition date within five business days.

Why is this measure important?
This measure supports timely response for vulnerable adults that may be experiencing maltreatment. Additionally, it promotes statutory compliance for initial disposition being made within five business days. A timely response is important to safeguard vulnerable adults.

What affects performance on this measure?

- System factors include the number of reports received.
- Staff factors include lack of staff, understaffed, lack of knowledge and training, level of supervision, staff have many different roles and work many programs at once, and inconsistent interpretation of policy.
- Documentation factors include the accuracy of data and the timeliness of data entry.
- Environmental or external factors include delays in return response from reporter or others.

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

Kanabec County Performance

Outcome: Adults and children are safe and secure.

Percent of vulnerable adults reported as maltreated with initial disposition for response made within five working days.

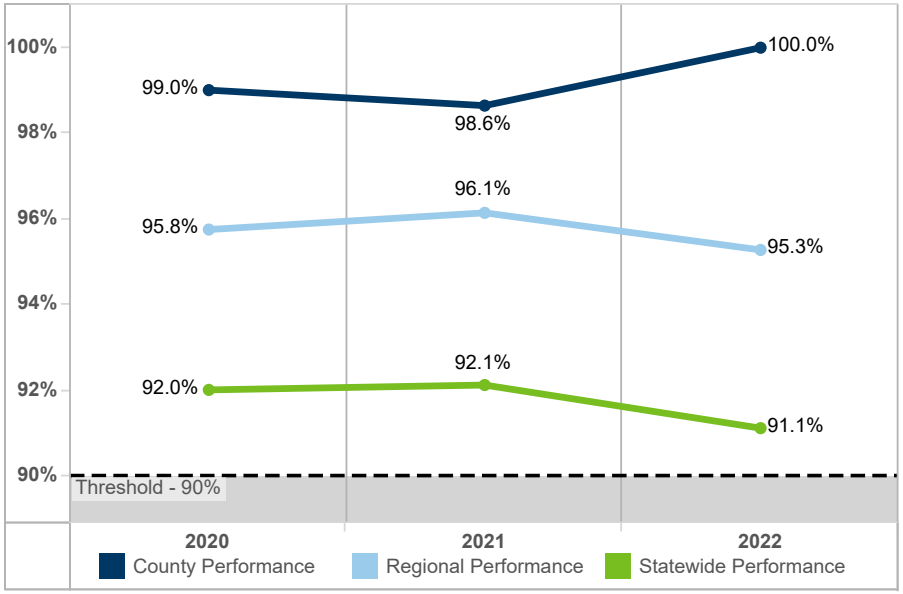
Kanabec County Performance by Year

	2020	2021	2022
County Performance	99.0%	98.7%	100.0%
Denominator	101	74	80

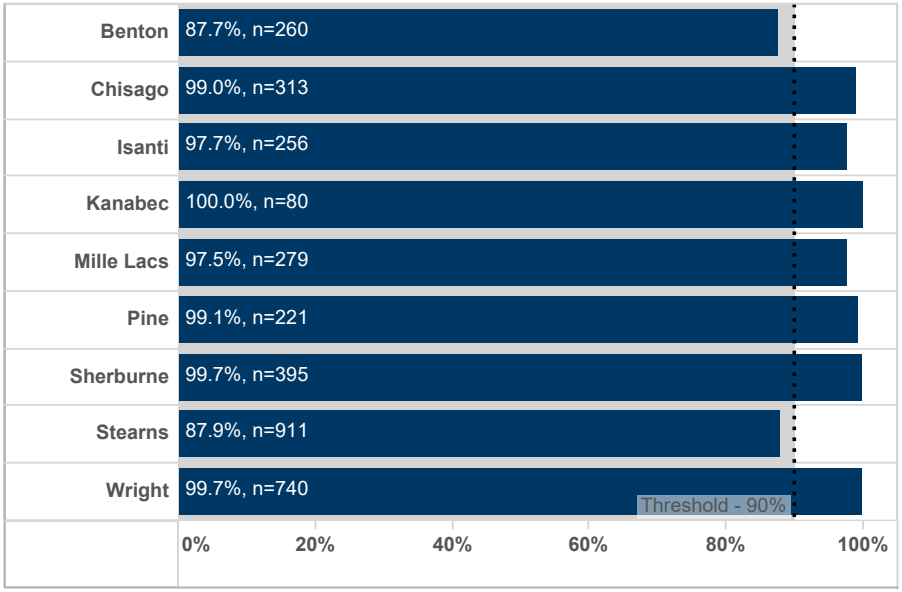
PIP Decision

No PIP Required - This is a baseline report, the PIP requirement for this measure will begin in 2023.

County, State and Regional Performance



2022 Performance for MACSSA Region 7



*Blank values represent counties with no cases for a reporting year.

**The dotted line on each graph indicates 90%, the threshold for this measure.

Kanabec County Performance by Year

	2020	2021	2022
County Performance	99.0%	98.7%	100.0%
Denominator	101	74	80

County Performance and Denominator broken down by Year Year. The data is filtered on County-Parameter Alignment, which has multiple members selected.

About the Measure

Outcome: Children have the opportunity to develop to their fullest potential

Percent of open child support cases with paternity established.

What is this measure?
This measure divides the number of children in open Child Support cases that were not born in marriage in the previous federal fiscal year by the number of children in open Child Support cases that had paternities established in the report year. The paternities established by Child Support workers during the federal fiscal year may not necessarily be for the same children born of non-marital births in the previous year. This is why percentages often exceed 100 percent.

Why is this measure important?
Establishing parentage gives a child born outside of marriage a legal father and the same legal rights as a child born to married parents. Parentage must be established before an order for support can be established. Within the Child Support program, counties are responsible for connecting parents and their children by locating parents and establishing paternity. The counties initiate court actions to determine parentage. Paternity is important not only for the collection of child support, but also for other legal matters like inheritance and survivor benefits.

What affects performance on this measure?

- Service factors such as staff availability, the hours a county office is open, the location of the agency in relation to people needing services, and the age of technology and computer systems.
- Staff factors such as staff training levels, staff-to-client ratios, and business continuity planning as older, more experienced workers retire.
- Participant factors such as demographics, trust or mistrust of government, housing stability, and immigration status.
- Environmental or external factors such as cooperation between law enforcement, counties, courts, and hospitals; working across state and American Indian reservation borders; and clients' ability to obtain transportation.

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

Kanabec County Performance

Outcome: Children have the opportunity to develop to their fullest potential

Percent of open child support cases with paternity established.

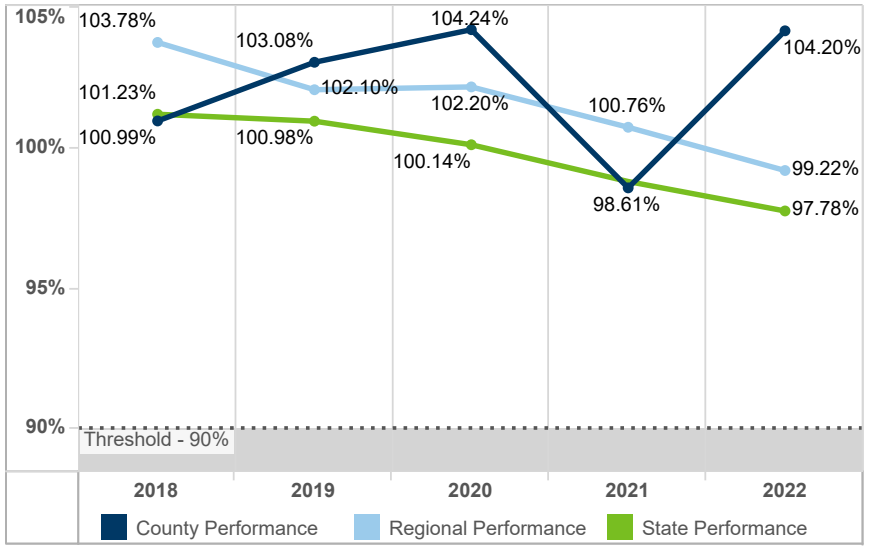
Kanabec County Performance by Year

	2018	2019	2020	2021	2022
County Performance	100.99%	103.08%	104.24%	98.61%	104.20%
Denominator	607	585	590	574	548

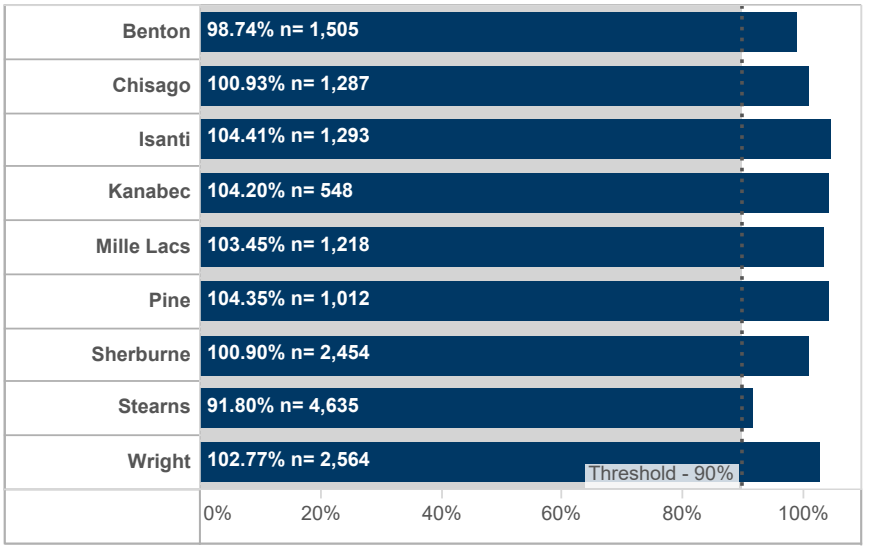
PIP Decision

No PIP Required - Performance is equal to or above the threshold of 90%.

County, State and Regional Performance



2022 Performance for MACSSA Region 7



**The dotted line on each graph indicates the measure threshold of 90%.*

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

About the Measure

Outcome: People are economically secure

Percent of open child support cases with an order established.

What is this measure?
This measure is the number of cases open at the end of the federal fiscal year with support orders established divided by the number of total cases open at the end of the federal fiscal year.

Why is this measure important?
This is a measure of counties' work toward ensuring children receive financial support from both parents. Through their role in the Child Support program, counties help ensure that parents contribute to their children's economic support through securing enforceable orders, monitoring payments, providing enforcement activities, and modifying orders when necessary.

What affects performance on this measure?

- Service factors that influence this measure include relationship with the county attorney, ability to schedule timely court hearings, information-sharing between courts, tribal nations, and Child Support, and relationships with other states that impact the ability to collect support across state boundaries.
- Staff factors that influence this measure include the number of staff dedicated to Child Support, training and education, and legacy planning and hiring of new staff as staff retire.
- Participant factors that influence this measure include family size, the separation or divorce rate and whether children are born in marriage, custody arrangements, and incarceration of non-custodial parents.
- Environmental or external factors influencing this measure include local economy and ability of non-custodial parents to find employment, employer response time to paperwork, parents that work for cash, and level of trust in the government to provide service.

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

Kanabec County Performance

Outcome: People are economically secure

Percent of open child support cases with an order established.

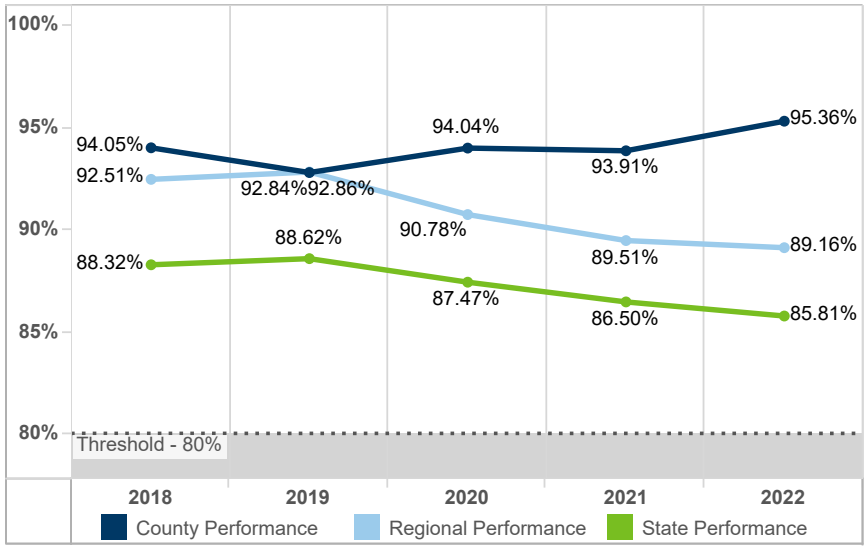
Kanabec County Performance by Year

	2018	2019	2020	2021	2022
County Performance	94.05%	92.84%	94.04%	93.91%	95.36%
Denominator	807	782	738	722	689

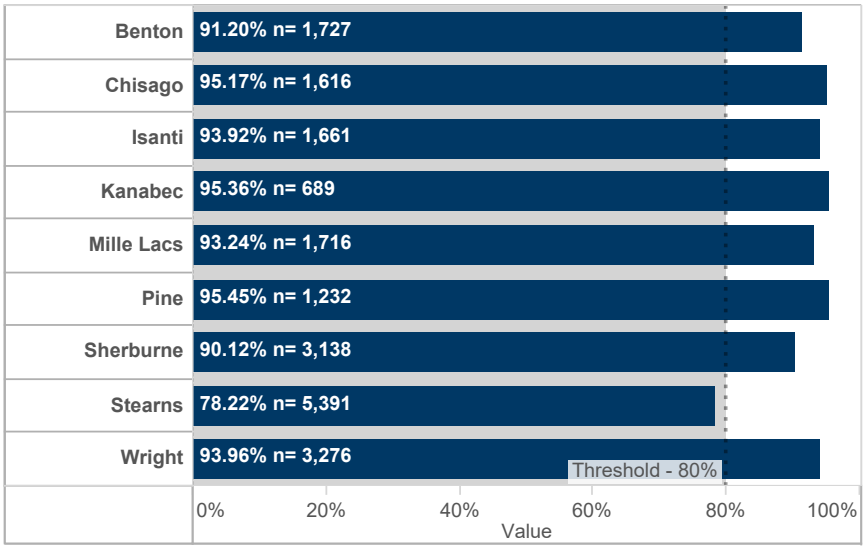
PIP Decision

No PIP Required - Performance is equal to or above the threshold of 80%.

County, State and Regional Performance



2022 Performance for MACSSA Region 7



**The dotted line on each graph indicates the measure threshold of 80%.*

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

About the Measure

Outcome: Children have stability in their living situation

Percent of current child support paid.

What is this measure?
This measure is the total amount of support distributed divided by the total amount of current support due during that fiscal year. The numerator and denominator are dollar amounts, rather than children, families, or people.

Why is this measure important?
Children need both parents contributing to their financial security, and child support is one means of accomplishing that. Counties, through their role in the Child Support program, help ensure that parents contribute to their children's economic support through securing enforceable orders, monitoring payments, providing enforcement activities, and modifying orders when necessary.

What affects performance on this measure?

- Service factors that influence this measure include the size of the interstate caseload and ability to collect support across state boundaries, relationships with other counties and tribes, court processes, coordination with other county services, and technology that is sometimes out-of-date. For example, technology limitations do not allow non-custodial parents to pay by credit card.
- Staff factors that influence this measure include caseload size, legacy planning and training of new staff as staff retires, and challenges attracting and retaining new staff.
- Participant factors that influence this measure include parent initiative or interest in pursuing a modification of their order, non-cooperation by non-custodial parents, visitation schedules, employment rate, self-employment, and homelessness.
- Environmental or external factors that influence this measure include the local economy, resources of the county attorney, the availability of community resources to help parents find and keep employment and address issues leading to unemployment, and the increased state minimum wage.

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

Percent of Current Child Support Paid Threshold Review

Background on Percent of Current Child Support Paid Threshold

In 2017, a stakeholder workgroup recommended and the Human Services Performance Council approved a two part plan to update the Child Support Paid Threshold:

- **Increasing Five-year Average (Currently in Use)**
  Temporary Threshold Launched in 2017
  This modified version of the historical threshold was launched in 2017. The current, temporary threshold rewards performance improvement while minimizing the effect of one-year performance anomalies. This threshold will be used until the Regression Adjusted Performance Model is finalized.

- **Develop a Regression Adjusted Performance Model**
  The DHS Child Support division, in partnership with the Performance Management team, is developing a Regression Adjusted Performance Model to use statistical regression analysis to predict what a county's performance should be based on contributing factors. The regression model is under development and will be implemented when complete.

Calculating the Increasing Five-year Average Threshold

The Current Child Support Paid threshold uses a five-year average of the year-over-year (YOY) point change in performance. If the average YOY growth for the county is positive, there is no PIP. If there was no growth (0 percentage points) or negative growth, the county receives a PIP. The threshold includes a clause for counties performing above the state median; regardless of year-over-year change, counties with performance above the state median performance for the reporting period (75.3% for 2022) will not receive a Performance Improvement Plan (PIP).

Sample Calculation

County Data:

Milkweed County had 64.79 percent of its orders paid in 2017, 65.22 percent in 2018, 65.35 percent in 2019, 66.21 percent in 2020, 65.08 percent in 2021, and 66.11 percent in 2022.

Calculate Year-over-year Change:

2018 - 2017 = 65.22 - 64.79 = 0.43
2019 - 2018 = 65.35 - 65.22 = 0.13
2020 - 2019 = 66.21 - 65.35 = 0.86
2021 - 2020 = 65.08 - 66.21 = -1.13
2022 - 2021 = 66.11 - 65.08 = 1.03

Calculate Average Change:

(Δ2018 + Δ2019 + Δ2020 + Δ2021 + Δ2022) / 5 =
(.43 + .13 + .86 + -1.13 + 1.03) / 5 =
.264 percentage points

The average is positive, therefore the threshold has been met.

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

Percent of Current Child Support Paid 2022 PIP Suspension

Overview of Performance Changes for Percent of Current Child Support Paid

Performance data for 2022 revealed an unprecedented statewide decline in performance on the Percent of Current Child Support Paid measure. This year's data showed that:

- Since last year, 68 counties and SDA's had a decline in performance (many of the drops significant).
- More than 50 counties and SDA's had a negative threshold.
- Based on the threshold and median county performance, 30 counties would be required to complete a PIP. This is more than twice the number we had last year and the most we have had in one reporting cycle since the Performance Management system started for this measure.
- Of the 30 counties who are below the threshold, 20 of them would be a new PIP this year. This is nearly triple the new PIPs we had last year. The statewide average has dropped from 75.75% last year to 72.62%, which is near 2015 levels for this measure. This is the single largest drop for this measure since the Performance Management system began.

Major systemic issues appear to be at play, but so far the specific issues remain unclear. Asking counties to create individual PIPs to create strategies for issues that seem to be affecting the entire system does not seem valuable, instead the Performance Management team wants to take a systemic and collaborative approach to improvement efforts for this measure.

Action Plan

The Human Services Performance Council has suspended 2022 PIPs for Percent of Current Child Support Paid measure. This year, instead of asking counties to complete PIPs for the measure, the DHS Performance Management team and Child Support Division will be asking counties to help us research the decline in performance, identify barriers and develop strategies to improve performance throughout the state. We hope that a collaborative approach will help us stop the decline and identify meaningful improvement opportunities.

Watch for additional information about how to share your input into the barriers to child support collections in the near future.

DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES PERFORMANCE MANAGEMENT

Kanabec County Performance

Outcome: Children have stability in their living situation

Percent of current child support paid.

Kanabec County Performance by Year

	2018	2019	2020	2021	2022
County Performance	74.94%	74.74%	75.15%	77.14%	74.02%
Denominator	$2,307,830.96	$2,182,093.33	$2,119,735.25	$2,020,708.71	$1,995,789.00

2022 Threshold

Five-Year Average Change
-0.47%

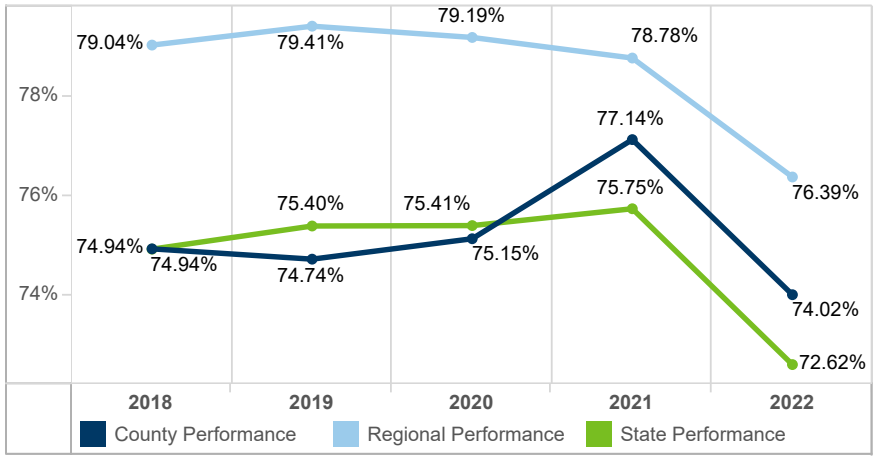
Minimum Performance Target
75.30%

The Child Support Paid threshold is a five-year average of the year-over-year change in performance. A positive number indicates the performance threshold has been met (see page 13 for details).
The performance target was the minimum performance needed for a positive five-year average change or the state median performance, 75.3%, whichever is lower.

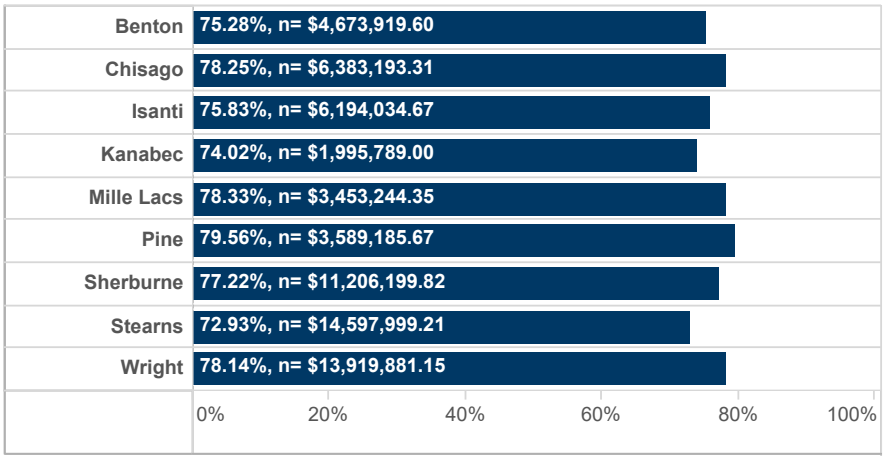
PIP Decision

No PIP required - After an unprecedented statewide decline in performance on this measure, the Human Services Performance Council has suspended 2022 PIPs.

County, State and Regional Performance



2022 Performance for MACSSA Region 7



Kanabec County Performance

Outcome: Children have stability in their living situation

Racial Data for Percent of current child support paid.

Performance data is provided below by racial and ethnic groups for counties where there were 30 or more people of a group included in the denominator. The racial and ethnic data provided is that of the noncustodial parent.

Purpose

The racial and ethnic data included in this report is for informational and planning purposes. We encourage you to review this data to identify opportunities for improvement. The racial and ethnic group data included in this report does not give a complete picture of county performance, the communities being served, nor systemic inequities. The Performance Management system is not currently using this data to assess a county's need for PIPs.

No Data Available

Counties with low numbers (fewer than 30) for all but one racial or ethnic group do not have a graph of performance by racial and ethnic group available in this report. Currently, racial data is not available for the other Child Support measures, only percent of current Child Support Paid.

No Data Available

Counties with low numbers (fewer than 30) for all but one racial or ethnic group do not have a graph of performance by racial and ethnic group available in this report. Additional information may be available upon request, please contact DHS.HSPM@state.mn.us for additional information.

Family Service Director's Report

October 2022

Staffing

No change currently we may have a retirement soon and are looking at that position for replacement, need and function.

Purchase of Equipment

Recently I was notified by the I.S. Director of an opportunity to purchase computers at a discount during a sale through one of their vendors. The Family Services Agency had funds budgeted and available to make this purchase but did not have adequate time to come before the board to have the purchase approved, since it would have been above the $2500 threshold. At this time I am asking the board to approve in advance, me and the I.S. Director to purchase equipment that is budgeted for and that is significantly discounted but above the $2500 threshold required to be approved by the board. This would also only be done at times when the budget is positive for that time in the year.

- Action requested
- See attached resolution

Ongoing Update on Number of Children in Placement

Last month we had _21__children in our care in out of home placements. We have _24_ children in care this month compared to _14__ last year for the same month.

Resolution # FS - 11/15/2022

Purchase of Budgeted Equipment Resolution

WHEREAS, the Family Services Agency has a significant budget for equipment annually, and

WHEREAS, as a result of a recent missed opportunity to purchase budgeted equipment at a discount, the Family Services Director wishes to receive Board approval in advance for budgeted equipment which can be over and above the $2500 threshold to be completed without board approval, and

WHEREAS, vendors have intermittent sales/discounts with limited, last minute notifications and the Family Services Director and I.S. Director prefer to purchase during these occasions in order to take advantage of the savings benefits for the County.

THEREFORE BE IT RESOLVED the Family Services Board approves in advance the Family Services Director and I.S. Director to work cooperatively to procure budgeted equipment through approved vendors when they receive notification of sales or discounts which benefit the County through significant savings.

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May 6, 2022

Kanabec County Community Health
905 Forest Ave E Ste 127
Mora, MN 55051

Re: Addendum to the Blue Plus Referral Health Professional Provider Service Agreement for Public Health Nursing Clinic Services
Blue Shield ID Number(s): 003536201
Enclosure: Updated Addendum effective July 1, 2022

Dear Provider:

Blue Cross and Blue Shield of Minnesota, Blue Plus and Affiliates ("Blue Plus") has been working with the public health nursing services community to learn about the challenges faced by providers. After conducting a thorough review of all details and information, Blue Plus is pleased to advise you that we are increasing your reimbursement in recognition of the increased complexity and value of the services provided to our members.

As stated in Article IV.A of the attached Addendum to the Blue Plus Referral Health Professional Provider Service Agreement for Public Health Nursing Clinic Services, effective July 1, 2022, Blue Plus will begin reimbursing participating providers at the rate of $180.00 for claims submitted under procedure code S9123.

It is not necessary for you to sign or return anything for the Addendum to become effective July 1, 2022. Please keep this document for your records.

If you would like to receive a comprehensive copy of the Blue Plus Referral Health Professional Provider Service Agreement to which the enclosed Addendum is attached, please email a request to: Request.Contract.Renewal@bluecrossmn.com.

We appreciate and value your participation throughout the year and the quality health care services you offer our members. If you have any questions about the updated addendum, please contact our provider service center at 1-866-518-8448.

Sincerely,

Provider Relations

BlueCross BlueShield Minnesota

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Addendum to the Blue Plus Referral Health Professional Provider Service Agreement for Public Health Nursing Clinic Services

The Blue Plus Referral Health Professional Provider Service Agreement ("Agreement") between Blue Plus and Provider ("Provider"), to which this Addendum is to be attached and by reference becomes a part thereof, shall be amended as provided in this Addendum.

The purpose of this Addendum is to establish the terms and conditions under which Provider will provide Health Services for eligible Subscribers for Health Services covered under a Minnesota Health Care Program. For purposes of the services detailed in this Addendum, Provider is not required to hold an Aware Provider Service Agreement.

In the event of conflict between terms and provisions detailed in this Addendum with those occurring in the Agreement, such terms and provisions as stated in this Addendum shall take precedence with respect to the subject matter detailed herein.

Blue Plus and Provider agree that this Addendum and the Agreement apply only to Health Services as detailed herein and that the eligible Health Services as defined herein are applicable only to Subscribers who are covered under a Minnesota Health Care Program.

NOW, THEREFORE, it is agreed as follows:

ARTICLE I: DEFINITIONS

The following term as used in this Addendum shall have the meanings as ascribed to them below:

A. "Certified Public Health Nurse (CPHN)" means a registered nurse who is licensed and providing services within the scope of practice as defined in Minnesota Statutes, and who is certified in public health nursing by the Minnesota Board of Nursing or who received certification from the Minnesota Department of Health prior to January 1990.

ARTICLE II: COVERED HEALTH SERVICES

A. Services Provided. Only services performed by qualified Public Health Nurses and allowed by DHS shall be eligible for reimbursement when provided to Subscribers. Provider will not be considered a participating provider for any other Health Services unless Blue Plus and Provider enter into a separate written agreement with regard to any such other Services.

B. Service Standards. Health Services shall be eligible for reimbursement by Blue Plus under the terms of the Agreement only when performed by (1) a Certified Public Health Nurse; or (2) a licensed Registered Nurse, under supervision by a Certified Public Health Nurse.

C. Provider agrees to abide by all terms of the Agreement, including but not limited to the CMS delegation requirements which are detailed in the Blue Cross Provider Policy & Procedure Manual.

ARTICLE III: CARE COORDINATION

A. Consent. Provider shall secure from each Subscriber treated a signed consent form that gives Provider permission to share information on diagnosis, treatment and results of laboratory tests with the Subscriber's Primary Care Clinic. Upon receipt of such consent, Provider agrees to send a report to the Subscriber's Primary Care Clinic of all Health Services provided, and to refer the Subscriber to the Primary Care Physician for care as needed.

B. Provider shall perform as Blue Plus' delegate, in accordance with Government Programs Care Coordination guidelines available at: https://carecoordination.bluecrossmn.com/msho/

ARTICLE IV: PAYMENT

A. Terms. Blue Plus will pay Provider for eligible Health Services at the lesser of Provider's Regular Billed Charge or 100% of the Blue Plus medical assistance fee schedule as determined by Blue Plus. However, (1) for procedure code S9123 only, Blue Plus shall pay Provider at the rate of $180.00 for Health Services; and (2) for procedure code S9445 only, Blue Plus shall pay Provider at the rate of $86.40 for Health Services.

ARTICLE V: REVISIONS AND TERMINATION

A. Blue Plus reserves the right to revise or terminate the Agreement upon 30 days' prior written notice to Provider in the event that the State of Minnesota changes or terminates the benefit under which Health Services are provided to Blue Plus Minnesota Health Care Program Subscribers under this Addendum.

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IN WITNESS WHEREOF, this Addendum is executed by signature of the authorized representative of Blue Plus.

Blue Plus

(signature)

Eric Hoag

(typed name)

Vice President, Provider Relations

(title)

May 6, 2022

(date)

BlueCross BlueShield Minnesota

October 25, 2022

Kanabec County Community Health
905 Forest Ave E Ste 127
Mora, MN 55051

RE: Blue Plus Referral Health Professional Provider Service Agreement renewal, effective July 1, 2022
For: Nurse Practitioner - Community Health
Blue Shield ID Number: 003536201
NPI: 1578014486

Dear Participating Provider:

Attached is your updated Blue Cross and Blue Shield of Minnesota, Blue Plus and Affiliates ("Blue Plus") Blue Plus Referral Health Professional Provider Service Agreement (“Agreement"), as requested. You do not need to sign or return anything.

Consolidated Agreement: The enclosed Agreement is an amended and restated Agreement, which incorporates the provisions of your original signed Agreement and all renewal amendments to date. This restated Agreement is for your convenience and clarity, to maintain current and consistent language with state and federal health care rules and regulations and to help ensure the highest standards of health care services for the patients you serve.

Provider Bulletin Summary of Changes: Substantive changes to the Agreement are summarized annually in our April/May Provider Bulletin available for your review in the “For Providers” section of our website at bluecrossmn.com/providers (select the “Forms & Publications” link then Search “bulletins”). Visit the site to access monthly Provider Bulletins, the Provider Policy & Procedure Manual, reimbursement policies, coding tips, network and product guides, medical policies and other helpful information.

Medicare Amendment: Inclusion of the Medicare Amendment with other documents comprising this Provider Service Agreement does not affect your Medicare status.

If you have any questions about the enclosed material, please call our provider service center at 651-662-5200 or 800-262-0820 or 888-420-2227. Thank you for your continued participation with Blue Plus.

Sincerely,

Provider Relations

BlueCross BlueShield Minnesota

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2022 Blue Plus Referral Health Professional Provider Service Agreement

Article I - Purpose

HMO Minnesota, d/b/a Blue Plus ("Blue Plus") and the Provider hereby agree to the terms and provisions of this Agreement. Provider must maintain an Aware Provider Service Agreement in order to be offered this Referral Health Professional Provider Service Agreement. Hereinafter, Blue Plus and the Provider may be individually referred to as a "Party" and jointly referred to as “the Parties."

Article II - Definitions

A. "Affiliate" means (i) any entity now existing or hereafter organized that, directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with Blue Plus, and/or (ii) any entity in which an entity described in "(i)" above holds not less than 33% of either the membership interest, voting interest or issued and outstanding voting securities thereof.

B. "Agreement" means this Referral Health Professional Provider Service Agreement, including (1) the originally executed signature page, which shall be binding upon all of Provider's Health Care Professionals, (2) the applicable fee schedule(s), (3) the Amendment to the Agreement – Medicare Programs, as applicable, (4) the Provider Policy & Procedure Manual as it may be amended from time to time (available at bluecrossmn.com/providers), (5) the Blue Plus Manual as it may be amended from time to time (available at bluecrossmn.com/providers), (6) any and all existing and effective Provider Bulletins (available at bluecrossmn.com/providers) as well as any Provider Bulletins issued by Blue Plus during the term of this Agreement, (7) the Reimbursement Policies as may be amended by Blue Plus from time to time (available at bluecrossmn.com/providers), (8) any and all existing and effective Exhibits, (9) the provisions of the Credentialing and Recredentialing Provider Policy Manual as it may be amended by Blue Plus from time to time (available at bluecrossmn.com/providers), (10) Medical and Behavioral Health Policies (available at bluecrossmn.com/providers), and (11) any other Addenda or Amendments whose terms and provisions are incorporated into and made a part of this Agreement.

C. "Blue Plus" means HMO Minnesota d/b/a Blue Plus and may include at Blue Plus' discretion, one or more of its Affiliates.

D. "Concurrent Review" means ongoing review during the Subscriber’s care to ensure that the care meets established medical criteria in a timely manner and certifies the necessity, appropriateness and quality of Health Services.

E. "Health Care Professional" means an individual employed by Provider or an independent contractor of Provider who maintains the necessary state health care license, registration or certification appropriate to practice or perform a type of Health Service in the state in which it delivers the Health Services.

F. "Health Service" means any health care service, product, procedure, or item provided to a Subscriber regardless of whether or not the health care service, product, procedure or item is covered under the Subscriber Contract and subject to all terms of the Subscriber Contract.

G. "Medically Necessary and Appropriate" or "Medical Necessity and Appropriateness" shall have the meaning as defined in the Subscriber Contract.

H. "Minnesota Health Care Programs" means prepaid public programs, including Medical Assistance, MinnesotaCare, Families and Children, or other prepaid public programs in which Blue Plus provides coverage under a contract with any Minnesota County or with the Minnesota Department of Human Services (“DHS”).

I. "Plan Sponsor" means an employer or other party who provides benefits or administers the benefit plan for Subscribers under a plan which utilizes a Blue Plus participating provider network.

J. "Pre-certification" or "Pre-Service Review" or "Prior Authorization" means an advance review of a proposed facility admission or certain Health Services or procedures in order to determine whether the proposed admission, Health Services or procedures meet the Medical Necessity and Appropriateness criteria for payment and to ensure that the Subscriber receives the maximum benefits available under the Subscriber Contract.

K. "Primary Care Clinic" (“PCC”) means a physician or group of physicians who have entered into an Agreement with Blue Plus and who have the necessary health care resources available to function as a health care entry point in providing or arranging to provide covered Health Services to Subscribers pursuant to an Agreement as part of a managed care plan. A managed care plan is a health benefit plan in which Subscribers may designate a primary care provider or other delivery system to provide or coordinate all health care services.

L. "Primary Coverage Responsibility" means coverage under Blue Plus Subscriber Contracts which is not secondary pursuant to any coordination of benefits, auto insurance or similar provisions.

M. "Protected Health Information" (“PHI”) means individually identifiable information transmitted or maintained in any format as further defined in 45 Code of Federal Regulations ("C.F.R.") Section 160.103.

N. "Provider" means the individual or entity that is a Party to this Agreement and indicated on the Signature Page, that is engaged in the delivery of and is authorized to provide Health Services in the state in which it delivers the Health Services.

O. "Referral" means care generally by a specialist that is Medically Necessary and Appropriate for the Subscriber and which cannot be provided by the Subscriber's PCC.

P. "Self-Referral" means a Health Service, other than a medical emergency as defined by the applicable Subscriber Contract, which is not provided by or arranged by the PCC and which is covered under a wraparound coverage provision or direct access for coverage provision of the applicable Subscriber Contract.

Q. "Subscriber" refers to any person with whom or for whose benefit Blue Plus has entered any agreement to provide coverage, administer coverage, or provide access to a participating provider network for Health Services.

R. "Subscriber Contract" means the contract, agreement, or other arrangement under which Blue Plus or the Plan Sponsor provides benefits to Subscribers for Health Services.

S. "Third Party Provider" means a provider other than the PCC receiving payment from Blue Plus for providing certain Health Services to Subscribers as designated in this Agreement, or such other provider designated from time to time by Blue Plus as a Third Party Provider, provided notification of such designation shall be given to Provider.

T. "Utilization Review Process" means Blue Plus' or the Plan Sponsor's process for evaluating the necessity, appropriateness, and efficacy of the provision of Health Services and use of facilities by a person or entity other than the attending Health Care Professional, for the purposes of determining Medical Necessity and Appropriateness.

Article III - Authority and Covenants

A. Verification of Eligibility. Before providing Health Services to a Subscriber, the Provider shall require a valid identification card and other positive photo identification, such as a valid government issued identification card, or shall otherwise verify with Blue Plus that the Subscriber is eligible to receive Health Services. The Provider shall not be entitled to payment from Blue Plus or the Plan Sponsor for Health Services provided to any person who is not in fact a Blue Plus Subscriber at the time the Health Services were rendered.

B. Claims Submission. Provider shall promptly submit claims for Health Services to Blue Plus or the Plan Sponsor as directed by Blue Plus. Blue Plus requires Provider to make every effort to submit complete, comprehensive, and accurate risk adjustment data as established by the State of Minnesota and Blue Plus, and Blue Plus may implement a financial penalty for failure to submit timely, complete, comprehensive, and accurate data. Provider shall abide by all applicable state or federal laws and rules, such as the Affordable Care Act, with respect to data submission. Provider shall use its best efforts to submit claims within 30 days of the date of service. In no event may Provider submit claims later than 120 days from the date of service. Such claims shall include all Health Services provided to a Subscriber and all documented diagnoses must be submitted on the claim as specifically as possible. Provider must submit claims using electronic claims submission formats, processes and procedures as set forth in the Provider Policy & Procedure Manual, Provider Bulletins or as required by the Plan Sponsor, including the proper provider identification number. Provider shall have the right to review its claims that have been processed by Blue Plus, at Blue Plus' offices, during Blue Plus' regular business hours. Provider waives any right to collect for charges not included in the claim as submitted and agrees not to bill the Subscriber for any such omitted services, claims or late charges.

C. Additional Information. Provider shall promptly furnish at its own expense, any additional information that Blue Plus or the Plan Sponsor shall reasonably request as necessary to correctly administer the Agreement, including to respond to claims, utilization review, coordination of benefits, credentialing, quality improvement and care management reviews, Pre-certification reviews, Pre-Service Reviews, admission notification, prior authorizations, Medical Necessity and Appropriateness reviews, and medical abstract reports if applicable. Provider shall be responsible for any penalties for failure to abide by required admission notifications, pre-certification requirements, or other such advance notice requirements. The Provider shall be responsible for obtaining any authorization required to release such information to Blue Plus and/or the Plan Sponsor. Provider shall comply with requests related to Risk Adjustment and other government required activities, such as Medicare Advantage Star Ratings or requirements of the Affordable Care Act or other applicable rules or requirements.

D. Coding Requirements. Provider shall place all appropriate diagnosis and procedure codes and other necessary codes on each claim prior to submission to Blue Plus or Plan Sponsor. Provider is required to submit a written description, the manufacturer's suggested retail price for the item(s), if applicable, and an itemization of the Regular Billed Charges for such Health Services item(s), health care service or supply whenever submitting an unlisted procedure code for such services. Claims submitted to Blue Plus with an unlisted procedure code without a written description and manufacturer's suggested retail price, if

applicable, will be denied. Provider agrees to use unlisted procedure codes only when no code exists for the service being provided. The reimbursement process for unlisted procedure codes can be found at: https://www.bluecrossmn.com/providers/reimbursement-policies and https://provider.publicprograms.bluecrossmn.com/minnesota-provider/claims/reimbursement-policies.

E. Medical Records. Provider shall, at Provider's expense, maintain and promptly submit when requested medical record documentation that is complete, clear, comprehensive, concise, consistent, and legible and which conforms with reasonable documentation standards as set forth in the Provider Policy & Procedure Manual. Health Services rendered to Subscribers with no corresponding documentation in the medical record are not eligible for payment and will be the Provider's financial responsibility. Provider shall maintain all Subscriber medical records for a minimum of ten (10) years after the last date a Health Service was provided to the Subscriber under this Agreement. Provider shall ensure that all diagnoses are supported in the medical record documentation for each encounter.

F. Provider Bulletins. To promote efficiency and network consistency, Blue Plus shall have the right at any time to issue Provider Bulletins pursuant to this Agreement for the purpose of implementing certain policies, procedures and requirements relating to this Agreement, such as for claims submittal protocol or care management programs, and Provider shall comply with such Provider Bulletins that are in effect on the first date of the term (or renewal term, as applicable) of this Agreement or subsequently communicated to Provider. Blue Plus shall provide Provider with at least forty-five (45) days' advance written notice from date of publication on bluecrossmn.com/providers of any new Provider Bulletins, unless such Provider Bulletins are issued to comply with a state or federal regulatory or accreditation requirement or to address only minor administrative or operational clarifications, as reasonably determined by Blue Plus, in which case Blue Plus shall provide as much advance notice as is reasonably practical.

G. Access to Records. Provider shall allow Blue Plus or its designee to access, at Provider's offices during Provider's regular business hours, the treatment and billing records of Subscribers to verify claims information, and any aspect of services performed and to access such other records including but not limited to the charge master, for the purpose of verifying compliance with the terms of this Agreement including conducting a charge audit. Provider also agrees to allow any state or federal regulatory or governmental agency, including but not limited to the State of Minnesota, CMS or the Comptroller General, or their designees, peer review organizations, external quality review organizations and other entities with which Blue Plus has a contractual or legal obligation to allow access to Provider records or contracts to inspect, evaluate, and audit any pertinent books, documents, papers and records involving transactions related to this Agreement.

H. Quality Improvement/Managed Care Requirements; Nondiscrimination. Provider agrees to comply with quality improvement and care management requirements and procedures established by Blue Plus or the Plan Sponsor and as communicated to Provider (for example, utilization of preferred prescription drugs, advance notification, completion of Pre-certification reviews, Preauthorization, completion of Pre-Service Reviews, completion of a Utilization Review Process). Provider is responsible for obtaining any Pre-certification, prior authorization, Pre-Service Review or similar advance review required. If such advance authorization is required but not obtained, Provider shall be financially responsible and the Subscriber is held harmless. Provider shall support efforts to encourage the use of patient-centered shared decision making for appropriate conditions in an effort to improve health outcomes and health care value in accordance with Minnesota Statutes, § 256B.69, subd. 9, (c). Provider agrees not to withhold or delay treatment to Subscribers for reasons, including but not limited to: 1) Blue Plus' payment allowances,

including any withhold or other payment method; 2) managed care review requirements; or 3) the Subscriber's age, race, religion, gender, sexual orientation, disability, public assistance status, or suspected or actual presence of the HIV virus or other communicable disease. Provider shall abide by all nondiscrimination provisions of Section 1557 of the Patient Protection and Affordable Care Act (ACA) (42 U.S.C. 18116) or successor legislation. However, if Provider's practice is limited to a given specialty, Provider is not required to provide treatment outside of that specialty.

I. Referral Requirements. Whenever a referral is necessary, Provider shall refer Subscribers to Blue Plus participating providers in accordance with the referral policy guidelines set forth in the Provider Policy & Procedure Manual.

J. Limited Provider Networks. Blue Plus reserves the right to implement or discontinue limited provider networks (e.g., tiered networks, narrow networks, select networks or other limited networks) or services provided by such networks for certain Health Services or for certain Subscriber Contracts, which may or may not include Provider. Provider agrees to make referrals to such limited network providers, where applicable, subject to exceptions authorized by Blue Plus.

K. Coordination of Benefits. Provider agrees to abide by Blue Plus' benefit determinations and cooperate fully with Blue Plus in the administration of the Coordination of Benefits ("COB") and subrogation provisions of the Subscriber Contract using procedures set forth in the Provider Policy & Procedure Manual.

L. Compliance with Laws. Provider and Blue Plus each agree to comply with all applicable state and federal laws, rules, regulations, orders and requirements. Provider further agrees to cooperate with Blue Plus with regard to Blue Plus' efforts to comply with any and all obligations imposed upon Blue Plus under any state and federal laws, rules, regulations, orders and requirements.

M. Subcontracts. All subcontracts of Provider under this Agreement must be in writing. All subcontracts of Provider are subject to Blue Plus review and approval, upon request by Blue Plus. All subcontractors of Provider shall meet all applicable terms and conditions of this Agreement. Subcontracts shall not abrogate or alter Provider's responsibilities under this Agreement.

N. Notices; Updates; Changes. Provider shall promptly notify Blue Plus of any changes to any administrative, demographic, or other provider information of any kind to ensure that Blue Plus has the most current and accurate Provider information. With the exception of termination notices, all notices, reports, changes, and records sent to Blue Plus, unless otherwise requested by Blue Plus, shall be addressed to:

Provider Data Operations
PO Box 982809
El Paso, TX 79998-2809

Notices, reports and records sent to Provider shall be sent to the street address (or email address if applicable) Provider supplied to Blue Plus, as may be updated from time to time. Provider shall promptly, and no later than 10 days from the date of an address change, advise Blue Plus of any such changes to ensure Blue Plus has current Provider information that will be included in provider directories and other Subscriber communications. To assist Provider in communicating such changes, the Provider Demographic Change Form is available at https://www.bluecrossmn.com/providers/provider-demographic-updates. Completed forms can be emailed to provider.data@bluecrossmn.com, faxed to 651-662-6684, or mailed to the above address.

Article IV - Provider Payment

A. Payment Amount. Blue Plus shall ensure prompt payment directly to Provider for Health Services covered under the Subscriber Contract and prompt response to Provider's claims and inquiries. Clean claims that are correctly submitted with all required information shall be paid or denied within 30 calendar days of receipt by Blue Plus if applicable under Minnesota Statute 62Q.75. Except as provided below, payment to Provider for Health Services shall be the lesser of 90% of Provider's Regular Billed Charge or 90% of the Blue Plus fee schedule allowance as determined by Blue Plus (including consideration of Provider's and/or Health Care Professional's license and training), minus Subscriber or other party liabilities (e.g., deductible, coinsurance, non-covered Health Services, and coordination of benefits with other health plans, employer liability plans, Workers' Compensation, or automobile insurance plans) (collectively, "Other Party Liabilities"). Provider agrees to accept such payment amount as payment in full.

- Payment to Provider for Health Services furnished by mid-level practitioners, if applicable and as detailed in the Provider Policy & Procedure Manual, shall be the lesser of 90% of Provider's Regular Billed Charge or 85% of the applicable Blue Plus fee schedule allowance, less Subscriber or Other Party Liabilities. Provider agrees to accept such payment as payment in full.
- Payment for Health Services furnished by Certified Registered Nurse Anesthetists shall be the lesser of 90% of Provider's Regular Billed Charge or 80% of the applicable Blue Plus fee schedule allowance, less Subscriber or Other Party Liabilities, which Provider agrees to accept as payment in full.
- Payment for Health Services furnished by Masters Level practitioners shall be the lesser of 90% of Provider's Regular Billed Charge or 80% of the applicable Blue Plus fee schedule allowance, less Subscriber or Other Party Liabilities, which Provider agrees to accept as payment in full.
- Payment for Health Services furnished by PhD licensed psychologists shall be the lesser of 90% of Provider's Regular Billed Charge or 90% of the applicable Blue Plus fee schedule allowance, less Subscriber or Other Party Liabilities, which Provider agrees to accept as payment in full.

B. Replacement of Medical Devices. No payment will be made by Blue Plus, and neither Blue Plus nor the Subscriber shall be billed for, the cost of a replacement device in excess of the actual cost paid by Provider for the replacement device.

C. Negligence, Omission or Errors. When the negligence, omission, or error on the part of Provider results in the Subscriber incurring additional medical expenses, no payment will be made by Blue Plus for, nor shall Provider bill either Blue Plus or the Subscriber for medical expenses resulting from negligence, omissions, or errors. Information regarding those situations for which no payment shall be made by Blue Plus or the Subscriber shall be set forth in the Provider Policy & Procedure Manual.

D. Minnesota Health Care Programs. For those Health Services provided to Minnesota Health Care Programs Subscribers, Blue Plus will pay Provider for Health Services at 100% of the Blue Plus medical assistance fee schedule as determined by Blue Plus, not to exceed Provider's Regular Billed Charge.

E. Medicare Cost and Medicare Advantage Programs. When applicable for a Medicare Cost contract and/or Medicare Advantage Program, Blue Plus shall pay Provider according to the rates specified in the Amendment to the Agreement – Medicare Programs.

F. Overpayments. Provider shall promptly report and return overpayments of any kind to Blue Plus. Blue Plus may recover overpayments of any kind to ensure correct administration of the Agreement. If the overpayment is the result of data incorrectly submitted on a claim for Health Services provided, Provider must promptly send a replacement claim correcting the data and allowing Blue Plus to recoup such overpayment. Submission of replacement claims is limited to six (6) months from last remittance date. Blue Plus shall have the right to make, and Provider shall have the right to request, corrective adjustments to any previous payment for a claim for Health Services provided, however, that any corrective adjustments by Blue Plus, or requests for corrective adjustments by Provider that are approved by Blue Plus, shall be made within twelve (12) months from the date the claim for such Health Services was paid or denied by Blue Plus. No corrective adjustments shall be made by Blue Plus after such twelve (12) month period provided however, that corrective adjustments may be made by Blue Plus after such twelve (12) month period for adjustments related to fraud, coordination of benefits recovery, subrogation recovery and certain other payments as set forth in the Provider Policy & Procedure Manual.

Blue Plus may conduct an audit to determine if Provider's aggregate reimbursement adjustment exceeded the Negotiated Reimbursement Adjustment that was expected and agreed upon in writing between the Provider and Blue Plus during their good faith negotiations. In the event that Provider's actual Charge Description Master Adjustment causes an aggregate change to reimbursement in excess of the Negotiated Reimbursement Adjustment, Blue Plus shall have the right to adjust Reimbursement Rates to the Provider in order to achieve the Negotiated Reimbursement Adjustment that should have been implemented to yield the expected and agreed upon aggregate reimbursement. The adjusted Reimbursement Rates shall also be applicable to the calculations used by Blue Plus for any future Negotiated Reimbursement Adjustments.

This audit will use one consistent Data Set and apply the Reported Charge Description Master Adjustment and agreed upon Reimbursement Rates to determine the modeled aggregate increase that should have occurred for the Contract Period. The Data Set will then be used to apply the actual Charge Description Master Adjustments and the agreed upon Reimbursement Rates to determine whether any variance in expected reimbursement exists.

Recovery of Identified Overpayments. If an audit determines that an overpayment exists, Blue Plus shall have the right to take the following actions:

1. Recover amounts paid in excess of the Negotiated Reimbursement Adjustment. This may be accomplished via a lump sum cash settlement, adjustment of claims, or an offset of future claims payments. Adjustment of claims generally shall be limited to Health Services incurred during the current calendar year. For Health Services rendered prior to the current calendar year, generally a lump sum cash settlement or other similar retrospective reconciliation shall occur. Provider must make payment to Blue Plus within 180 days of notification by Blue Plus of an overpayment due. Any amounts that remain owed to Blue Plus following 180 days will be recovered by Blue Plus through deductions from future payments owed to Provider. Any such settlement or reconciliation amounts will be rounded to the nearest dollar to simplify administration

2. Blue Plus may adjust the Reimbursement Rates applicable to future claim payments in order to neutralize the impact of the Provider's charge adjustments that exceeded the agreed upon reimbursement. Blue Plus shall provide 45 days advance written notice of Provider's new Reimbursement Rates, and payment shall continue at such Reimbursement Rates until a new agreement is reached between the Parties according to the terms of the Agreement.

G. Insolvency. In the event a Plan Sponsor fails or is unable to meet its financial obligations in connection with its health benefit plan, and the Health Services provided by the Provider are therefore determined not to be covered under the terms and conditions of the Subscriber Contract, the Provider may bill the Subscriber directly for such Health Services. In addition, Provider may exercise all remedies provided by law against a Plan Sponsor to collect amounts due Provider.

H. Subscriber Liability. Provider agrees to make a good faith effort to collect any deductible, coinsurance, and/or copayment amounts due from Subscribers. This provision shall not prohibit Provider from collecting a lesser amount on individual hardship cases as determined by Provider. This provision in no way obligates Provider to pass on to Blue Plus any discounted payment arrangements it has negotiated with other third party payers. Deductible and coinsurance liability of the Subscriber shall be calculated based upon the lesser of the Blue Plus Fee Schedule amounts or 90% of Provider's Regular Billed Charge, as calculated by Blue Plus, unless otherwise authorized by Blue Plus. Blue Plus shall calculate the appropriate Subscriber liability amounts and notify Provider of the Subscriber's liability following submission of the claim by Provider. Provider shall abide by all applicable statutes and requirements, including Minnesota Statute 62Q.751 with respect to collection of and return of deductibles and coinsurance amounts at or prior to service. Provider shall not withhold or delay service to a Subscriber based on the Subscriber's failure to pay the deductible or coinsurance at or prior to service. Overpayments by a Subscriber to Provider must be returned to the Subscriber by Provider by check or electronic payment within 30 days of the date in which the claim adjudication is received by Provider. Further, Provider agrees that all terms of this Agreement apply to all Health Services provided to Subscribers, regardless of the Health Services provided. Provider further agrees not to charge Minnesota Senior Health Options ("MSHO") Subscribers coinsurance or copayment amounts that would exceed amounts permitted under Minnesota Health Care Programs.

I. Subscriber Hold Harmless. Pursuant to Minnesota law, except for applicable deductible, coinsurance and copayment amounts, Provider agrees not to bill, charge, collect a deposit from, seek remuneration from, or have any recourse against a Subscriber or persons acting on their behalf for Health Services provided under this Agreement. This provision applies, but is not limited to, the following events: (1) nonpayment by or insolvency of Blue Plus (including nonpayment due to lack of timely filing of claims by Provider) or (2) breach of the Agreement. This provision does not prohibit Provider from collecting copayments or fees in the event that the Subscriber Contract, as interpreted by Blue Plus or the Plan Sponsor, does not cover the Health Services. This provision also does not prohibit Provider from billing the Subscriber for experimental, investigative or not Medically Necessary and Appropriate Health Services provided that the Subscriber is notified immediately prior to those Health Services being provided that those specific Health Services are experimental, investigative or not Medically Necessary and Appropriate and, after such notice, the Subscriber agrees in writing to pay for those Health Services. Provider shall have the right to appeal initial Medical Necessity and Appropriateness decisions through the Utilization Review Process.

This provision survives the termination of this Agreement for authorized Health Services provided before this Agreement terminates, regardless of the reason for termination. This provision is for the benefit of Subscribers and does not apply to Health Services provided after this Agreement terminates. This provision supersedes any contrary oral or written Agreement existing now or entered into in the future between the Provider and the Subscriber or persons acting on their behalf regarding liability for payment for Health Services provided under this Agreement.

Article V - Applicability

A. Scope of the Agreement. In addition to Health Services provided to Subscribers enrolled in health benefit plans underwritten or administered by Blue Plus, the Agreement applies to Health Services provided by other Blue Plus Blue Shield Plans approved by the Blue Plus Blue Shield Association or where Blue Plus provides access to a participating provider network, as further described in the Provider Policy and Procedure Manual:

1. Health Services provided to Subscribers enrolled in health benefit plans in which Blue Plus or an Affiliate is responsible for administering the benefit plan provided to Subscribers. If a specific payment arrangement is mandated by law for some or all Health Services, such payment arrangement will apply to the extent applicable.

2. Health Services provided to Subscribers of Affiliates at Blue Plus' discretion. For the avoidance of doubt, such Affiliates are entitled to all rights of Blue Plus under this Agreement and shall comply with all terms and conditions of this Agreement. If Provider and an Affiliate have entered into a separate provider service agreement, the terms of such separate provider service agreement will control over this Agreement as long as such separate provider service agreement remains in effect. Nothing in this provision shall place additional risk or obligations on Provider not elsewhere stipulated in this Agreement. This provision allows the extension of this Agreement for Health Services provided to Subscribers enrolled with any applicable Blue Plus Affiliate.

B. Blue Cross and Blue Shield Association Branding. Pursuant to Blue Cross and Blue Shield Association (an association of independent Blue Cross and Blue Shield Plans) (the "Association") licensure requirements, Provider hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Provider and Blue Plus, that Blue Plus is an independent corporation operating under a license from the Association permitting Blue Plus to use the Blue Cross and Blue Shield Service Marks in Minnesota, and that Blue Plus is not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Blue Plus and that no person, entity, or organization other than Blue Plus shall be held accountable or liable to Provider for any of Blue Plus' obligations to Provider created under this Agreement with respect to any plans underwritten or administered by Blue Plus. This paragraph shall not create any additional obligations whatsoever on the part of Blue Plus other than those obligations created under other provisions of this Agreement.

Article VI - Provider Requirements

A. Credentialing. Provider shall bill only for Health Services personally performed by Provider's Health Care Professionals who continuously meet all eligibility criteria defined by Blue Plus. Eligibility of Provider's Health Care Professionals will be based on Provider Participation Requirements as defined in the Credentialing and Recredentialing Policy Manual. All such Health Care Professionals must be successfully credentialed by Blue Plus prior to treating any Subscriber. Provider shall: (1) notify Blue Plus immediately if any Health Care Professional's license is ever revoked, suspended, or restricted; (2) notify Blue Plus within 15 days from the date of hire or termination, as applicable, of any additions or deletions of names of individuals who are subject to this Agreement through Provider; and ; and (3) notify Blue Plus immediately of any bankruptcy filing, or insolvency or in the event Provider fails or is unable to meet its financial obligations in connection with Health Services provided to Subscribers. Blue Plus may exercise all remedies provided by law against Provider to collect amounts, if any, due Blue Plus.

B. Excluded Health Care Professionals. In the event one or more of Provider's Health Care Professionals are excluded from participation with Blue Plus because he or she has not met the credentialing standards of Blue Plus, or because Blue Plus has terminated or suspended the Health Care Professional as provided for in the Agreement, that Health Care Professional will be treated as a nonparticipating provider by Blue Plus. Provider agrees to provide prior written notice to any Subscriber receiving treatment from such Health Care Professional that he or she is nonparticipating. If such notice is not provided, neither Provider nor Provider's nonparticipating Health Care Professional may collect from the Subscriber more than the amount allowed by Blue Plus as set forth in the Subscriber Contract. This provision shall survive termination of this Agreement.

C. Contracted Employees. In the case where Provider contracts with a Health Care Professional at a different rate than that Health Care Professional is paid through employment by another provider holding an Agreement with Blue Plus, the Health Care Professional will be reimbursed at the lesser of the two rates.

D. Participating Provider Availability. Provider shall ensure that all Health Services provided to Subscribers are furnished by Health Care Professionals participating fully with Blue Plus at the time such Health Services are rendered.

Article VII - Insurance and Indemnification

A. Insurance. Provider shall have and continuously maintain adequate insurance for professional liability and personal injury, as determined from time to time by Blue Plus. Provider agrees to provide such evidence of coverage as required by Blue Plus and as detailed in the Credentialing Policy and Procedure Manual, including, but not limited to, identification of the malpractice and other applicable liability insurer, policy number, coverages and liability limits.

B. Indemnification. Each party (the "Indemnifying Party") agrees to hold the other party harmless from any and all claims, damages, and expenses of all kinds (including reasonable attorneys' fees) by reason of any act or omission caused by, or alleged to have been caused by, the Indemnifying Party or any agent or employee of the Indemnifying Party.

Article VIII - Conditions and Limitations

A. PCC Authorization. Health Services shall be provided to a Subscriber only upon the authorization of the Subscriber's PCC and only during such time as the Subscriber is under the treatment and care of such PCC except in the case of emergencies, or where the Subscriber Contract allows for Self-Referrals. If Provider performs services not authorized by the PCC, Provider shall be solely responsible for the cost of those services and will not bill or collect from Blue Plus, the PCC, or the Subscriber (except where the Provider has notified the Subscriber immediately prior to services being provided that those specific services have not been authorized by the PCC, and subsequent to such notice, the Subscriber agrees in writing to pay for those specifically identified services).

Article IX - Quality Improvement and Utilization Review and Evaluation

A. Evaluation. Provider shall cooperate with Blue Plus in the ongoing evaluation of the delivery of Health Services and shall, if requested by Blue Plus, furnish relevant information and periodically participate in special studies that assess the availability, accessibility and appropriateness of Health Services rendered to Subscribers.

B. Second Opinions. Blue Plus may obtain independent medical advice and opinions concerning specific episodes of care or overall patterns of Health Services rendered or arranged by Provider.

C. Quality Care Delivery. Blue Plus and Provider shall cooperate to assure the delivery of quality, Medically Necessary and Appropriate care to Subscribers and ensure that no compensation or other incentives exist for the purpose of limiting care delivery. Provider and Blue Plus acknowledge that all decision-makers (practitioners, providers and staff including, but not limited to, medical directors, utilization management directors or managers, medical services management personnel, and utilization management staff members of Provider or Blue Plus) encourage appropriate utilization, ensure measures to prevent under-utilization, and discourage inappropriate denials. Utilization management decision making is based on appropriateness of care and services, and no compensation is made for denials of coverage or services, nor are any incentives given to decision makers to encourage denials of coverage of services. Blue Plus facilitates the delivery of appropriate care and has mechanisms in place to detect and correct potential under-utilization and over-utilization. Provider shall not offer compensation, discounts, or other incentives to solicit Subscribers to select the services of the Provider.

Article X - Amendment and Termination; Arbitration

A. Term; Amendments. The initial term of this Agreement shall be as specified on the Signature Page, and this Agreement shall thereafter automatically renew for one-year terms commencing on July 1 for each subsequent renewal term. The Agreement may be modified and/or amended at any time by Blue Plus upon at least forty-five (45) days' advance written notice to the Provider, provided however, that forty five (45) days' advance written notice shall not be required for changes to correct errors or omissions or to reflect state or federal regulatory requirements, in which case Blue Plus shall provide as much advance notice as is reasonably practical. In the event of any amendment by Blue Plus that Provider does not accept, Provider shall have 45 days to request termination of the Agreement. Such termination shall be effective 130 days following the date written notice is received by Blue Cross. Any such amendment shall be effective until the date of termination of the Agreement.

B. Termination. This Agreement may be terminated by either Party according to any one or more of the following provisions. Termination determinations are not subject to appeal. Written notice of termination must sent via certified mail to Blue Plus, Attn: Provider Relations, R317, P. O. Box 64560, St. Paul, Minnesota 55164-0560.

1. This Agreement may be terminated without cause by a Party upon prior written notice to the other Party with termination to become effective 130 days after receipt of written notice.
2. If the Agreement is terminated for any reason, Blue Plus may extend the terms of the current Agreement (and thus any termination effective date) for a period of up to an additional 180 days, to allow Blue Plus proper notification to Subscribers and continuity of care practices where applicable. During such additional period of 180 days of participation, the Provider shall receive payment at the same rates that were in effect on the date termination notification was provided.
3. This Agreement may be terminated upon prior written notice in the event of a material breach of this Agreement and which breach remains uncured 30 days after written notice reasonably specifying the nature of the breach is given to the breaching Party, with termination to become effective on the 30th day after receipt of such notice.
4. This Agreement may be terminated immediately upon written notice by Blue Plus to Provider in the event that Blue Plus acquires evidence of the potential for patient harm or of potential fraudulent or

illegal conduct on the part of Provider or any of Provider's Health Care Professionals with regard to the practice of medicine, claim submission, health care professional eligibility, the delivery of care under this Agreement or in the event of any sanction, 1) by CMS under the Medicare program; or (2) by the Minnesota Department of Human Services under a Minnesota Health Care Program.

5. Blue Plus reserves the right to terminate the Agreement upon 30 days' prior written notice to Provider with respect to any Provider or Health Care Professional of Provider which fails to complete the credentialing or recredentialing process or is sanctioned or reprimanded by any review organization, including but not limited to, any other health insurer or health plan, peer review organization, hospital medical staff or any state licensing board. The Provider agrees to immediately notify Blue Plus in writing of any such sanction or reprimand or any investigation of any Provider or Health Care Professional of which Provider is aware. If the sanction or reprimand is limited to a single Health Care Professional, then the termination shall be effective as to that Health Care Professional only.
6. Blue Plus shall have the right to terminate Provider's participation in benefit plans (including but not limited to the Minnesota Advantage Health Plan, political subdivisions, and Workers' Compensation) if Provider is determined by DHS to be out of compliance with Minnesota Statutes, Section 256B.0644 (requiring providers to accept medical assistance patients) or any other applicable laws. Provider shall notify Blue Plus immediately in event of such non-compliance. The termination shall be effective as of the first date of such non-compliance.
7. If the Agreement is terminated according to Article X. B. 1., above, and the Provider and Blue Plus are in the process of pursuing an updated Agreement, the terms and conditions of this Agreement shall continue in effect until one of the Parties gives written notice that negotiations are at an end. During this time, Provider and Blue Plus agree to abide to the terms and conditions of this Agreement and pay claims according to the rates in effect on the date notification was provided to the other Party.
8. In the event that Blue Plus does not receive any claims submitted by Provider for a 12-month period, Blue Plus may terminate the Agreement upon the expiration of that 12-month period.
9. If Provider plans to relocate its practice outside of the contracting service area served by this Agreement, Provider must immediately notify Blue Cross of such plans, and Blue Plus shall terminate the Agreement effective upon the date of the relocation, providing prior written notice to Provider. If such change of address has occurred and Provider failed to notify Blue Plus, Blue Plus shall immediately terminate the Agreement.
10. Blue Plus shall terminate the Agreement upon 30 days' notice to Blue Plus of Provider’s addition to the CMS Preclusion List.
11. In the event of a Provider acquisition or expansion, Blue Plus shall in its sole discretion, determine if a participating agreement will be extended to the acquired entity and/or additional locations of Provider.

C. Obligations. Termination shall not relieve Blue Plus or Provider of obligations with respect to Health Services furnished prior to the termination date. In certain cases, Subscribers have the right to continue care with Provider for up to 120 days after the effective date of termination, as permitted by Minnesota Statute 62Q.56. Provider shall also provide to all Subscribers who are in an active course of treatment advance written notice of the termination of the Agreement prior to the effective date of termination. Such notice shall specify the effective date of such termination of this Agreement and shall indicate that Provider will become nonparticipating on the effective date of termination. If such notice is not provided, Provider

may not collect from the Subscriber more than the amount allowed by Blue Plus. For Minnesota Advantage Health Plan and Federal Employee Plan Subscribers only, if the Agreement terminates during a calendar year, all the terms of the Agreement will continue until the end of the current calendar year.

D. Arbitration. The Parties agree that any disputes or controversies related to this Agreement shall be subject to mandatory binding arbitration. For all disputes or controversies that arise on or after the effective date of this Agreement, and in any manner are related to this Agreement, the Parties agree that the exhaustion of all review and appeal rights set forth in the Provider Policy & Procedure Manual will first be completed prior to commencing arbitration. The Provider Policy & Procedure Manual sets forth the time limits for commencing arbitration, venue, source of arbitration rules, the process to invoke arbitration, and other limits on arbitration. The terms of this provision (including the terms included in the Provider Policy & Procedure Manual) will survive termination and/or expiration of the Agreement and supersede and replace any and all previous provisions regarding arbitration between the Parties.

Article XI - Complaint and Inquiry Procedures

A. Provider's Responsibilities. Provider shall report all Subscriber complaints it receives to Blue Plus and comply with Blue Plus' reporting requirements. Provider and Blue Plus shall cooperate in the resolution of all such complaints in accordance with the provisions of the Provider Policy & Procedure Manual.

B. Appeals. Provider and Subscriber shall have the right to appeal Utilization Review decisions through Blue Plus' Utilization Review Process as set forth in the Provider Policy & Procedure Manual.

Article XII - Confidentiality; Non-Interference

A. Confidentiality Requirements. The Parties shall maintain in strict confidence during the term of this Agreement, and subsequent thereafter, except as required by law or for reporting to any third party who has entered into, or proposed to enter into, a Subscriber Contract on behalf of the Subscriber: 1) all Subscriber information that identifies a specific Subscriber (including health and medical record information); 2) all quality improvement and utilization review information; and 3) all financial information related to this Agreement, except as otherwise authorized or required by law, including but not limited to Minnesota Statutes 62J.81, or as required to administer this Agreement. The Parties agree to abide by any applicable state and federal laws regarding confidentiality and use best efforts to protect confidential information from any unauthorized and unwarranted disclosure. In the event that either Party breaches this confidentiality provision, the affected Party, in addition to all other remedies available under law, shall be entitled to injunctive or equivalent relief. The offending Party also agrees to pay reasonable attorney's fees incurred as a result of breach of this provision. This paragraph shall survive termination of this Agreement.

B. HIPAA Compliance. Pursuant to the federal Health Insurance Portability and Accountability Act (“HIPAA”) and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") that are applicable to business associates, Provider agrees to abide by all pertinent instructions in the Provider Policy & Procedure Manual and to comply with those Acts and requirements in all respects.

Article XIII - Miscellaneous

A. Transplant Services. Other than for kidney and cornea transplants, this Agreement shall not apply to any transplant services unless a separate agreement is fully executed between Blue Plus and Provider.

B. Assignment. This Agreement shall inure to the benefit of and shall bind the successors of both Parties to the Agreement, but it shall not be assigned or transferred by Provider without the written consent of Blue Plus, such consent not to be unreasonably withheld. Provider agrees that the terms for payment under this Agreement may be assigned to a Plan Sponsor.

C. Trademarks/Service Marks. Each Party to this Agreement reserves the right to, and control of the use of, its names and all symbols, trademarks and service marks presently existing or hereafter established with respect to it. Provider authorizes Blue Plus to use Provider's name or names, including address(es), and telephone number(s), in an ethical and reasonable manner for purposes of promotion and advertising. Except as authorized herein, each Party agrees that it will not use the names, symbols, trademarks or service marks of the other Party in advertising, promotion, on the Party's website(s), or in any other manner without the prior written consent of the other Party and will cease any and all usage immediately upon termination of this Agreement. Blue Plus shall have sole responsibility for all advertising and promotion and for solicitation of Subscribers for its programs, unless the Provider is given express prior written permission to do so by Blue Plus.

D. No Third Party Beneficiaries. Nothing herein contained shall be construed to confer any right or cause of action upon any person, group, firm, corporation or public official other than the Provider and Blue Plus (and in any event including with respect to Blue Plus, Blue Plus' Affiliates) or Plan Sponsor, and except for the Subscriber protection provisions of this Agreement.

E. Independent Contractors. Blue Plus and Provider are and shall continue to be independent entities and not agents or representatives of the other.

F. Invalid Provisions; Governing Law. This Agreement shall be governed by the laws of the State of Minnesota and any applicable federal laws or rules. In the event one or more provisions of this Agreement is invalidated, the remainder of the Agreement will remain enforceable.

G. Entire Agreement; Amendments. This Agreement and the documents referenced herein constitute the entire Agreement between Blue Plus and Provider regarding the specific subject matter of this Agreement. This Agreement supersedes any prior agreements and amendments, written or verbal, issued prior to the effective date of this Agreement and relating to the same specific subject matter. Except as expressly authorized in this Agreement, no amendments or modifications to this Agreement shall be valid unless in writing and signed by both Parties. This Agreement may be amended unilaterally by Blue Cross as required due to changes in state or federal law, regulations, rules and/or accreditation standards, or upon demand by a state or federal agency or accreditation body. Any such amendment will be effective the date so required or demanded.

H. Force Majeure. Neither Party shall have any liability for any delay, failure to perform, or damages caused by acts of nature, war, terrorism, pandemic or any other causes reasonably beyond its control. In the event of pandemic influenza or other pandemic as declared by the U.S. Government or the World Health Organization, Blue Plus shall have the right to extend the term of the Agreement until 90 days after the pandemic has been declared over, and Provider shall not terminate this Agreement prior to the expiration of this 90-day period.

I. Waiver. No waivers of or to this Agreement shall be valid unless in writing signed by the Party to be charged with such waiver. No waiver by either Party of any breach or violation of any provision of this Agreement shall operate as, or be construed to be, a waiver of any subsequent breach of the same or any other provisions.

J. Ambiguities. Each Party has participated fully in the review of this Agreement and has had the opportunity to review said Agreement with such Party's legal counsel. Any rule of construction to the effect that ambiguities are to be resolved against the drafting Party shall not apply in interpreting this Agreement. The language in this Agreement shall be interpreted as to its fair meaning and not strictly for or against any Party.

K. Survival. No termination or expiration of this Agreement shall affect the rights and obligations of the Parties which have accrued prior to the effective date of termination or expiration.

L. Cumulative Rights. All rights and remedies of Blue Plus and Provider, respectively, under this Agreement are cumulative, and the exercise by a Party hereto of any rights or remedy herein provided will be without prejudice to the right to exercise any other right or remedy of such Party herein provided all of which are expressly reserved.

M. Headings. Section headings are for reference only and shall not be used in construing this Agreement.

N. Provider Merger and Expansion. In the event the Provider expands their practice to additional locations or acquires, is acquired by, or merges into or with a third party health care provider that also has a participating provider agreement in effect with Blue Plus at the time of such acquisition or merger, then Blue Plus will in its sole discretion, determine whether or not, and the extent to which, this Agreement shall be extended to apply to any such location and/or the participating provider agreement of such third party health care provider, will be applicable, control and/or be effective. Blue Plus shall also have sole discretion regarding whether to offer a contract to Provider for additional locations/sites. Notification of any material business transactions, such as a merger or acquisition, must be provided to Blue Plus no later than 60 days prior to the finalization of the transaction.

BlueCross BlueShield Minnesota

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Addendum to the Blue Plus Referral Health Professional Provider Service Agreement for Public Health Nursing Clinic Services

The Blue Plus Referral Health Professional Provider Service Agreement ("Agreement") between Blue Plus and Provider ("Provider"), to which this Addendum is to be attached and by reference becomes a part thereof, shall be amended as provided in this Addendum.

The purpose of this Addendum is to establish the terms and conditions under which Provider will provide Health Services for eligible Subscribers for Health Services covered under a Minnesota Health Care Program. For purposes of the services detailed in this Addendum, Provider is not required to hold an Aware Provider Service Agreement.

In the event of conflict between terms and provisions detailed in this Addendum with those occurring in the Agreement, such terms and provisions as stated in this Addendum shall take precedence with respect to the subject matter detailed herein.

Blue Plus and Provider agree that this Addendum and the Agreement apply only to Health Services as detailed herein and that the eligible Health Services as defined herein are applicable only to Subscribers who are covered under a Minnesota Health Care Program.

NOW, THEREFORE, it is agreed as follows:

ARTICLE I: DEFINITIONS

The following term as used in this Addendum shall have the meanings as ascribed to them below:

A. "Certified Public Health Nurse (CPHN)" means a registered nurse who is licensed and providing services within the scope of practice as defined in Minnesota Statutes, and who is certified in public health nursing by the Minnesota Board of Nursing or who received certification from the Minnesota Department of Health prior to January 1990.

ARTICLE II: COVERED HEALTH SERVICES

A. Services Provided. Only services performed by qualified Public Health Nurses and allowed by DHS shall be eligible for reimbursement when provided to Subscribers. Provider will not be considered a participating provider for any other Health Services unless Blue Plus and Provider enter into a separate written agreement with regard to any such other Services.

B. Service Standards. Health Services shall be eligible for reimbursement by Blue Plus under the terms of the Agreement only when performed by (1) a Certified Public Health Nurse; or (2) a licensed Registered Nurse, under supervision by a Certified Public Health Nurse.

C. Provider agrees to abide by all terms of the Agreement, including but not limited to the CMS delegation requirements which are detailed in the Blue Cross Provider Policy & Procedure Manual.

ARTICLE III: CARE COORDINATION

A. Consent. Provider shall secure from each Subscriber treated a signed consent form that gives Provider permission to share information on diagnosis, treatment and results of laboratory tests with the Subscriber's Primary Care Clinic. Upon receipt of such consent, Provider agrees to send a report to the Subscriber's Primary Care Clinic of all Health Services provided, and to refer the Subscriber to the Primary Care Physician for care as needed.

B. Provider shall perform as Blue Plus' delegate, in accordance with Government Programs Care Coordination guidelines available at: https://carecoordination.bluecrossmn.com/msho/

ARTICLE IV: PAYMENT

A. Terms. Blue Plus will pay Provider for eligible Health Services at the lesser of Provider's Regular Billed Charge or 100% of the Blue Plus medical assistance fee schedule as determined by Blue Plus. However, (1) for procedure code S9123 only, Blue Plus shall pay Provider at the rate of $180.00 for Health Services; and (2) for procedure code S9445 only, Blue Plus shall pay Provider at the rate of $86.40 for Health Services.

ARTICLE V: REVISIONS AND TERMINATION

A. Blue Plus reserves the right to revise or terminate the Agreement upon 30 days' prior written notice to Provider in the event that the State of Minnesota changes or terminates the benefit under which Health Services are provided to Blue Plus Minnesota Health Care Program Subscribers under this Addendum.

Medica
PO Box 9310
Minneapolis, MN 55440-9310
(952) 992-2900

October 19, 2022

Chuck Hurd
Kathy Burski
Kanabec County
905 East Forest Avenue
Mora, MN 55051

RE: SNBC/SNBC D-SNP CASE MANAGEMENT PARTICIPATION AGREEMENT

Dear Chuck and Kathy,

Medica is looking forward to working with you and your organization to meet the needs of our members. Enclosed for your review is the SNBC/SNBC D-SNP Case Management Participation Agreement. This Agreement is effective January 1, 2023. If you do not have any questions or changes please return by email a scanned signed copy for Medica signature. Medica will return a fully signed copy to you.

Becky Bills at Medica is available to answer any questions you might have regarding this Agreement. She can be contacted at 952-992-2603.

Sincerely,

Kristy Wilfahrt
Vice President and General Manager Medicaid
Markets Growth and Retention

MEDICA HEALTH PLANS

KANABEC COUNTY

SNBC/SNBC D-SNP CASE MANAGEMENT PARTICIPATION AGREEMENT

This SNBC/SNBC D-SNP Case Management Participation Agreement ("Agreement"), effective on January 1, 2023 (the "Effective Date"), is made by and between Medica Health Plans, a health maintenance organization organized pursuant to the laws of the State of Minnesota ("Medica") and Kanabec County ("Agency") for the purpose of setting forth the terms and conditions under which Agency will render Case Management Services to Members who are enrolled for coverage under Medica AccessAbility Solution, also known as Minnesota Special Needs BasicCare ("SNBC"), and/or Medica AccessAbility Solution Enhanced ("SNBC D-SNP") (collectively, "SNBC") in accordance with this Agreement.

Article 1
Definitions

Section 1.1 Definitions. The following terms have the meanings given below:

Administrative Requirements:	Administrative requirements and protocols of Medica as set forth in Medica's Care Coordination Resources, Medica's Provider Administrative Manual, Credentialing Plan, Medical Policies and Clinical Guidelines (such as reimbursement, coverage, utilization management, and pharmacy policies), Provider Requirements for Medicare, Medicaid and other government program products, administrative guidelines, provider protocols, training manuals, state-specific addenda, and other manuals and provider requirements, each of which can be found at www.medica.com.
Benefit Contract:	A plan of health care coverage issued by Medica for its SNBC Program Members under the Medica & DHS SNBC Agreement that contains the terms and conditions of the Member's coverage, as set forth in the payment appendix to this Agreement.
Care Coordination Services:	Services that coordinate the provision of services under a Benefit Contract, including without limitation, Health Services, social services, dental services, mental health/substance abuse services, and long term care services for a Member among different health and social service professionals and across settings of care including, but not limited to: needs assessment, service authorization, care communication, care coordination and risk assessment.
Care Coordination Resources:	Care Coordination Resources and protocols are available on www.medica.com.

Care Coordinator:	An individual who provides Care Coordination Services. Care Coordinators must be a registered nurse, licensed social worker, county social worker evaluated by the Minnesota Merit System, physician assistant, nurse practitioner or physician. Alternatively, in lieu of the foregoing requirements, Care Coordinators must be supervised by a licensed social worker, county social worker evaluated by the Minnesota Merit System, registered nurse, physician assistant, nurse practitioner or physician and must meet the DHS requirements for the provision of case management by meeting the social work standards under the Minnesota Merit System. Care Coordinators must have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services and must complete all relevant training required by DHS.
Care System:	A network of health care providers, including primary care physicians, that assumes responsibility for managing and ensuring the provision, coordination, referral and delivery of Health Services for Care System Members who have designated the Care System as their primary care provider.
Case Management:	The assignment of an individual who coordinates Medicare, to the extent feasible, and Medicaid SNBC Services for a Member.
Case Management Fee:	The per Member per month amount to reimburse Agency for Case Management Services, administrative support and care coordination oversight.
Case Management Services:	Care Coordination Services provided under this Agreement in accordance with the Medica & DHS SNBC Agreement. The term "Case Management" is being used in this Agreement for consistency with use of the term in the Medica & DHS SNBC Agreement.
Case Management Subcontractor:	A properly licensed or certified individual, organization or agency that Medica may otherwise contract with (as determined by Medica from time to time) and that renders Case Management Services to a Member through an arrangement with Agency, including a professional services agreement, management services agreement and similar arrangements, when payment for such Case Management Services are included in Medica's payment to Agency. An employee of Agency is not a Case Management Subcontractor.
Case Manager:	An individual who provides Case Management Services and meets the definition of a Care Coordinator.
Certified Assessor	Certified Assessor means a person who completes training and obtains certification from DHS and performs Long Term Care Consultation

	assessments. For SNBC Members, if a lead agency staff person meets all of the training and education requirements of a Certified Assessor the Certified Assessor may perform multiple roles such as a Certified Assessor, waiver case manager and care coordinator.
CMS:	The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.
Copayment or Coinsurance:	The amount a Member is required to pay for certain Health Services in accordance with the Member's Benefit Contract.
Deductible:	The annual amount of charges for Health Services, as provided in the Member's Benefit Contract that the Member must satisfy before triggering any obligation to pay by Medica.
DHS:	The Minnesota Department of Human Services.
Health Risk Assessment ("HRA"):	The assessment of Members for the purpose of identifying health needs, health risks, and social determinants of health, and linking the Member with interventions to promote health, sustain function, and/or prevent disease.
Health Services:	The health care services and supplies provided to a Member and covered under the Member's Benefit Contract.
HIPAA:	The Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereby, as amended.
Home and Community Based Services ("HCBS"):	Services provided under a federal waiver under §1915(c) of the Social Security Act, 42 USC §1396n(c), and pursuant to Minnesota Statutes, § 256B.092, Subd. 4, § 256B.49, and Chapter 256S. These services are for Members who meet specific eligibility criteria including being at risk of institutional care if not for the provision of HCBS. The services are intended to prevent or delay ICF-DD (Intermediate Care Facility for the Developmentally Disabled) placements, Nursing Facility placements, and neurobehavioral rehabilitative hospitalizations. HCBS also include Housing Stabilization Services (HSS).
Local Agency	A county or multi-county agency that is authorized under Minnesota Statutes, §§ 393.01, Subd. 7, and 393.07, Subd. 2, as the agency responsible for determining a Member's eligibility for the Medical Assistance program. Local Agency also means a federally recognized American Indian tribe's social service, human service, and/or health services agency that is responsible for DD (Developmental Disabilities), CADI (Community Alternatives for Disabled Individuals) or BI (Brain Injury) waiver services.

Long Term Care Consultation ("LTCC"):	The assessment of Members, pursuant to Minnesota Statutes, § 256B.0911, for the purposes of preventing or delaying Nursing Facility placements or for admission to or transitioning out of Nursing Facilities and to offer cost-effective alternatives appropriate for the Member's needs, and to assure appropriate admissions to a Nursing Facility. In accordance with the Medica & DHS SNBC Agreement, all Long Term Care Consultation functions under Minnesota Statutes, § 256B.0911 are the responsibility of the Local Agency.
Medica & DHS SNBC Agreement:	The Minnesota Department of Human Services contract with Medica Health Plans for Medica's administration of SNBC as amended or renewed from time to time.
Member:	An individual properly enrolled for coverage under a Benefit Contract.
Nursing Facility:	A facility that meets the requirements of the terms "skilled nursing facility" or "nursing facility," as defined in 42 U.S.C. Sections 1395i-3(a) and 1396r, respectively.
Nursing Facility Services:	Services provided by a Nursing Facility that are covered under the Benefit Contract.
Nursing Home Certifiable ("NHC"):	A designation based on the LTCC that a Member is in need of Nursing Facility level of care, as defined by the Minnesota Department of Health level of care criteria.
Preadmission Screening ("PAS"):	The assessment of Members for the purpose of avoiding unnecessary or inappropriate Nursing Facility placements and offering cost-effective alternatives appropriate for the Member's needs in accordance with the Medica & DHS SNBC Agreement.
Provider:	A health care provider, including a physician or other health care professional, facility, or agency, that is appropriately licensed and/or certified in the state or states where that provider renders Health Services. The health care provider also must have: (a) been accepted by Medica to provide Health Services to Members; (b) satisfied all of the requirements, including but not limited, to licensing, certification, and permits of the state or states where services are rendered to Members by Provider; and (c) status as a participating provider that has not been terminated by Medica.
SNBC Services:	Health Services, Enhanced Services, Nursing Facility Services and all other services and supplies covered under a Member's Benefit Contract and coordinated pursuant to this Agreement. Such SNBC Services include services provided to SNBC Members.

Special Needs Basic Care ("SNBC"):	A Minnesota managed care program pursuant to Minnesota Statutes § 256B.69, Subd. 28, that provides health care and support services delivery system for people with disabilities ages 18 to 64 and who are eligible for Medicaid.
Special Needs BasicCare Medicare Advantage Dual Eligible Special Needs Plan ("SNBC D-SNP"):	An SNBC plan that is also a special type of Medicare Advantage plan and that provides health benefits for people who qualify for both Medicare and Medicaid.

Article 2
Eligibility for Health Services

Section 2.1 Identification Cards. Medica will give Members an identification card that contains the name of the Member and his or her Member number and identifies the specific Benefit Contract under which the Member has obtained coverage. In addition, for Members covered under a Benefit Contract that requires the Member to choose a primary care clinic, the identification card will indicate the Member's primary care clinic.

Section 2.2 Verification of Eligibility. Agency may verify the current status of the Member's eligibility for SNBC by requesting presentation by the Member of his or her identification card or by contacting Medica during normal office hours. However, if Medica subsequently determines that the individual was not eligible for coverage for the services rendered, those services are not eligible for payment.

Article 3
Provision of Health Services and Administrative Requirements

Section 3.1 Provision of Case Management Services and Quality of Care. Agency will provide Case Management Services through its Case Managers who are Agency employees and/or Case Management Subcontractors in accordance with this Agreement. Agency will cause each Case Manager to provide such Case Management Services to Members in accordance with the standards of practice in the community, including protocols established by Medica and as specified in the Medica & DHS SNBC Agreement, and any sub-regulatory guidance, where such Case Manager renders Case Management Services and in a manner so as to ensure quality of care and treatment.

Section 3.2 Case Management Participation and Authority to Contractually Bind Case Managers. Agency will and will cause each Case Manager to be subject to and comply with the terms and conditions of this Agreement.

Section 3.3 Case Management Subcontractors. All Case Management Subcontractors must be eligible for participation with Medica. Agency must provide to Medica, upon request, a list of Agency's Case Management Subcontractors. Medica may, at any time and in its sole discretion, direct Agency to terminate any subcontract with respect to the provision of Case Management Services to Members.

Each subcontract between Agency and a Case Management Subcontractor must:

(a) be in writing;

(b) comply with all applicable laws, regulations (including HIPAA), sub-regulatory guidance and accreditation standards regarding subcontract arrangements;

(c) acknowledge the Case Management Subcontractor's responsibility to comply with Agency's duties under this Agreement and the duties of health maintenance organization operation required by applicable statutes and regulations;

(d) acknowledge Medica's right, during reasonable business hours and upon reasonable notice, to obtain access to all information and records of the Case Management Subcontractor relative to the provision of Case Management Services to Members for the purpose of auditing the Case Management Subcontractor's compliance with the terms of this Agreement; and

(e) be enforced by Agency as necessary to ensure the Case Management Subcontractor's compliance therewith.

Agency will be responsible for any additional financial liability that Medica incurs as a result of either Agency's noncompliance with this Section 3.3 or the Case Management Subcontractor's noncompliance with its subcontract with Agency.

Section 3.4 No Relationship with Excluded Providers. Agency has not been and will not employ or contract with any individual or entity that has been excluded, suspended or debarred from participation in the Medicare, Medicaid or other government programs.

Section 3.5 Access and Standards of Case Management Service.

3.5.1 Access to Case Management Services. Agency will cause each Case Manager to:

(a) provide Case Management Services, as established in this Agreement as well as in Medica's Administrative Requirements and as specified in the Medica & DHS SNBC Agreement and sub-regulatory guidance, to Members as such Case Manager's client load and appointment calendar permit; and

(b) subject to such Case Manager's client load and appointment calendar, accept Members as new clients.

In performing the duties described in this Agreement, Agency will, and will cause each Case Manager to, provide Case Management Services (as specified in 3.5.1 (a) above) to Members and accept new clients on the same basis as Agency and each Case Manager provides such services to and accepts new clients who receive coverage under another, non-Medica benefit plan or health insurance policy. Agency will not, and will cause each Case Manager not to, discriminate against any person based on his or her race, color, religion, national origin, gender, marital status, status with regard to public assistance, disability, sexual orientation, age, physical or mental health status, or any other classification protected by law.

3.5.2 Standards of Case Management Services. On the Effective Date and for the term of this Agreement, Agency will demonstrate the ability and utilize all reasonable efforts to provide Case Management Services in Medica's service areas and maintain the following standards (except where otherwise mutually determined by Medica and Agency):

(a) employ health care professionals and/or technicians available in Medica's service area(s) who are licensed and/or certified in their applicable area of practice by an agency acceptable to Medica, or who have a level of certification, licensure, education, and/or experience

acceptable to Medica or who are under the supervision of a health care professional who is able to satisfy requirements of certification, licensure, education, and/or experience acceptable to Medica;

(b) per DHS notification of Certified Assessor requirements, employ a sufficient number of Certified Assessors to meet enrollment requirements; and

(c) provide education and support to Medica Members, and as may be requested by Medica, including, but not limited to the following;

(i) cooperate with Medica in its efforts to educate physicians and Medica staff regarding current and latest practices in Case Management Services,

(ii) participate in interdisciplinary team meeting (i.e. meetings with Medica case manager and physician, or other appropriate third party) as deemed necessary by Medica case manager,

(iii) participate in case management meetings on a quarterly basis, at a minimum, or as otherwise determined by Medica,

(iv) comply with and be familiar with Medica provided resources, member letters, training manuals, policies and other resources available on the Care Coordination website, and

(v) be responsible for the oversight of Agency staff to include training of new Agency staff working with Medica Members.

3.5.3 Administrative Requirements. Agency will, and will cause each Case Manager to, be subject to and fully comply with all administrative requirements and protocols of Medica as set forth in Medica's Administrative Requirements, Care Coordination Manual, policies, protocols, training manuals or other manuals and guidance, including without limitation those found on Medica's designated website for Care Coordinators ("Administrative Requirements") as well as any and all administrative requirements or protocols specified in the Medica & DHS SNBC Agreement, and any sub-regulatory guidance.

Medica will provide Agency with access to Medica's Administrative Requirements on or prior to the Effective Date and will provide Agency advance notice of any material change or addition to Medica's Administrative Requirements, including the nature of any such changes or additions, unless such change is required of Medica by law, regulation or sub-regulatory guidance in which case Medica will notify Agency of the change when the requirement is made known to Medica. Such notices and materials will be provided or made available to Agency either through access to electronic transmission of such materials or by distribution of paper copies.

3.5.4 Cooperation With and Participation in Review, Service and Performance Improvement Programs. To the extent allowed by law, Agency will, and will cause each Case Manager to, participate in and cooperate fully with such programs as are established by Medica to assess, evaluate and improve the ongoing performance of Agency and Case Managers related to the:

(a) operation of Agency;

(b) provision of Case Management Services; and

(c) provision of SNBC Services designed to improve the health of Members, Member satisfaction or administrative efficiency, including without limitation, quality assurance, health improvement and utilization programs.

During the term of this Agreement, Medica and Agency will confer periodically to review the performance of Agency and Medica under this Agreement.

Section 3.6 Practice Guideline Compliance. Agency will, and will cause each Case Manager to:

(a) cooperate with the implementation of practice guidelines developed by Medica; and

(b) report to Medica, Agency's level of compliance with such guidelines, in the format and within the time frames specified by Medica.

Section 3.7 Member Complaints. Agency will, and will cause each Case Manager to:

(a) report to Medica, in accordance with the requirements set forth in Medica's Administrative Requirements, complaints received from Members regarding Case Management Services provided under this Agreement; and

(b) cooperate with Medica to resolve such complaints from Members, and be bound by the results of such complaint resolution process as it relates to Medica.

Section 3.8 Failure to Comply. Failure to comply with an Administrative Requirement or any requirement under this Agreement may result in loss of reimbursement to Agency or imposition by Medica of a sanction or fine, and/or termination of this Agreement, as may be set forth in this Agreement or the Administrative Requirements. Agency will cooperate with all reasonable utilization management, quality assurance, peer review, Member grievance or other similar programs established by Medica. In the event Medica modifies these programs following the Effective Date of this Agreement, Medica will communicate such changes to Agency prior to their adoption and permit Agency 45 days to comply with such additional or revised programs, unless a longer period of time is agreed upon by both parties. If Medica requests from Agency records related to a Member assessment and care plan for the purpose of regulatory review or for any other reason, Agency will submit such information to Medica promptly and no later than 48 hours after Medica's request or upon the timeline provided by Medica.

Section 3.9 Consumer Data. Agency will comply with all reasonable requests by Medica for information or review of information that Medica intends to release to purchasers of health care coverage, Members, and other consumers, in order to promote high-quality, cost-effective care. Agency may have an opportunity to review consumer data prior to Medica's publication for Medica initiated transparency programs and Agency consents to Medica's release of Agency-related data, including, without limitation, Agency quality, outcomes, and patient satisfaction data, and will not attempt to prohibit or restrict Medica's release of such information in accordance with the Administrative Requirements. Notwithstanding the foregoing, any state or federal statutory or regulatory transparency requirements for Medica or Agency will not be subject to prior review and not subject to the Confidentiality provisions of this Agreement.

Section 3.10 Accessibility for Handicapped Members. Agency will comply with applicable provisions in the Americans with Disabilities Act of 1990, 42 U.S.C. 12101, *et seq*., regarding accessibility of Agency facilities and services to handicapped Members.

Section 3.11 Provision of SNBC Services.

3.11.1 General Requirements. Agency will arrange for the provision of all "medically necessary" SNBC Services for Members in accordance with the standard of practice in the

community in which Agency renders Case Management Services and in a manner so as to ensure quality of care and treatment. Such Case Management Services must include services appropriately tailored to minority and special needs Members as described in detail in the Medica & DHS SNBC Agreement. The medical necessity of mental health services will be determined in accordance with Minnesota Statutes, § 62Q.53. Home and Community Based Services and SNBC Services mandated by state or federal law are not subject to a medical necessity determination, unless otherwise permitted by law and the Medica & DHS SNBC Agreement. The medical necessity of all other SNBC Services will be determined in accordance with the Medica & DHS SNBC Agreement. Agency will ensure Member receives the transition services described in the Medica & DHS SNBC Agreement.

Agency will allow, and will cause each of its Case Managers to allow, qualified Members to directly access any Indian Health Services facility operated by a tribe or tribunal organized under funding authorized by 25 U.S.C. Sections 5321 through 5324 or Title I of the Indian Self-Determination Act, Public Law Number 93-638, for SNBC Services that would otherwise be covered by the Member's Benefit Contract. No prior approval or prior authorization may be placed on such services.

When providing SNBC Services to Members, Agency and Case Managers will consider the Members' rights described in the Medica & DHS SNBC Agreement.

In the event Agency determines it does not have capacity to accept additional Members as clients, Agency will advise Medica of the reasons for Agency's determination. In such instances, Medica may, in its sole discretion, cease offering Agency as a Case Management option to new Members, until Agency has capacity to accept additional Members as clients. Agency's refusal to accept additional Members after expiration of this period of time will constitute material breach of this agreement for which Medica may pursue termination pursuant to Section 9.2.1. Notwithstanding the foregoing, Medica may cease offering Agency as a Case Management option to new Members in its sole discretion at any time.

3.11.2 Preadmission Screening ("PAS") for SNBC. Agency will provide or arrange for each Member an initial evaluation of his/her required level of care to determine eligibility for Nursing Facility placement. The Agency must determine the Member's risk of Nursing Facility admission or current need for Nursing Facility care to ensure that each Member eligible to receive Nursing Facility benefits is screened accordingly. The Agency will perform the PAS on each Member entering Nursing Facilities who have been identified by the Agency, MCO or by a referral from the Senior LinkAge Line. Agency shall conduct the PAS process as described in the Medica & DHS SNBC Agreement.

When a Member is determined to be Nursing Home Certifiable ("NHC"), Agency will ensure that the Member or his or her legal representative is:

(a) informed of feasible alternatives to nursing home care;

(b) offered a plan of care consistent with the screening assessment that is designed to meet the needs of the Member and protect his or her health and safety; and

(c) informed of the right to appeal the level of care decision as required under the Medica & DHS SNBC Agreement and pursuant to Minnesota Statutes, § 256.045.

3.11.3 Health Risk Assessment. Agency shall conduct an HRA of each Member's health needs using the appropriate DHS or Medica form as set forth in the Administrative Requirements. The HRA shall be completed within the first sixty (60) calendar days of the Member's enrollment effective date in Medica, and at least annually thereafter or earlier as necessary due to a change in the Member's health status and/or needs. Agency and/or its Case Managers must not be in a position to directly influence Members' housing or employment to help avoid possible conflicts of interest. Agency may conduct the HRA via telephone or an in-person visit; however, Agency must offer an in-person assessment at least annually to Members who are not on a waiver program and to Members who permanently reside in a nursing facility unless otherwise directed by DHS or Medica. If Agency does not conduct all initial HRAs in-person, Agency shall establish written criteria, policies and procedures, identification processes, schedules and timelines for follow up in-person visits for all Members, based on each Member's needs and health conditions and service status as indicated and as set forth in the Administrative Requirements. The HRA shall include questions designed to identify health risks and chronic conditions, including but not limited to: (a) activities of daily living; (b) risk of hospitalizations; (c) need for primary and preventive care; (d) mental health needs; (e) rehabilitative services; (f) protocols for follow up to assure that physician visits, additional assessments or Case Management interventions are provided when indicated, and (g) social determinants of health. Use of the HRA component of DHS's MnCHOICES tool by Agency will meet the requirements of this section and will become mandatory when MnCHOICES is implemented. Agency shall enter the activities of daily living and other required information collected through the HRA, or Member refusal of having an HRA performed, into MMIS according to the Medica & DHS SNBC Agreement until such time MnCHOICES is implemented and this information is processed automatically.

If a Member refuses to participate in a HRA or Agency is unable to reach the Member after a minimum of three telephone attempts and a letter, Agency shall follow the protocol for unable to reach and refuser Members as set forth in the Administrative Requirements.

Agency shall develop and implement an appropriate plan of care based on information identified in the HRA and in accordance with the timeframes set forth in the Administrative Requirements. Agency will maintain the HRA and the plan of care in the Member's care coordination file.

3.11.4 Nursing Facility SNBC Services. For any Member who was not residing in a Nursing Facility at the time of enrollment under a Benefit Contract governed by this Agreement, Agency will arrange for 100 calendar days of Nursing Facility care to any Member who becomes eligible for such services.

3.11.5 Agency's Rights to Refuse Care. Notwithstanding anything to the contrary in this Agreement, Agency may refuse to provide SNBC Services to any Member when the Member's behavior threatens the safety or well-being of others, or is otherwise disruptive. Agency must receive prior written approval from Medica to refuse to provide SNBC Services to a Member.

Medica may terminate a Member when the Member's behavior threatens the safety or well-being of others, or has otherwise engaged in disruptive behavior as determined by the CMS process described in 42 CFR 422.74 in accordance with the Medica & DHS SNBC Agreement. Medica shall comply with applicable CMS and DHS regulations regarding termination of a Member.

All such decisions will comply with applicable federal and state laws, regulations, and any applicable sub-regulatory guidance. Further, Medica, Agency and Case Managers will cooperate to ensure continuity of care through any necessary care transitions including, but not limited to, providing care until transitional care is located.

3.11.6 Spousal Impoverishment Referral. In the event a Member is married and is admitted to a Nursing Facility, Agency will refer the Member's spouse to the appropriate Agency medical assistance eligibility office for financial evaluation.

3.11.7 Time Frame to Evaluate Requests for SNBC Services.

3.11.7.1 General Request for SNBC Services. Agency and its Case Managers will evaluate all requests for SNBC Services for Members in accordance with the standard of practice in the community in which Agency renders Case Management Services and in a manner so as to ensure quality of care and treatment for Members. Agency and its Case Managers will evaluate all requests for SNBC Services by a Member within the lesser of 10 working days or the time frame required by applicable law. Agency will promptly communicate its decision by telephone in accordance with the Administrative Requirements. If Agency's decision is to deny the request, Agency will follow Medica's process related to denials, including review of and communication about denials. Medica will provide written notification of the decision to the Member or his or her authorized representative and the provider. Each party must notify the other party of any information it has regarding applicable laws, regulations, sub-regulatory guidance and/or the National Committee for Quality Assurance accreditation requirements. The Member may appeal the decision in accordance with the Complaints and Appeals process described in the Benefit Contract and in the Medica & DHS SNBC Agreement.

3.11.7.2 Request for Urgent Services. If the need for SNBC Services is urgent or required to prevent institutionalization, Agency must evaluate the request for SNBC Services and communicate its decision to the Member or authorized representative and the appropriate provider within an expedited time frame that is appropriate to the type and necessity of SNBC Services requested by the Member or on the Member's behalf and in accordance with applicable law, but not later than 72 hours after receipt of the request, or a lesser time period if required by law. Additionally, all such services must be provided within the time frames as required by law.

3.11.7.3 Request for Mental Health/Substance Abuse Services. Agency will arrange mental health/substance abuse services as follows:

- Members requiring mental health/substance abuse crisis services will be treated immediately.
- Members requiring any other mental health/substance abuse services will be given an appropriate assessment of needs within 2 weeks from the Member's request. Members will be treated with any "medically necessary" SNBC Services indicated by the assessment of needs.
- Agency will refer to and follow all of Medica's mental health/substance abuse protocols, including its use of certain participating providers.

3.11.8 Modifications to Benefit Contract. The parties understand and agree that Medica may, on an annual basis, be required to modify or change the Benefit Contract as required by federal or state laws, regulations or sub-regulatory guidance. Any modification or change to this Agreement as a result of a change or modification to the Benefit Contract will be subject to the amendment procedure described in Section 11.1.1 or 11.1.2 of this Agreement.

3.11.9 Medica's Addition of Medica Providers. Medica may at any time add Medica Providers to Medica's participating provider network.

3.11.10 Restrictions in Use and Modification of Agency by Medica. Medica may not include Agency in a network for any additional Medica products without prior approval by Agency.

3.11.11 Case Management, Care Delivery and Care Coordination. Agency shall comply with Medica's Administrative Requirements and the requirements in the Medica & DHS SNBC Agreement related to Case Management Services for Members requiring assistance in accessing Case Management Services, including Members who require intensive Case Management due to serious health conditions. Agency and its Case Managers shall provide a range of Case Management Services from telephone consultation to in-person visits or intensive ongoing intervention based on defined criteria in accordance with the Medica & DHS SNBC Agreement. At least annually, Agency will offer to all Members not on a waiver a in-person visit to assess their needs. Case Managers of Agency will have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services. Case Managers are required to meet Medica's training requirements in the use and referral parameters for home care and mental health services covered by Medica and relevant linkages to fee for service Medicaid. Case Management will be provided and/or supervised by a qualified professional such as a registered nurse, social worker, nurse practitioner, physician assistant, or physician.

If there is a request or need for intensive case management by a county, health care provider, family member or Member, Agency must respond to that request within one (1) business day. Agency must contact Medica to access clinical consultation services as needed to identity the health care needs of the Member and develop a care plan that appropriately addresses the Member's health care needs.

Agency understands and agrees that in furtherance of the goals and purposes of the SNBC and/or SNBC D-SNP program, a substantial objective of Medica is developing the plan of health care coverage identified in the Benefit Contract that coordinates care pursuant to the Medica & DHS SNBC Agreement. Medica is entering into this Agreement to: (a) foster the creation of Care Systems in which all involved Case Managers are encouraged to fully coordinate care of Members among themselves and with Medica in ways that will ensure that all needed care is provided in an optimal manner; and (b) cause SNBC Services to be provided to Members through such means. Pursuant to the foregoing, Medica, in conjunction with Agency, is responsible for ensuring the delivery of the full continuum of SNBC Services available to Members under the Benefit Contract. In fulfilling this responsibility, Medica, in conjunction with Agency, will develop and utilize a disability-oriented case management program for Members. At a minimum, the disability-oriented Case Management program will:

a) ensure that the Case Management Services have the capacity to coordinate the provision of all Medicaid acute and basic care services, including services under a Care System;

b) facilitate annual Provider visits for Members for primary and preventive care;

c) provide an individual needs assessment and plan of care, monitor outcomes, and revise as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs and disability conditions of the Members;

d) develop a care plan within thirty (30) days from the completion of the HRA based on available information including but not limited to issues or needs identified by risk and comprehensive assessments, medical records and/or previous utilization, and Member and/or family input;

e) provide Case Management Services which include procedures for promoting rehabilitation of Members following acute events, and for ensuring smooth transitions and coordination of information among acute, sub-acute, rehabilitation, home care and other settings;

f) use strategies that ensure that all Members and/or authorized family members, representatives, or guardians are involved in care planning, and consent to the medical treatment;

g) make referrals to specialists and sub-specialists as appropriate;

h) coordinate care for American Indian Members;

i) coordinate with Individual Education Plan ("IEP"), an Individual Family Service Plan ("IFSP") or assessment summary including services and supports;

j) coordinate for SNBC Services with children's mental health collaboratives and family services collaboratives, and adult county mental health initiatives;

k) coordinate with county social services and case management systems; and

l) provide transitional care for children between the ages of eighteen (18) and twenty-one (21) who require ongoing services as they transition to adult programs covered under this Agreement.

At any time during the term of this Agreement, upon 30 calendar days prior written notice, either party may require the other party to meet to discuss in good faith the nature of the relationship between the parties and the extent to which the party or parties have been successful or unsuccessful in accomplishing the objectives described in this Section 3.11.11.

Section 3.12 Enhanced Services. Medica has determined that providing Enhanced Services favorably affects Members' total health. "Enhanced Services" are services that Medica believes may enhance the health or well-being of Members through prevention, promotion, assessment or other special interventions or services. Agency will coordinate Enhanced Services for Members as appropriate to achieve maximum health of Members.

Section 3.13 Mental Health/Substance Abuse, Pharmaceutical Providers and Chiropractic. Agency understands and agrees that Medica may, in its sole discretion, designate certain providers as Medica's sole mental health/substance abuse, pharmaceutical, and chiropractic Medica Providers under this

Agreement. If Medica makes any such designations, Agency will refer only to those entities for mental health/substance abuse, pharmaceutical, and chiropractic Health Services for Members.

Section 3.14 Transfers of Members. A Member may change his or her designation of Care System or primary care clinic according to the terms of the Member's Benefit Contract. It is Medica's standard practice that voluntary changes of Care Systems will be effective the first day of the month following notification to Medica. Medica may permit Care System changes at other times of the month in the event of exigent circumstances, such as a Member's allegation of malpractice by his/her Care System.

When Medica receives notice of a change in Care System, Medica will provide notice of such change to the Member's existing Care System and to the Care System into which the Member is changing. If the Member is experiencing an acute or sub-acute inpatient hospital or Nursing Facility episode as of the date at which the change in Care Systems is to occur for such Member, the Member's existing Care System will continue to provide SNBC Services to such Member until such acute or sub-acute episode ceases.

Agency will, and will cause Case Managers to, ensure that, if a Member transfers to another Care System at any time other than month end due to change of circumstances, including but not limited to transferring to a nursing home that is not a Nursing Facility or moving to an agency in which there are no Case Managers, the Case Manager who was the Member's most recent Case Manager will provide or arrange for the provision of Health Services to such Member through the end of the month of the transfer.

Section 3.15 Actions by Medica and Agency. Medica and Agency will use all reasonable efforts to timely and accurately provide all services required to be provided under this Agreement to accomplish the objectives of this Agreement.

Section 3.16 Waiver of Inpatient Hospital Admission. At the discretion of Agency, the three day hospital admission required before skilled nursing care coverage is available for care in a Nursing Facility, as outlined under the Benefit Contract, may be waived and Agency may authorize coverage for skilled nursing care in a Nursing Facility without a previous three day hospital admission under the following conditions: (a) all other applicable legal and regulatory criteria for the provision and coverage of skilled nursing care are met; and (b) the Nursing Facility has the capability of providing all appropriate Health Services pursuant to this Agreement.

Section 3.17 Compliance with Medica Contract with State for SNBC Program. Agency will, and will cause each Case Manager to, comply with all terms and provisions of any contract entered into between Medica and the State regarding the SNBC program. Medica will promptly notify Agency of any material amendments to any such agreement, including the Medica & DHS SNBC Agreement.

Article 4
Reimbursement for Case Management Services

Section 4.1 Reimbursement for Case Management Services. Medica will pay Agency the Case Management Fee and any additional payments in accordance with Appendix A to the extent Agency renders Services to SNBC Members. The total Case Management Fee will be calculated using the information available to Medica at the time of the calculation for the number of Members receiving Case Management Services from Agency for the month, including any adjustments from prior months. Medica will make payments under this Agreement to Agency unless Agency has assigned the right to payment to a third party. Medica will honor the assignment starting not more than 60 days after Agency has provided written notice of such assignment to Medica.

Agency is solely responsible for compensating Case Managers for Case Management Services rendered to Members, regardless of whether payments made to Agency by Medica for such Case Management Services are sufficient to reimburse Agency for payments made to Case Managers.

Section 4.2 Data and documentation related to Case Management Services. Upon request by Medica, Agency will submit data and documentation related to Case Management Services to Medica in a manner and format prescribed by Medica.

Section 4.3 Payment in Full. Agency will, and will cause each Case Manager performing Case Management Services to, accept as payment in full for such services the reimbursement paid by Medica in accordance with this Agreement. Agency will not, and will cause each Case Manager not to, hold financially responsible, collect or attempt to collect additional reimbursement for Case Management Services from:

(a) any Member, except for:

(i) Copayments or Coinsurance;

(ii) Deductibles; and

(iii) any service rendered by Agency or a Case Manager that is ineligible for coverage under the Member's Benefit Contract; provided, however, that if Agency or Case Manager has knowledge that such service is or will be ineligible for coverage under the Member's Benefit Contract, Agency or Case Manager must have informed the Member, in writing, of the ineligibility of any such service prior to its delivery. Agency or Case Manager must also receive Member's signed acknowledgment of such ineligibility and resultant responsibility to pay for such service prior to its delivery; or

(b) any third party, including without limitation:

(i) any insurer or other payor on behalf of a Member;

(ii) any alleged tortfeasor; and

(iii) such alleged tortfeasor's insurer or other payor.

Section 4.4 Member Protection Provisions.

(a) The following provisions are incorporated into this Agreement:

(i) as required by the Minnesota Health Maintenance Act of 1973, Minnesota Statutes, Chapter 62D, Agency agrees not to bill, charge, collect a deposit from, seek remuneration from, or have any recourse against any Member or persons acting on his or her behalf for services provided under this Agreement. This provision applies to, but is not limited to, the following events:

A. nonpayment by Medica; or

B. breach of this Agreement.

This provision does not prohibit Agency from collecting Copayments, Coinsurance, Deductibles, or charges for any services rendered by Agency that are ineligible for coverage.

This provision survives the termination of this Agreement for authorized services provided before this Agreement terminates, regardless of the reason for termination. This provision is for the benefit of Members. This provision does not apply to services provided after this Agreement terminates.

This provision supersedes any contrary oral or written agreement existing now or entered into in the future between Agency and Member or persons acting on his or her behalf regarding liability for payment for services provided under this Agreement.

For purposes of this provision, nonpayment by Medica includes nonpayment by Medica in the event of its insolvency.

(b) The following provision is incorporated into this Agreement as required by the federal regulations promulgated by the Secretary of Health and Human Services pursuant to authority granted to the Secretary under the Health Insurance for the Aged Act, 42 U.S.C. Section 1395hh, which regulations are codified at 42 C.F.R. 417.122(b).

Agency agrees that in the event of Medica's insolvency, Agency will continue to provide any Member with Case Management Services from the date of Medica's insolvency for the duration of the contract period for which premium payment has been made by such Member. Furthermore, Agency will continue to provide Case Management Services to those Members who are confined in an inpatient facility until such Members are discharged.

Section 4.5 Right of Offset. Medica may make adjustments to payments for any overpayments or underpayments, and Medica may exercise a right of offset with respect to any payments made pursuant to this Agreement.

Article 5
Relationship Between Parties

Section 5.1 Relationship Between Medica, Agency and Case Managers. The relationship between Medica and Agency is solely that of independent contractors. Nothing in this Agreement or otherwise will be construed, implied, or deemed to create any other relationship between the parties, including one of employment, agency, joint venture, association, partnership, or any other form of separate legal entity or organization. Neither party to this Agreement will have an express or implied right of authority to assume or create any obligation or responsibility on behalf of or in the name of the other party. The rendering of all Case Management Services and the operation and maintenance of all offices, facilities, and equipment of Agency, solely and exclusively is under the control and supervision of Agency. Medica will not control or be responsible for the Case Management Services rendered by Agency or any Case Manager.

Section 5.2 Relationship Between Agency, Case Manager and Members. The relationship between Agency, Case Managers and any Member is that of Case Manager and client.

Section 5.3 Communications with Members.

(a) Each Case Manager has the right and is encouraged within the Case Manager's scope of practice to discuss with each Member pertinent details regarding the diagnosis of such Member's condition, the nature and purpose of any recommended procedure or service, the

potential risks and benefits of any recommended treatment or service, and any reasonable alternatives to such recommended treatment or service.

(b) The obligations of Agency and each Case Manager to maintain the confidentiality of certain information, as described in this Agreement, do not apply to any disclosures to a Member determined by a Case Manager to be necessary or appropriate for the provision of Case Management Services or the diagnosis and care of a Member except to the extent such disclosure would otherwise violate the Case Manager's legal or ethical obligations.

Section 5.4 Designation as Being Part of Medica's Provider Network. Medica has the right to designate and make public reference to Agency and each Case Manager by name, symbol and/or service mark as being part of Medica's Provider Network. Agency and Case Managers have the right to designate and make public reference to their status as being part of Medica's Provider Network.

Article 6
Liability Insurance, Hold Harmless and Indemnification

Section 6.1 Liability Insurance.

Agency will ensure that Agency and each Care Coordinator/Case Manager under contract with Agency procures and maintains general and professional liability insurance with coverage limits as set forth in Minnesota Statutes, Chapter 466.

Upon request by Medica, Agency will give evidence of any insurance coverage procured pursuant to this Section 6.1. Agency will notify Medica within 30 days of any of the following events related to such insurance coverage:

(a) changes in carriers;

(b) changes in remaining coverage.]

Section 6.2 Agency Hold Harmless and Indemnification. Agency will indemnify and hold Medica harmless against any and all claims, liabilities, costs, damages, losses or judgments, including reasonable attorneys' fees and expenses, asserted against, imposed upon or incurred by Medica that arise out of or relate to acts or omissions, including malpractice, negligence or breach of this Agreement, by Agency or any Agency Case Manager or any of Agency's other employees, agents or representatives. Nothing herein is intended to waive any applicable liability limits set forth in Minnesota Statutes, Chapter 466.

Section 6.3 Medica Hold Harmless and Indemnification. Medica will indemnify and hold Agency harmless against any and all claims, liabilities, costs, damages, losses, or judgments, including reasonable attorneys' fees and expenses, asserted against, imposed upon or incurred by Agency that arise out of the acts or omissions, including the negligence or breach of this Agreement, by Medica or Medica's employees, agents or representatives; provided, however, that no person is an employee, agent or representative of Medica because of his or her relationship to Agency.

Article 7
Compliance and Licensure Requirements

Section 7.1 Compliance and Licensure Requirements. Agency will ensure that all Case Management Services provided under this Agreement will be provided by Case Managers acting within the scope of their authority. Agency will and will cause each Case Manager employed by or under contract with

Agency or any Case Manager to maintain, without material restriction, accreditation as may be required by Medica including all federal, state, and local licenses and permits required to provide Case Management Services under this Agreement and to fully comply with all applicable federal, state, and local laws, regulations, and any sub-regulatory guidance issued in the provision of such Case Management Services.

Agency and Medica are individually responsible for ensuring that their activities are in compliance with all applicable federal, state, and local laws, regulations, and any sub-regulatory guidance issued in the provision of such Case Management Services. Each party will cooperate with the other party in its efforts to achieve and/or maintain regulatory compliance. Agency shall comply with oversight activities imposed by Medica in accordance with the Medica & DHS SNBC Agreement, and Medica's policies.

Section 7.2 Fraud and Abuse Requirements.

(a) Agency understands that this Agreement involves the receipt by Agency of state and federal funds, and that Agency is, therefore, subject to criminal prosecution and/or civil or administrative actions for any intentional false statements or other fraudulent conduct related to its obligations under this Agreement.

(b) Agency will, upon the request of CMS, the Comptroller General, or their designees, and the applicable state fraud control unit or Attorney General's office make available to such requesting agency, unit or office all administrative, financial, medical and any other records that relate to the delivery of items or services under this Agreement. Agency will allow the investigating agency, fraud control unit or office access to these records during normal business hours. To the extent legally permitted and not prohibited by the requesting agency, state fraud control unit or office, Agency will notify Medica in the event of a request by an agency, state fraud control unit or Attorney General's Office to review any Agency records.

(c) Agency will report to Medica any suspected insurance fraud relating to Medica.

(d) In accordance with Section 1902(a)(68) of the Social Security Act, if Agency receives or makes annual payments under Medicaid of at least $5,000,000, Agency must:

(i) establish written policies for all employees, managers, officers, contractors, subcontractors and agents of Agency that provide detailed information about the federal False Claims Act, administrative remedies for false claims and statements, any applicable state laws pertaining to civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A);

(ii) include as part of such written policies detailed provisions regarding Agency's policies and procedures for detecting and preventing fraud, waste and abuse; and

(iii) include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and Agency's policies and procedures for detecting and preventing fraud, waste and abuse.

Section 7.3 Notice of Change in Licensure. Agency will notify Medica in writing within 10 days of any termination, suspension, revocation, restriction, stipulation, limitation, qualification, or other disciplinary action, corrective action plan or investigation regarding any Agency or Case Manager's status.

Section 7.4 Disclosure of Transactions and Ownership Information. Agency will and will ensure that its Case Managers comply with DHS and CMS requirements for disclosure of business transactions and ownership information in accordance with the Administrative Requirements.

Section 7.5 Business Continuity Disaster Recovery Plan. Agency will develop and implement a Business Continuity Disaster Recovery Plan ("BC/DR Plan") that is consistent with industry best practices and conforms to the terms of this Agreement and applicable law. Agency will maintain, review and annually test its BC/DR Plan throughout the term of this Agreement. Agency will provide Medica with a copy of its BC/DR Plan no later than ten (10) days after Medica's request.

Article 8
Books and Records

Section 8.1 Access to and Release of Books and Records. To the extent allowed by law, during the term of this Agreement and for 10 years following termination or expiration of this Agreement, or final audit, whichever is later, or longer in certain instances, as required by law, Agency will provide Medica and its authorized agents, during regular business hours and upon reasonable notice and demand, with access to all information and records, or copies of records, of Agency and each Case Manager related to Case Management Services under this Agreement, to the extent permitted by applicable law and without further authorization by any Member. Agency will and will cause each Case Manager to provide records or copies of records requested by Medica within the time frame provided under applicable law including, but not limited to, laws related to the resolution of Member complaints. If Agency or Case Manager fails to comply with this Section 8.1, Medica will have the right to withhold Agency reimbursement to Agency for Case Management Services furnished by Case Manager until Agency corrects such failure by fully complying with this Section 8.1 and Medica and/or its authorized agents have reviewed the requested information and records or copies of records. Nothing herein modifies or limits Medica's rights under the Dispute Resolution and Termination Articles of this Agreement, nor is it to be construed to bar other legal or equitable remedies that may be available to Medica. This Section 8.1 will not be construed to provide Medica with access to information related solely to the overall financial operations of Agency. Agency will allow Members to access their protected health information and amend incorrect protected health information contained within a designated record set and to receive an accounting of certain disclosures of protected health information as required by HIPAA privacy regulations and applicable state law.

Section 8.2 Access to Records by State and Federal Government. The state and federal government and any of their authorized representatives have access, in accordance with state and federal statutes and regulations, to all information and records, or copies of such, within the possession of Medica, Agency and/or Case Managers that are pertinent to and involve transactions related to this Agreement. Furthermore, Medica is authorized to release any such information and records, or copies of records as is necessary to comply with federal and state laws, regulations, and sub-regulatory guidance as well as requirements of CMS and DHS, applicable to Medica.

Article 9
Term and Termination

Section 9.1 Term. The term of this Agreement commences on the Effective Date, and continues through December 31, 2023 (the "Termination Date"). Unless otherwise terminated pursuant to this Article, this Agreement will automatically renew on the Termination Date and on each one-year anniversary of such date for additional terms of one year.

Section 9.2 Termination. This Agreement may be terminated as follows:

9.2.1 Termination upon Event of Default.

(a) This Agreement may be terminated by Medica immediately upon written notice to Agency upon the occurrence of an Event of Default by Agency hereunder. Each of the following constitutes an Event of Default by Agency:

(i) Agency's ability to perform under this Agreement is materially impaired;

(ii) Medica determines that the health, safety or welfare of Members is in immediate jeopardy if this Agreement is continued;

(iii) Agency files a voluntary petition in bankruptcy, admits in writing its inability to pay its debts, makes a general assignment for the benefit of creditors, is adjudicated as bankrupt or insolvent, or has an involuntary petition in bankruptcy or similar proceeding commenced against it, that continues undismissed for a period exceeding 60 days;

(iv) Agency fails to maintain an insurance program as described in Section 6.1;

(v) Medica reasonably believes that Agency is engaged in fraud or abuse with regard to the provision of Case Management Services under this Agreement. This reasonable belief may be, but is not required to be, based upon the finding of a state or federal government agency, a state fraud control unit, a court of law, or other legal entity that Agency is or has been engaged in fraud or abuse with regard to Case Management Services provided under this Agreement or similar services;

(vi) Agency fails to comply with Medica's privacy practices;

(vii) Agency fails to satisfy any other material term, covenant or condition of this Agreement, and fails to cure such breach within 30 days following its receipt of written notice from Medica describing with specificity the nature of the breach; or

(viii) Agency fails to respond to Medica's inquiries for information within the timeline specified in the communication and, if not specified, within 14 business days.

(b) Subject to the Member protection provisions of Section 4.3 hereof, this Agreement may be terminated by Agency immediately, upon written notice given by Agency to Medica upon the occurrence of an Event of Default by Medica hereunder. Each of the following constitutes an Event of Default by Medica:

(i) Medica continuously fails to make undisputed payments due to Agency pursuant to this Agreement within 45 days after payment is due in accordance with Appendix A for Medica Health Plans business conducted in Minnesota;

(ii) Revocation of any certification or license of Medica necessary for performance of this Agreement; or

(iii) Medica fails to satisfy any other material term, covenant or condition of this Agreement, and fails to cure such breach within 30 days following its receipt of written notice from Agency describing with specificity the nature of the breach.

9.2.2 Without Cause Termination. This Agreement may be terminated by Medica or Agency, without cause, by providing the other party with notice of its intent to terminate at least one hundred twenty-five (125) days in advance of the termination date and such termination will be effective on the date specified in the notice of termination.

9.2.3 Termination for Amendment. This Agreement may be terminated by Agency in the event of an amendment to this Agreement under Section 11.1.1 by providing one hundred twenty-five (125) days advance written notice to Medica, such notice to be provided not more than forty-five (45) days after the date notice of the amendment is received by Agency and such amendment will not take effect during the one hundred twenty-five (125)-day termination notice period if such amendment alters the reimbursement terms or materially alters the Administrative Requirements. All other amendments will take effect on the respective effective date of such amendment.

Section 9.3 Termination of Agency or Case Manager Participation. The participation status of Agency, or each Case Manager terminates upon the earliest of:

(a) the date termination of this Agreement is effective;

(b) the date such Agency, or Case Manager fails to continuously satisfy the standards and procedures of Medica;

(c) the date such Agency's, or Case Manager's state or federally required certification, licensing or other such requirement is suspended or terminated by any state or federal authority;

(d) the date a Case Manager's employment or other association with Agency terminates; and

(e) the date of such Case Manager's death or disability.

If Medica terminates the participation status of a Case Manager pursuant to this Section 9.3, Agency will establish a procedure to ensure that such Case Manager does not deliver Case Management Services to Members, other than in cases of emergency.

Section 9.4 Consequences of Termination. The following apply in the event this Agreement terminates pursuant to Section 9.2, or in the event the participation status of Agency or any Case Manager terminates pursuant to Section 9.3.

9.4.1 Continued Provision of Case Management Services from Date of Notice of Termination to Date of Termination. If termination of this Agreement or of the status of any

Case Manager is not immediate upon provision of notice of such termination, during the period after notice of termination and before the effective date of such termination, the status of Agency or such Case Manager as a provider of Case Management Services remains in full force and effect, except to the extent Medica, in its sole discretion, determines that such status will be restricted by, or otherwise controlled by, Medica:

(a) to ensure that Case Management Services are available and provided to Members in a manner consistent with:

(i) the obligations of Medica under its Benefit Contracts or under any state or federal laws, regulations or sub-regulatory guidance; and

(ii) other standards for provision and availability of Case Management Services established by Medica; or

(b) as a result of actions by Agency or such Case Manager that Medica determines negatively affect Medica's relationship with its Members.

Medica will notify Agency in writing upon imposition of any such restriction.

9.4.2 Review of Communications. Medica and Agency have the right to review any written communication proposed to be delivered by the other party to Members, Case Managers, or Providers regarding termination or suspension prior to distribution of such communication.

Article 10
Dispute Resolution

Section 10.1 Dispute Resolution. In the event a claim, controversy or dispute (collectively "Dispute") between Medica and Agency arises out of this Agreement, any party seeking to pursue the Dispute must proceed with the remedies and procedures as outlined in Medica's Administrative Requirements. If Medica's Administrative Requirements do not address the type of Dispute, timely written notice outlining the Dispute must be supplied by the party seeking to pursue the Dispute. The parties shall attempt in good faith to resolve the Dispute promptly through discussions and negotiations with each other. If the Dispute remains unresolved, either party may initiate litigation of such Dispute.

Nothing in this Agreement will preclude a party from seeking any action necessary to preclude imminent and irreparable harm, including, but not limited to, a temporary restraining order, temporary injunction or other equitable relief for any breach of any duty, obligation, covenant, representation, or warrant set forth in this Agreement.

During the period of time in which the Dispute is under consideration, the parties will proceed diligently with the performance of their duties under this Agreement in a businesslike and efficient manner.

Any and all disputes, controversies or claims involving fraud shall not be deemed to be a Dispute under this Section and; therefore, are exempt from this Section and either party may utilize litigation to resolve such disputes.

In addition, in the event a third party initiates litigation involving one of the parties to this Agreement, and the party hereto who is involved in such third party litigation desires to bring a claim against the other party hereto for indemnity or contribution, the indemnity or contribution claim may be brought in the same venue as the third party litigation.

Article 11
Miscellaneous

Section 11.1 Amendment. This Agreement may be amended as follows:

11.1.1 Amendment by Medica. Any amendment to this Agreement, including a change by Medica to the reimbursement terms or any material change or addition to Medica's Administrative Requirements, issued by Medica at least 45 days prior to the effective date of such amendment will be incorporated into this Agreement on the effective date of the amendment; provided, however, that an amendment that alters the reimbursement terms or materially alters Medica's Administrative Requirements will not take effect if Agency elects to terminate this Agreement as provided in Section 9.2.3.

11.1.2 Regulatory Amendment. Medica may amend this Agreement to comply with applicable laws, regulations, and/or sub-regulatory guidance. Such amendment will be effective on the date the applicable law, regulation, or sub-regulatory guidance becomes effective.

11.1.3 Mutual Amendment. Notwithstanding Section 11.1.1, this Agreement may be amended without satisfaction of the forty-five (45) days' notice requirement in the event the parties mutually agree to amend this Agreement effective on another date.

Section 11.2 Confidentiality. Medica and Agency (including Case Managers and other Agency personnel) will maintain the confidentiality of all information regarding Members in accordance with all applicable state and federal laws and regulations, including without limitation HIPAA privacy and security requirements. To the extent Agency is acting as a Business Associate of Medica as defined by HIPAA, it will comply with the HIPAA Business Associate Requirements set forth in Medica's Administrative Requirements. Agency will and will ensure that Case Managers and other Agency personnel safeguard Member privacy and confidentiality and assure the accuracy of Member health records. For purposes of complying with HIPAA security standards, Agency will maintain the appropriate administrative, technical and physical safeguards for individually identifiable health information that is electronically transmitted or maintained. In addition, except as otherwise required by law or regulation and except as otherwise permitted by Section 5.3 of this Agreement, Agency will, and will cause each Case Manager and other Agency personnel to, maintain, during the term of this Agreement and thereafter, the confidentiality of:

(a) all Member information;

(b) all quality assessment and utilization review information; and

(c) the terms of this Agreement, including without limitation, the amounts paid by Medica to Agency under this Agreement, and will not disclose any such information to:

(i) any third party, or

(ii) any division, business unit or affiliate of Agency that offers or intends to offer services similar to those offered by Medica.

Agency will, and will cause each Case Manager and other Agency personnel to, use its best efforts to protect such information from unauthorized disclosure by any person and will not use or allow any person to use any such information in any way that is detrimental to Medica or that may cause competitive disadvantage to Medica.

Section 11.3 Assignment; Notice of Mergers or Acquisitions. Agency's assignment of its rights or obligations under this Agreement is prohibited without Medica's written consent, whether the assignment

is voluntary or involuntary, by merger, consolidation, dissolution, operation of law, or otherwise. Any purported assignment of Agency's rights or obligations in violation of this Section 11.3 is null and void. Medica may, without the prior consent of Agency, assign its rights and obligations under this Agreement to any entity which controls Medica, is controlled by Medica, or is under common control with Medica. In the event of an assignment, this Agreement is binding upon and will inure to the benefit of each party's successors and assigns.

Agency will notify Medica of any transactions whereby Agency will acquire, be acquired by, be merged with another entity, or incur any other material change in ownership or control. Such notice will be provided at least one hundred twenty-five (125) days in advance of the effective date of such acquisition or merger, or as soon as reasonably practical. The acquired entities will remain under their existing Medica contract including the reimbursement provisions until their Medica contract's next renewal date.

Section 11.4 No Waiver of Rights. The failure of any party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy does not impair or waive any such right or remedy.

Section 11.5 Notice. All notices required under this Agreement will be in writing, signed by the party giving notice, and will be delivered by hand, email, or first class mail and sent to the address set forth at the end of this Agreement for Medica, unless otherwise indicated by Medica, and to the address on file with Medica for Agency, unless otherwise indicated by Agency. Notices to Medica will be addressed to the Director of Medicaid, SNP Product and Strategy. Notices sent by mail are deemed received 2 business days after the postmark date, notices delivered by hand are deemed received on the date of delivery, and email notices will be sent with a return receipt requested, if the return receipt is not received the sender will follow-up by first class mail.

Section 11.6 Administrative Duties. Agency acknowledges and agrees that certain administrative duties required to be performed by Medica under this Agreement may be performed by an entity that is under contract to provide management services to Medica.

Section 11.7 Entire Agreement. This Agreement, as it may be hereafter amended pursuant to Section 11.1, and any Addenda, Appendices, Exhibits and Attachments and Medica's Administrative Requirements as may be modified from time to time by Medica, and the application for participation of Agency and each Case Manager, constitute the entire agreement between the parties regarding the subject matter contained herein. This Agreement supersedes and replaces any agreement previously entered into between Medica and Agency or Medica and any Case Manager relating to the same subject matter and no prior representations or agreements between the parties relating to the same subject matter, oral or written, have any force or effect.

Section 11.8 Governing Law. This Agreement will be construed in accordance with the applicable laws of the State of Minnesota.

Section 11.9 Survival. The provisions of Section 4.4 (Member Protection Provisions), Article 6 (Liability Insurance, Hold Harmless and Indemnification), Section 7.2 (Fraud and Abuse Requirements), Article 8 (Books and Records), Article 10 (Dispute Resolution) and Section 11.2 (Confidentiality) survive termination of this Agreement.

Section 11.10 Severability. Each provision of this Agreement is intended to be severable. If any provision hereof is waived, deemed illegal or invalid for any reason, such waiver, illegality or invalidity does not affect the validity and enforceability of the remainder of this Agreement. The parties agree to

negotiate to achieve a comparable Agreement on a provision in the event such provision is deemed illegal or invalid.

IN WITNESS WHEREOF, duly authorized representatives of both parties have caused this Agreement to be executed.

Kanabec County
Street Address: _____
City, State and Zip Code: _____
_____

By: _____
Name: _____
Title: _____

Date_____

Medica Health Plans
P.O. Box 9310
Minneapolis, MN 55440-9310

Or

401 Carlson Parkway
Minnetonka, MN 55305

By: _____
Kristy Wilfahrt
Title: VP and GM Medicaid,
Markets Growth and Retention

Date_____

EXHIBIT 1

APPENDIX A

PAYMENT APPENDIX

TO

AMENDED AND RESTATED

SNBC CASE MANAGEMENT PARTICIPATION AGREEMENT

(the "AGREEMENT")

FOR

MINNESOTA SPECIAL NEEDS BASICCARE PROGRAM ("SNBC") and

MEDICA ACCESSABILITY SOLUTION ENHANCED ("SNBC D-SNP")

BETWEEN

MEDICA AND KANABEC COUNTY ("AGENCY")

Section 1. Case Management Services Payment.

a. Medica will pay Agency a monthly Case Management Fee of $115.00 per SNBC Member per month ("PMPM"), for Case Management Services rendered by Agency to each SNBC Member in accordance with the Agreement. The Case Management Fee will be paid to Agency on a monthly basis no later than the end of the month following the previous month for which payment is being made based on the enrollment information Medica receives from DHS.

b. The number of SNBC Members factored into the Case Management Fee calculation to determine total monthly payments will include those SNBC Members receiving Case Management Services from Agency at the beginning of the month for which reimbursement is being made. Monthly membership will be restated in order to accommodate changes in enrollment (such as additions or terminations of SNBC Members) that affect the previous months.

Section 2. Provider Taxes. To the extent any payment of taxes are required by law, amounts paid by Medica to Agency as reimbursement for Case Management Services will be inclusive of all taxes imposed on Agency's receipt of such reimbursement amounts, including taxes for which Agency has authority to transfer the additional tax-related expense to a third party. In the event legislative or regulatory action determines that any such tax does not apply to such reimbursement, reimbursements to Agency will exclude any payment for the tax, and Medica may recover from Agency all amounts paid to Agency attributable to such tax. In the event legislative or regulatory action increases or decreases the amount of such tax, reimbursement to Agency will be increased according to applicable law or may be decreased to reflect such change.

PROVIDER PARTICIPATION AGREEMENT

by and between

UCARE MINNESOTA

and

KANABEC COUNTY, dba KANABEC COUNTY FAMILY SERVICES

THIS PROVIDER PARTICIPATION AGREEMENT ("Agreement") is made and entered into by and between UCare Minnesota, together with its affiliate UCare Health, Inc. ("UCare"), and **Kanabec County** ("Participant"), (each a "Party" and collectively, the "Parties") and shall be effective as of the January 1, 2023 **OR** the first day of the second month following the month in which UCare signs this Agreement (the "Effective Date").

WHEREAS, UCare Minnesota, a health maintenance organization licensed by the State of Minnesota and its affiliate health plan companies, are engaged in the business of making quality health care available on a prepaid basis; and

WHEREAS, UCare strives to fulfill its mission to improve the health of its members through innovative services and partnerships across communities; and

WHEREAS, Participant desires to participate as a provider of certain covered services for UCare Enrollees in support of the UCare mission; and

WHEREAS, UCare desires that Participant participate as a provider of certain covered services for UCare Enrollees in support of the UCare mission;

NOW, THEREFORE, it is agreed as follows:

ARTICLE 1: DEFINITIONS

1.1 Definitions. The following terms as used in this Agreement shall have the meanings ascribed to them below unless the context clearly requires a different meaning:

"Abuse" means the definition set out in Minnesota Rules, Part 9505.2165, subpart 2, and in the Medicare Managed Care Manual Chapter 21, section 20. Abuse shall also include substantial failure to provide Medically Necessary items and services that are required to be provided to an Enrollee under this Agreement if the failure has adversely affected or has substantial likelihood of adversely affecting the health of the Enrollee.

"Advance Directives" means those requirements as specified under 42 C.F.R. § 422.128.

"Agent" means an entity which is under contract with UCare to perform certain functions related to this Agreement on behalf of UCare.

"Agreement" means this Provider Participation Agreement including any exhibits, schedules, appendices, addenda, or other attachments hereto, as well as the Provider Manual and Provider Communications, all as presently in effect or as hereafter modified and amended.

"Benefit Contract" means a plan of health care coverage issued by UCare to an Enrollee who is eligible for benefits under any of the products listed in Exhibit A, and which contains the terms and conditions of such coverage. Benefit Contract includes plans of health care coverage generally referred to as "evidence of coverage" for Enrollees enrolled in a Medicare product, as well as qualified health plans, as defined in 42 U.S.C. §18021(a), as may be amended from time to time, which are issued or offered by UCare.

"Billed Charges" means the charges for Covered Services included on a claim submitted by Participant.

"Clean Claim" means a claim that is submitted without defect or impropriety, includes any required substantiating documentation (which includes but is not limited to information regarding coordination of benefits and (1) in the case of interpreter services, Interpreter work order and Interpreter MDH roster number and (2) in the case of transportation services, Transportation Assignment number), and has no particular circumstance requiring special treatment that prevents timely payment from being made on a claim.

"Co-payment" or "Coinsurance" means the amount an Enrollee is required to pay for certain Covered Services in accordance with the Enrollee's Benefit Contract.

"Covered Services" means those medical, surgical, hospital, prescription drug, and other health care services designated as covered by the terms of the Benefit Contract, as well as interpreter and transportation services, to the extent designated as covered in the Benefit Contract.

"Deductible" means the annual dollar amount of allowed charges for Covered Services, as specified in the Enrollee's Benefit Contract, that the Enrollee is required to pay as a precondition to payment by UCare.

"Enrollee" means any person who is enrolled in a UCare plan and who is therefore eligible for benefits under a Benefit Contract.

"Event of Default" means a breach which provides an immediate right of termination as specified under this Agreement.

"Medicaid" means the Medical Assistance Program under Title XIX of the Social Security Act established pursuant to 42 U.S.C. § 1396 *et seq*.

"Medical Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the physical or mental health of the Enrollee (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) continuation of severe pain; (3) serious impairment to bodily functions; (4) serious dysfunction of any bodily organ or part; or (5) death.

"Medically Necessary" or "Medical Necessity" means a health service that is consistent with the Enrollee's diagnosis or condition and: (1) is recognized as the prevailing standard or current practice by the provider's peer group; (2) is rendered in response to a life threatening condition or pain; or to treat an injury, illness or infection; to care for a mother and child through the

maternity period; or to treat a condition that could result in physical or mental function consistent with prevailing community standards for diagnosis or condition; or (3) is a preventive health service defined under Minnesota Rules, Part 9505.0355.

"Medicare" means the federal insurance program for aged and disabled people operated under 42 U.S.C. § 1395 *et seq*.

"Medicare Advantage Plan(s)" means a coordinated care plan offered pursuant to 42 U.S.C. § 1395w-21(a)(2)(A), including specialized Medicare Advantage Plans for special needs individuals ("Special Needs Plans").

"Network" means the network of Participating Providers available to Enrollees.

"Never Events" means Medicare non-reimbursable hospital acquired conditions that are reportable as adverse events, pursuant to Minnesota Statutes §144.7065 and applicable Medicare regulations.

"Participating Provider" means a provider of Covered Services, or other services as may be agreed upon in writing, that has a valid, signed contract with UCare and is eligible to provide in-network services to Enrollees.

"Primary Care" means a type of medical care delivery which emphasizes first contact care and assumes ongoing care and/or coordination for the Enrollee in both health maintenance and preventive care as well as management of chronic and acute illness. It is comprehensive in scope and includes appropriate referrals to specialty providers, community resources, all health care services and laboratory services customarily furnished by or through a general practitioner, family practice physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, or other licensed practitioner as authorized by the State in which Covered Services are to be provided, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

"Primary Care Clinic" means any clinic which is a Participating Provider, and which employs or contracts with Primary Care Providers.

"Primary Care Provider" means any provider who is employed by or under contract with Participating Provider who practices Primary Care, and who is professionally qualified in specialty organizations in one or more of the following disciplines: family medicine, general practitioner, pediatrics, internal medicine, geriatrics, obstetrics and gynecology.

"Professional" means any healthcare provider licensed or otherwise authorized by the state in which Covered Services are to be provided, transportation services provider, and qualified interpreter.

"Provider Communications" includes newsletters, alerts, and such other materials as may be made available to Providers on UCare's website.

"Provider Manual" includes any administrative manual made available to Participating Providers by UCare, specifying various administrative policies and procedures, including the Provider Manual at www.ucare.org, which may be amended by UCare from time to time.

"Service Authorization" means an approval by UCare or UCare's Agent that a particular service or treatment is Medically Necessary and that all appropriate, cost effective alternatives have been considered. Service Authorizations are required for specified services or treatment for claims to be processed for payment.

"Urgent Care" means acute, episodic medical services available on a 24-hour basis that are required in order to prevent a serious deterioration of the health of an Enrollee.

ARTICLE 2: APPLICABILITY

2.1 Products Covered Under this Agreement. This Agreement sets forth the rights, obligations, and duties of the Parties in connection with the furnishing of Covered Services to Enrollees enrolled in the products described in Exhibit A, and the conditions under which Covered Services shall be provided by Participant to such Enrollees.

ARTICLE 3: ELIGIBILITY FOR COVERED SERVICES

3.1 Identification Cards. UCare shall give Enrollees an identification card that shall contain the name of the Enrollee, his or her Enrollee number, and the specific product under which the Enrollee has obtained coverage.

3.2 Verification of Eligibility. Participant may verify the current status of the Enrollee's eligibility for Covered Services by requesting presentation by the Enrollee of his or her identification card, through the State of Minnesota's Electronic Verification System, or by contacting UCare. However, if UCare subsequently determines that the individual was not eligible for coverage for the services rendered, those services shall be ineligible for payment and could be subject to payment recovery by UCare. Obtaining a Service Authorization shall not mean that Participant is entitled to payment under this Agreement if the service is not a Covered Service or does not meet UCare's payment requirements.

3.3 Individuals Ineligible for Coverage. If UCare determines that the individual was not eligible for coverage for the services rendered and those services are ineligible for payment as described above, Participant may then directly bill the Enrollee for such services, if permitted by applicable state and federal rules and regulations. UCare shall reimburse Participant for Covered Services when Participant affirmatively verifies the Enrollee's eligibility by using the UCare-approved process for electronic eligibility in accordance with Minnesota Statutes § 62J.536, even if UCare subsequently determines that the individual was not eligible for coverage under a UCare product at the time such services were rendered.

ARTICLE 4: PARTICIPANT OBLIGATIONS

4.1 Scope of Covered Services. Participant shall provide to Enrollees the Covered Services of the type specified in Exhibit B and appropriate ancillary Covered Services related thereto, in accordance with professionally recognized standards of practice, in a manner so as to assure quality of care and treatment, and the terms and conditions of this Agreement and the Provider Manual. In the event Participant provides services which are not Covered Services or are not provided in accordance with this Agreement, UCare will not compensate Participant for such services without prior written approval by UCare. However, if prior written approval was gained by Participant based upon false, misleading, or misrepresented information, or if Participant

otherwise knew or should have known that the provided services are not Covered Services or are not provided in accordance with this Agreement, UCare is not responsible for payment and claims may be denied or recouped, despite prior written approval.

4.2 Provision of Services. Participant agrees that, to the extent feasible, the Covered Services provided by it shall be made available and accessible to Enrollees promptly and in a manner which assures continuity of care. In addition, Participant shall:

a) Not differentiate or discriminate in the treatment of its patients by reason of the fact that a certain portion of its patients are government programs Enrollees;
b) Provide services to Enrollees and accept all referrals of Enrollees in the same manner and within the same time availability as offered its other patients;
c) Not differentiate or discriminate in the treatment of Enrollees because of race, sex, color, creed, religion, health status, age, physical disability, national origin, public assistance status, ancestry, marital status or sexual orientation;
d) Provide Covered Services in a culturally competent manner to all Enrollees including those Enrollees with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds and physical and mental disabilities;
e) Admit all Enrollees to Participant's facilities in a manner similar to those provided to any other Participant patient;
f) Comply with all applicable statutes and regulations regarding accessibility and availability of health care services, including without limitation:
    i) Medical Emergency services shall be made available to Enrollees immediately, 24 hours per day, 7 days per week, either by treating the Enrollee at Participant's site or by directing the Enrollee to an appropriate care site, without requiring Service Authorization;
    ii) Urgent Care services shall be made available to Enrollees within 24 hours of the time services are requested either by treating the Enrollee at Participant's site or by directing the Enrollee to an appropriate care site;
g) Ensure that Covered Services are provided to Enrollees by trained Professionals acting within the scope of an appropriate license, certification, or registration;
h) Not withhold or delay Medically Necessary care that is otherwise covered by this Agreement if withholding or delaying such care adversely affects, or has a substantial likelihood of adversely affecting, Enrollee's health;
i) If Participant provides Primary Care services, not encourage Enrollees under its care to select a different Primary Care Provider due to Enrollee's health status, unless Participant is unable to adequately care for Enrollee;
j) Where applicable, inform Enrollees of follow-up care and provide training in self-care;
k) If available through Participant, provide direct access for Enrollees to mammography screening and influenza vaccinations;
l) If available through Participant, provide direct access for Enrollees to in-network women's health specialists for routine and preventive services; and
m) Not engage in fraud, waste, or abuse.

4.3 Referral and Authorization Requirements. Participant shall provide Enrollees with Covered Services in accordance with any referral or Service Authorization requirements described in the Provider Manual and on UCare's website. In the event Participant provides and/or coordinates Covered Services which require a referral or Service Authorization pursuant to the Provider Manual, but which have not been authorized by UCare or UCare's Agent, UCare will not

compensate Participant for such services. Pursuant to Minnesota Statutes § 62D.l2, subd. 19, UCare will not deny or limit coverage of the service which the Enrollee has received solely on the basis of lack of Service Authorization, to the extent that the service would otherwise have been covered by UCare had Service Authorization been obtained. Participant will not bill Enrollee for lack of compensation from UCare due to Participant's failure to obtain a required referral or Service Authorization. Written referrals or Service Authorizations are not required for obstetrical and gynecological services mandated through Minnesota Statutes § 62Q.52.

4.4 Medical Emergency. In cases of a Medical Emergency, Participant shall notify Enrollee's Primary Care Provider or the on-call physician prior to admission, if feasible. Participant shall make all reasonable efforts to ensure that Enrollees experiencing a Medical Emergency utilize a hospital's emergency department, and to divert or coordinate Enrollees who are not experiencing a Medical Emergency to utilize their Primary Care Provider or an Urgent Care provider.

4.5 Obligations and Duties. Participant shall be and remain subject to all of the same duties, liabilities, and responsibilities towards Enrollees as exist generally between a healthcare professional and a patient. Nothing in this Agreement shall limit or relieve Participant's duties to its patients.

4.6 Communications with Enrollees. Participant shall have the right and is encouraged to discuss with each Enrollee pertinent details regarding the diagnosis of such Enrollee's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment, regardless of benefit coverage limitations. Participant may discuss UCare's provider reimbursement method with an Enrollee, subject to Participant's general contractual and ethical obligations not to make false or misleading statements, to Participant's obligation under this Agreement to maintain the confidentiality of specific reimbursement rates paid by UCare to Participant and to Participant's agreement as a Participating Provider not to disparage UCare or to encourage Enrollees to disenroll in UCare.

4.7 Participant's Internal Operations. The operation and maintenance of the offices, facilities and equipment of Participant shall be solely under the control and supervision of Participant. Participant shall have sole control over the selection and supervision of its staff. UCare shall not control or be responsible for the medical opinions or treatment rendered by Participant.

4.8 Location of Facilities. On or prior to the Effective Date, Participant shall identify to UCare all locations where Covered Services of Participant are made available (or, in the case of transportation services, from which they are dispatched, and in the case of interpreter services, from which interpreter services are arranged and where records of services are maintained), as shown in **Exhibit C**. Information provided shall include the Participant's national provider identifier number (or Unique Minnesota Provider Identification Number, if applicable).

4.8.1 Notice of Changes to Facilities. Participant shall provide notice to UCare, not less than sixty (60) days prior to any site opening, closing, change of location or material reduction in services. UCare shall have the right to refuse to include any proposed location as a result of any transaction (including, without limitation, the foregoing transactions) under this Agreement by giving written notice to Participant within sixty (60) days of receiving such notice. Failure to notify UCare in a timely manner is a material breach of the terms

of this Agreement. In the event that Participant fails to provide appropriate notice pursuant to this section, UCare shall have the right to terminate this Agreement retroactive to the effective date of the change.

4.8.2 Payment Obligations. Participant shall not be entitled to payment hereunder for Covered Services provided at any location not approved of by UCare in accordance with this Section 4.8. Further, in the event that UCare approves of the addition of a location hereunder, UCare shall have the option of paying for services rendered at the new location under UCare's existing agreement with the provider(s) rendering services at that location (if any such agreement exists) or under this Agreement.

4.9 Service Exhibits. To the extent Participant provides Transportation Services, Participant shall comply with **Exhibit E**. To the extent Participant provides Interpreter Services, Participant shall comply with **Exhibit F**.

4.10 Notice of Changes of Ownership and Other Changes of Information. Participant shall provide sixty (60) days' prior written notice to UCare of any change in Participant's name, tax identification number, merger, acquisition, affiliation, or change in fifty percent (50%) or more of the ownership interests in Participant. Failure to notify UCare in a timely manner is a material breach of the terms of this Agreement. In the event that Participant fails to provide appropriate notice of a transaction pursuant to this section, UCare shall have the right to terminate this Agreement retroactive to the effective date of the transaction. In the event any such transaction results in a new legal entity, UCare has no obligation to assign this Agreement to such entity. In the event such a transaction leaves Participant or another UCare in-network provider as the surviving entity, UCare shall have the right to determine, in its sole discretion, whether Participant's or the other UCare in-network provider's agreement applies to the surviving entity.

ARTICLE 5: CONFIDENTIALITY AND RECORDS

5.1 Confidentiality. UCare and Participant shall safeguard an Enrollee's privacy and confidentiality of all information regarding Enrollees in accordance with all applicable Federal and State statutes and regulations, including the requirements established by UCare and each applicable product. In addition, Participant agrees to assure the accuracy of an Enrollee's medical, health and enrollment information and records, as applicable.

5.2 HIPAA Compliance. UCare and Participant agree that each shall be in compliance with the privacy and security standards of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d), including all applicable provisions of the federal privacy standards at 45 C.F.R. §§ 160-164. UCare and Participant also agree that they shall enter into a business associate agreement, as described in those regulations at 45 C.F.R. §164.504(e), if such an agreement is required, as reasonably determined by either Party.

5.3 Agreement Terms. Participant shall, and shall cause its agents and employees to, keep confidential the terms of this Agreement, including the reimbursement rates, during and after the term of this Agreement, except as required by law.

5.4 Collection and Retention of Information. Participant agrees to maintain records, as described in

those regulations at 42 C.F.R. § 422.504(d) and the contracts between UCare and the State of Minnesota governing products under this Agreement, pertaining to Covered Services provided under this Agreement for a period of at least ten (10) years following provision of services.

5.5 Right to Inspect: Release of Information to UCare. Participant agrees to provide to UCare, during the term of this Agreement and for a period of ten (10) years following the provision of services, access to all information and records, or copies of records, related to this Agreement or to Covered Services provided under this Agreement. Participant shall promptly provide, without charge to UCare, records or copies of records relating to this Agreement or to Enrollees as requested by UCare and shall cooperate in any UCare investigation or inquiry into Covered Services provided under this Agreement. Participant has no obligation to release records to the extent such release is unlawful.

5.6 Right to Inspect: Release of Information to Federal and State Agencies. Participant agrees to cooperate, assist, and provide information (in a manner consistent with State and Federal law, including those regulations at 42 C.F.R. § 422.504(i)(2), as requested by the U.S. Department of Health and Human Services, the Comptroller General, CMS, the Medicaid Fraud Control Unit of the Minnesota Attorney General's Office, the Minnesota Department of Health ("MDH"), the Minnesota Department of Human Services ("DHS"), the Minnesota Department of Commerce and/or their designees in any audit or inspection during this Agreement and for a period of ten (10) years following its termination or from the date of completion of any audit, whichever is later, without charge to UCare. With respect to UCare's Medicare Advantage Plans, Participant agrees to ensure that a contract with a "downstream entity" as defined by 42 C.F.R. § 422.2 requires the downstream entity to allow the U.S. Department of Health and Human Services, the Comptroller General, CMS or their designees the right to audit, evaluate, and inspect any books, contracts, and records, including medical records, of the downstream entity involving any transactions related to CMS contract(s) with UCare for Medicare Advantage Plans including special needs plans. Participant has no obligation to release records to the extent such release is unlawful.

5.7 Advance Directives. As set forth in 42 C.F.R. § 422.128(b)(1)(ii)(E), Participant shall prominently document in each Medicare Enrollee's medical record whether or not the Enrollee has executed an Advance Directive.

5.8 Data Practices. To the extent the Minnesota Data Practices Act is deemed to apply to data collected, created, received, maintained or disseminated by UCare or its subcontractors for any purpose in the course of performance of this Agreement, such data shall be governed by the terms of that Act, Minnesota Statutes, Chapter 13, and the rules adopted to implement the Act, as well as any other state and federal laws on data privacy. Participant agrees to comply with these statutes and rules currently in effect and as they may be amended.

5.9 Confidentiality of Substance Use Disorder Records. Participant represents, warrants and covenants that it has obtained (and, prior to disclosure, shall obtain) the required consent to disclose records of substance use disorder treatment protected under 42 C.F.R., Part 2 ("SUD Records"), to the extent SUD Records are provided or required to be provided to UCare under this Agreement, and that such consent does, or shall, permit UCare to use SUD Records for its payment and health care operations purposes. UCare acknowledges and agrees that, to the extent 42 C.F.R., Part 2 applies to its use or disclosure of any patient identifying information contained in SUD Records received hereunder, it is fully bound by the provisions of part 2 upon receipt of the patient

identifying information. UCare further acknowledges receipt of the following notice, in connection with SUD Records, and Participant agrees to provide the following notice, or any other notice required by law in connection with each such disclosure: "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65." UCare shall be permitted to re-disclose SUD Records to its agents, helping UCare provide services described in the Agreement, as long as the agent only further discloses the information contained in the SUD Records back to UCare.

ARTICLE 6: BILLING AND COMPENSATION

6.1 Payment. Participant shall accept as payment in full for Covered Services the reimbursement paid by UCare in accordance with Exhibit D of this Agreement. Other than in coordinating benefits with other payers, Participant shall not:

a) Hold Enrollees financially responsible;
b) Collect or attempt to collect from Enrollee's reimbursement for Covered Services except for Co-payments, Coinsurance, and Deductibles;
c) Collect or attempt to collect from Enrollees additional reimbursement for any service rendered by Participant that is ineligible for coverage under the Enrollee's Benefit Contract unless Participant informed the Enrollee, in writing, of the ineligibility of such service and obtained Enrollee's signed acknowledgement of such ineligibility and resultant responsibility to pay for such service prior to its delivery; or
d) Collect or attempt to collect from Enrollee's reimbursement for influenza, pneumococcal, hepatitis B, and any other vaccinations for which UCare is responsible for payment.

Participant shall hold UCare ultimately responsible for payment for authorized Medically Necessary Covered Services rendered to Enrollees, except for Co-payments, Coinsurance, and Deductibles related to Covered Services.

6.2 Enrollee Protection Provisions.

6.2.1 State of Minnesota Enrollee Protection Provision. The following provision is incorporated into this Agreement as required by Minnesota Statutes § 62D.123 as amended from time to time, understanding that "Provider" refers and applies to Participant:

PROVIDER AGREES NOT TO BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK REMUNERATION FROM, OR HAVE ANY RECOURSE AGAINST AN ENROLLEE OR PERSONS ACTING ON THEIR BEHALF FOR SERVICES PROVIDED UNDER THIS AGREEMENT. THIS PROVISION APPLIES TO BUT IS NOT LIMITED TO THE FOLLOWING EVENTS: (1) NONPAYMENT BY THE HEALTH MAINTENANCE ORGANIZATION OR (2)

BREACH OF THIS AGREEMENT. THIS PROVISION DOES NOT PROHIBIT THE PROVIDER FROM COLLECTING CO-PAYMENTS OR FEES FOR UNCOVERED SERVICES.

THIS PROVISION SURVIVES THE TERMINATION OF THIS AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THIS AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF THE HEALTH MAINTENANCE ORGANIZATION ENROLLEES. THIS PROVISION DOES NOT APPLY TO SERVICES PROVIDED AFTER THIS AGREEMENT TERMINATES.

THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN THE PROVIDER AND THE ENROLLEE OR PERSONS ACTING ON THEIR BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THIS AGREEMENT."

6.2.2 Medicare Enrollee Protection Provision. The following provisions are incorporated into this Agreement as required by 42 C.F.R. § 422.504(g)(1) and 42 C.F.R. § 422.504(i)(3)(i) as amended from time to time:

Participant is prohibited from holding an Enrollee liable for payment of any fees that are the legal obligation of UCare. Participant agrees that in no event, including but not limited to nonpayment by UCare, insolvency of UCare, or breach of this Agreement, shall Participant bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Enrollee or persons (other than UCare) acting on his/her behalf for services provided pursuant to this Agreement. This provision does not prohibit Participant from collecting Co-payments, Coinsurance, Deductibles, or charges for any services rendered by Participant that are ineligible for coverage. In addition, provided this Agreement has not been terminated, Participant shall continue to provide Enrollees with Covered Services through the duration of the contract period for which CMS premium payment has been made to UCare.

For Enrollees eligible to receive benefits under both Medicare and Medicaid, Participant shall not hold Enrollees liable for Medicare Parts A and B cost sharing when the State is responsible for paying such amounts. Participant shall accept UCare's payment as payment in full.

6.3 Billing Procedure. Participant shall submit to UCare all statements for Covered Services rendered by Participant to Enrollees under this Agreement, using complete statistical and descriptive medical and patient data for services provided. Unless otherwise directed by UCare in writing, Participant shall submit claims in accordance with the Provider Manual and Minnesota Statutes § 62J.536, including related regulatory guidance as amended from time to time, using current HCPCS, ICD, and CPT codes. Claims shall comply with all requirements of applicable law, this Agreement, and the Provider Manual. Participant shall certify that such statements accurately and completely reflect the services provided. Participant shall not bill the Enrollee for Covered Services in the event Participant fails to submit claims in accordance with the provisions of this Agreement.

6.4 Claims Submission Timeline. Participant shall submit to UCare, in a format approved by UCare and in compliance with state and federal law, claims for Covered Services no more than twelve (12) months from the date the Covered Services were rendered, or from the date Participant had knowledge of Enrollee's coverage under a UCare Benefit Contract, whichever is later. Claims submitted after such period shall be denied.

6.5 Payment of Claims. UCare shall pay Participant for timely filed claims for Covered Services in an amount determined in accordance with Exhibit D**,** less any applicable Co-payments, Coinsurance, and Deductibles. UCare shall make prompt payment of Clean Claims (unless pended for coordination of benefits or to investigate fraud or abuse) within thirty (30) days after receipt and shall comply with all applicable State and Federal statutes, rules, and regulations relating to reimbursement of claims. UCare has no obligation to reimburse claims for services which are not consistent with the terms for this Agreement or the Provider Manual. Specifically, and without limitation, UCare has no obligation to pay claims submitted by Participant and its practitioners for services until the Participant and its practitioners have successfully completed the credentialing process or for services during periods in which Participant and its practitioners were not appropriately licensed or enrolled in federal and state health care programs.

6.6 Payment Provisions Intent. The Parties acknowledge and agree that the intent of Exhibit D is to reflect increases and decreases in managed care premium rates to UCare from CMS and the DHS, regardless of the specific mechanism used by DHS or CMS to implement the change. Accordingly, unless UCare otherwise notifies Participant in writing, UCare will not apply a change in the reimbursement to Participant if: (a) DHS or CMS does not reflect the value of the fee-for-service change in managed care premium rates to UCare, or (b) the legislation otherwise specifically exempts health plans from applying the change to their payments to providers.

6.7 Corrective Adjustments. UCare shall have the right to make, and Participant shall have the right to request, corrective adjustments to any previous payment for, or denial of, a claim for Covered Services; provided, however, that any corrections by UCare or requests for corrective adjustments by Participant shall be made within twelve (12) months from the date the claim was paid or denied by UCare. For purposes of this section, such time limit shall not apply to adjustments initiated by UCare to address duplicate claims payments, payments for claims determined to be related to fraud or abuse, payment for medical errors, or payment for claims submitted in a manner contrary to this Agreement or applicable law and regulation. UCare may use random sample extrapolation, as described in Minnesota Rules 9505.2220, and other generally accepted statistical methods in calculating the amount of any correction or corrective adjustment.

6.8 Verification and Collection of Co-payments or Deductible. Participant shall not deny Covered Services to an Enrollee receiving Medical Assistance or MinnesotaCare because of the Enrollee's inability to pay the Co-payment or Deductible pursuant to 42 C.F.R. § 447.56, except as otherwise provided by applicable law or regulatory guidance. Notwithstanding the foregoing, and where not prohibited by applicable law, in the event that an Enrollee enrolled in any product other than Medical Assistance continuously fails to make payment of Co-payments or Deductibles after being provided reasonable opportunity to make such payment, Participant may choose not to provide Covered Services to such Enrollee. In all instances, Participant must not deny services to the Enrollee upon his or her first visit to the provider, must provide Enrollee advance notice of Participant's debt policy, and must allow the Enrollee a reasonable opportunity to make payment on any outstanding debt. Participant is prohibited from routinely waiving Enrollee liability amounts.

6.9 Insurance Coordination and Subrogation. Participant shall make a good faith effort to secure information on the sources of third-party coverage available to an Enrollee for whom Participant provides Covered Services and shall forward such information to UCare. Participant agrees to coordinate benefits with other payers in accordance with industry and Medicare standards and procedures, and to submit copies of all bills coordinated with other payers to UCare upon UCare's request. Participant shall cooperate with UCare in connection with UCare's subrogation and coordination of benefits activities.

If UCare has primary financial responsibility for Covered Services, UCare shall pay Participant an amount determined in accordance with the payment terms of this Agreement without regard to payments to be made to Participant by such other payer. If UCare has secondary financial responsibility for Covered Services, UCare shall pay Participant, after receipt by Participant of payment from the primary payer, an amount equal to the payment that UCare would have paid to Participant under the payment terms of this Agreement had UCare been the primary payer, less any amounts paid to Participant by the primary payer.

Without limiting the foregoing, with respect to Enrollees in state public health care programs, Participant must return any third party payments for Covered Services to UCare if Participant received such third party payment more than eight (8) months after the date the claim was adjudicated, or such other period as set forth in Minnesota law or regulation or the contracts between UCare and the State of Minnesota governing products under this Agreement, in order to enable UCare to return the payment to the State of Minnesota.

6.10 Risk Adjustment Data. With respect to UCare's Medicare Advantage plans and to the extent applicable to Covered Services provided by Participant, Participant shall cooperate with UCare to ensure compliance with 42 C.F.R. § 422.310 as amended from time to time, and, as a condition of payment by UCare for Covered Services, Participant shall submit complete and accurate risk adjustment data as required by CMS, including complete and accurate diagnosis codes on claims for payment. Such data shall be supported by Participant's medical records in accordance with CMS documentation standards. Participant shall timely submit medical records or other information requested by UCare, CMS or their subcontractors for the validation of risk adjustment data in accordance with 42 C.F.R. § 422.310(e). If UCare coordinates, provides or identifies training or education addressing the submission of risk adjustment data and related medical record support, Participant shall ensure that its practitioners and staff involved in recording diagnoses in medical records and submitting diagnoses codes in claims participate in such training or education as reasonably requested by UCare. If CMS seeks recovery of overpayments from UCare resulting from Participant's submission of diagnosis data which did not meet applicable CMS requirements or if a UCare audit identifies such data as non-compliant, the Parties agree that Participant shall pay UCare the penalty and that they shall work together to identify any additional amounts due to UCare from Participant based on the amount or proportion of Participant's data and medical records that CMS or UCare determined were non-compliant. Evidence of CMS' findings or UCare audit findings will be shared with Participant, identifying the diagnosis codes submitted but not substantiated by Participant's medical records that created the overpayment.

6.11 No Payment for Medical Errors. Participant shall not bill UCare for medical errors, or "never events," in accordance with CMS' Medicare coverage guidelines or Medicaid standards as they may be amended from time to time. Participant shall notify UCare if a medical error has occurred

related to a claim that has been paid so that UCare can make the appropriate adjustment. UCare shall not reimburse Participant for medical errors and shall follow CMS coverage guidelines in determining whether denial or recovery of payment is warranted.

6.12 Suspension of Payments. Except when UCare has good cause, as described below, UCare must suspend all state public health care program payments to Participant after the following:

a) DHS has notified UCare that it has suspended all Medical Assistance, or Medicaid, payments to Participant based on a determination there is a credible allegation of fraud against Participant for which an investigation of payments made under the Medicaid program is pending; or
b) UCare determines there is a credible allegation of fraud against Participant for which an investigation is pending under a state public health care program.

The suspension of payments under this paragraph will be temporary and will not continue after either of the following:

a) DHS or UCare or the prosecuting authorities determine there is insufficient evidence of fraud by Participant and DHS or UCare has notified Participant of the lack of evidence; or
b) Legal proceedings related to Participant's alleged fraud are completed.

UCare may find good cause exists not to suspend payments, not to continue a payment suspension previously imposed, or to suspend payment only in part if any of the provisions of 42 C.F.R. § 455.23(e) or (f) are applicable. For purposes of implementing a good cause exception under the provisions of 42 C.F.R. § 455.23(e) and (f), "UCare" determinations shall be substituted for "State" determinations.

For purposes of a payment suspension, "credible allegation of fraud" means an allegation which has been verified by DHS or another state or federal agency, or by UCare, from any source, and which has indicia of reliability. To effectuate the payment suspension, UCare may suspend participation of Participant in UCare's Network and restrict Enrollees' access to Participant's services. Suspension under this section is not subject to Section 10.4 Dispute Resolution.

ARTICLE 7: QUALITY ASSURANCE AND UTILIZATION MANAGEMENT AND EVALUATION

7.1 Services Review and Evaluation. Participant agrees to cooperate fully with, participate in, and abide by UCare's decisions concerning any reasonable programs, such as quality assurance review, utilization management, and peer review, that may be established from time to time by, at the direction of, or in cooperation with UCare to promote the provision of high-quality Covered Services to Enrollees and to monitor and control the quality, utilization and cost of Covered Services rendered to Enrollees by Participant. Participant further agrees to cooperate, as may be reasonably requested by UCare, with any independent organization or entity contracted by UCare to provide quality review, utilization review, or quality improvement activities related to Covered Services provided under this Agreement. Participant shall make available to UCare all information pertaining to Enrollees reasonably requested by UCare in connection with each such review or program.

7.2 Reports and Data. Participant agrees to furnish UCare with any reports or data concerning the services provided by Participant to Enrollees as UCare may reasonably require and in such form

as UCare shall reasonably designate. Such data and reports shall be accurate, provided at Participant's expense and by a date determined by UCare after consultation with Participant. Participant shall report to UCare credible information about fraud, waste and abuse related to services provided to Enrollees, as required by CMS and DHS. Participant acknowledges that Enrollees consent to such disclosures upon enrollment and shall not require UCare to obtain additional consents and releases from Enrollees prior to providing such data and reports to UCare. The chief executive officer of Participant, the chief financial officer, or an individual delegated the authority to sign on behalf of one of these officers, shall certify from time to time, as requested by UCare, in accordance with 42 C.F.R. § 422.504(l)(3) that the encounter data and other data supplied by Participant (based on their best knowledge, information and belief) are accurate, complete and truthful.

7.3 Complaints, Appeals and Grievances. Participant shall cooperate with UCare's Enrollee complaint system and procedures as described in the Enrollee's Benefit Contract. Participant shall designate a person with appropriate authority to be responsible for cooperating with UCare in the handling and resolution of all complaints, appeals, and grievances. Participant shall cooperate in providing information and access to documents and Participant's personnel in conjunction with any UCare investigation or inquiry. If requested by UCare, Participant shall conduct a thorough internal investigation and take appropriate remedial action to address complaints, appeals and grievances that involve any Participant Professionals or other staff. Such an investigation must be conducted as soon as practicable, but, in any event no longer than five (5) business days after UCare notifies Participant of an issue. In the event of serious allegations, such as sexual harassment, unsafe behavior or significant member safety concerns, the involved Professionals may not provide Covered Services under this Agreement during the period in which the allegation is being investigated. Participant shall adhere to the applicable state and federal appeals and expedited appeals procedures, including gathering and forwarding to UCare information regarding such appeals in accordance with the procedure described in the Provider Manual. Participant shall inform UCare of all material complaints, appeals, and grievances filed with Participant that are related to Participant's delivery of Covered Services. Participant shall cooperate with and participate in UCare's dispute resolution process, shall comply with UCare's requirements (as described in the Provider Manual) related to resolution of service denials or reductions, and shall assist UCare in resolving complaints, appeals, and grievances, as reasonably requested by UCare.

7.4 Medical Error Detection and Reduction. Participant shall develop and implement patient safety policies to systemically reduce medical errors. Such policies shall include systems for identifying and reporting errors and processes to discover and implement error-reducing technologies.

7.5 Review, Performance, and Service Improvement Programs. Participant shall be subject to and comply fully with all reasonable protocols established or modified from time to time by UCare with respect to the provision of Covered Services to Enrollees, including, without limitation:

a) Protocols related to coverage policies, quality assurance, and utilization management;
b) Protocols and procedures as set forth in the Provider Manual or other protocols and procedures disseminated to Participant;
c) Protocols and procedures related to UCare's surveys of Participant's sites;
d) Protocols and procedures to identify assess and establish treatment plans for Enrollees who have complex or serious medical conditions; and
e) Protocols and procedures to use patient-centered decision-making tools designed to engage Enrollees early in the decision-making process.

In the event UCare modifies these programs following the Effective Date of this Agreement, UCare shall communicate such changes to Participant prior to their adoption and permit Participant thirty (30) days to comply with such additional or revised programs, unless a longer period of time is agreed upon by the Parties. UCare may modify these programs through the Provider Manual, Provider Communications, or by communicating directly with Participant in writing. Participant is responsible to sign up to receive changes to the Provider Manual, Provider Communications, and other UCare communications, and to review and understand such changes. Continued failure to comply with any protocol, procedure, term of the Provider Manual, or term of this Agreement may result in loss of reimbursement to Participant and/or termination of the Agreement.

7.6 Performance Data. Participant agrees to allow UCare to use data regarding performance by Participant, including its practitioners, for purposes as permitted by law, including but not limited to quality improvement activities, public reporting to consumers, and designation as a preferred or tiered network.

7.7 Off-Shore Services. If Participant or any subcontractor of Participant performs or intends to perform any activities pursuant to this Agreement outside the territory of the United States of America or to send information regarding UCare members outside of such territory ("Off-Shore Services"), Participant must obtain the prior written consent of UCare's Chief Legal Officer or his or her designee. If UCare gives consent to Participant, or any subcontractor of Participant, to provide Off-Shore Services, UCare reserves the right to revoke such consent in its reasonable discretion, or if UCare is required to do so due to any regulatory or other legal requirements.

ARTICLE 8: LICENSURE STATUS, CREDENTIALING, AND COMPLIANCE

8.1 Licensure Status. Participant agrees to ensure that its employed and contracted physicians, other Professionals, and facilities will maintain, without material restriction, all federal, state, and local licenses and permits required to provide Covered Services under this Agreement. Participant also agrees to notify UCare in writing within ten (10) days of any of the following:

a) Anticipated or actual material change in the capability of its physicians, its Professionals, or facilities to provide Covered Services under this Agreement;
b) Restriction, termination, stipulation, suspension, qualification, surrender, loss or limitation of licensure (including, in the case of transportation providers, loss of a driver's license or insurance), registration, certification, medical staff privileges at any health care facility, interpreter privileges at any health care facility or health plan or other disciplinary actions regarding the license;
c) Disciplinary action, corrective action plan or investigation regarding Participant's or any Professional's license, certification, medical staff privileges at any health care facility, or interpreter privileges at any health care facility or health plan;
d) Change in participation status with Medicare, Medicaid or any Minnesota state health care program of any Professional(s) providing services under this Agreement or employed by Participant;
e) The filing of any legal action, excluding medical malpractice actions, against Participant or any of its employed or contracted physicians, other Professionals, or facilities;
f) Participant's, employed or contracted physicians, or other Professionals' conviction of a crime, excluding misdemeanors;
g) Any judicial or regulatory finding that Participant or any of its employed or contracted

physicians, other Professionals, or facilities, is liable for the death of a patient, passenger, or resident or has engaged in the maltreatment of a child or vulnerable adult;

h) The revocation, conditioning, restriction, denial, suspension, voluntary surrender, or other adverse action involving any of Participant's facilities' licenses, accreditations, certifications, or provider enrollments;

i) The assessment of any penalty or fine against, or the institution of any investigation involving, Participant by a governmental entity, including, without limitation, the Medicare program (or any of its private contractors), or any Medicaid program (or any of their private contractors);

j) Any third-party payer's revocation, reduction, denial, suspension, or other adverse action taken against Participant's network participating due to inappropriate utilization management or quality of care issues; and

k) Any other failure of Participant or any of its Professionals to meet the requirements of section 8.2 or other competency requirements set forth in this Agreement or an Exhibit hereto.

Failure to notify UCare in a timely manner is a material breach of the terms of this Agreement.

8.2 Credentialing. Participant and its Professionals shall be subject to and comply with UCare's applicable credentialing requirements as specified in the Provider Manual. UCare shall furnish to Participant notice of any change or addition to the credentialing requirements, including the nature of any such changes or additions, prior to the effective date of such changes or additions.

8.2.1 As specified in UCare's credentialing requirements, Participant shall demonstrate to UCare upon UCare's request, at minimum, that:

a) Each of its physicians has a current and unencumbered license to practice medicine in each state in which he or she practices;

b) Each of its non-physician Professionals who must be credentialed (as described in the Provider Manual) is appropriately licensed, registered, or certified, without restrictions, in each state in which he or she furnishes services;

c) Its physicians have current and unencumbered Drug Enforcement Agency (DEA) numbers;

d) It is not and will not during the term of this Agreement become a party to any exclusive agreement which, by its terms, precludes Participant or any Professional from rendering Covered Services hereunder; and

e) It and its Professionals have never been convicted of fraud in regard to the United States Internal Revenue Service or any state tax agency.

8.2.2 If appropriate, Participant shall further demonstrate to the satisfaction of UCare that its physicians are certified to practice in their respective medical specialty by the appropriate medical specialty board or other nationally recognized organization or are otherwise qualified to provide Covered Services pursuant to this Agreement.

8.2.3 A physician or other Professional employed by or under contract with Participant who is not yet credentialed by UCare, but who must be credentialed (as described in the Provider Manual), shall not provide services to Enrollees; however, this Agreement shall continue to be in effect for all physicians and other Professionals employed by or under contract with Participant who are and remain so credentialed.

8.3 Certification. Participant warrants that its contracted and employed providers are currently certified as providers under Title XVIII and Part A of Title XI of the Social Security Act (Medicare), and certified in accordance with the regulations governing participation of providers in the Medical Assistance Program under Title XIX of the Social Security Act (Medicaid) and that it will endeavor to maintain said certifications during the term of this Agreement. In the event any action is taken against a provider to revoke or suspend such certification, Participant shall, immediately upon learning of such action or the possibility of such action, give notice to UCare. Pursuant to 42 C.F.R. § 422.204, Participating Providers that are "providers of services" under Section 1861(u) of the Social Security Act must have a provider agreement with CMS permitting them to provide services under original Medicare.

8.4 Compliance with State and Federal Laws. Participant agrees to comply fully with all applicable state and federal statutes, rules, and regulations pertaining to the delivery of Covered Services, including but not limited to:

a) Medicare laws, regulations, and CMS instructions, as well as UCare's contractual obligations with CMS as applicable;
b) At minimum, quarterly updates to demographic data, as required by the Medicare Managed Care Manual;
c) DHS, MDH, Minnesota Department of Commerce and other Minnesota state laws, rules, regulations and instructions;
d) All state and federal laws applicable to entities which receive federal funds, including but not limited to the Stark Law set forth under 42 U.S.C. § 1395nn, and 42 C.F.R. § 411.350 through § 411.389, the federal Anti-Kickback Law set forth under 42 U.S.C. § 1320a-7b and related regulations, and the federal False Claims Act set forth under 42 U.S.C. § 3729 and related regulations;
e) Applicable provisions of contracts between UCare and the State of Minnesota governing products under this Agreement which have been communicated to Participant; and
f) All applicable laws and regulations promulgated under Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Americans with Disabilities Act.

8.5 Oversight. Participant acknowledges that UCare oversees and is accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations and shall cooperate with UCare's oversight efforts. To the extent UCare delegates any functions, it shall comply with the Medicare Advantage delegation regulatory requirements, as amended from time to time. UCare shall only delegate activities or functions to Participant pursuant to a written delegation agreement in compliance with 42 C.F.R. § 422.504(i)(3) and (4).

8.6 Fraud, Waste and Abuse. Participant shall cooperate with UCare as part of its investigative process and prevention efforts pertaining to fraud, waste and abuse, including participating, and requiring Participant's staff to participate, in such training coordinated or designated by UCare. Participant hereby attests and acknowledges that it has a compliance program which addresses fraud, waste and abuse (including but not limited to the federal laws described in Section 8.4(d) above) and includes training of employees and of contractors on a regular basis, but in no event less than annually. The chief executive officer of Participant, the chief financial officer, or an individual delegated the authority to sign on behalf of one of these officers, shall certify, when requested by UCare, that Participant is in compliance with all fraud, waste and abuse requirements and that all Participant staff have completed training on fraud, waste and abuse in accordance with this section. Participant shall document that training on fraud, waste and abuse has occurred in

accordance with this section, and promptly provide UCare evidence of such training upon UCare's request. For purposes of this section, the term "fraud" includes, without limitation, the definition set forth in Minnesota Rules, Part 9505.2165, subpart 4 and in the Medicare Managed Care Manual Chapter 21, section 20.

8.7 Physician Incentive Arrangements. Participant agrees that for Covered Services provided under this Agreement it does not, and will not without the prior written consent of UCare, enter into contracted relationships with any physician or "physician group," as that term is defined in 42 C.F.R. § 422.208, or any intermediate entity that contracts with any physician or physician group, which places physicians at "substantial financial risk," as that term is defined in 42 C.F.R. § 422.208, for services Participant does not furnish. In addition, Participant shall disclose to UCare, on an annual basis, the following information regarding any "physician incentive plans" (as that term is defined in 42 C.F.R. § 422.208 and used in 42 C.F.R. §§ 438.3(i) and 422.210) to which Participant or its approved subcontractors is a party, and shall comply with the following requirements: (1) The physician/physician group for which risk has been transferred for services not furnished by the physician/physician group, such as referral services; (2) The type of incentive arrangement such as withhold, bonus or capitation associated with the transfer of risk for the physician/physician group; (3) The percent of the potential payment to the physician/physician group that is at risk for referrals; (4) The panel size, and if patients are pooled, the pooling method used to determine if substantial financial risk (SFR) exists for the physician/physician group; (5) If SFR exists, Participant must provide an assurance that the physician or physician group at SFR has adequate stop-loss protection, including the threshold amounts for individual/professional, institutional, or combination for all services, and the type of coverage (for example, per member per year or aggregate); and (6) If the Participant has Physician Incentive Plans that place physicians or physician groups at SFR for the cost of referral services it must cooperate with UCare in conducting Enrollee surveys and provide a summary of the survey results, consistent with 42 CFR §§438.3(i), 422.208, and 417.479(h) and 417.479(g)(1).

8.8 Exclusion from Federal Health Care Programs. Participant agrees that it shall monitor the list of individuals and entities excluded from participating in the Medicare and Medicaid programs which is maintained by the HHS-OIG, as well as the Preclusion List maintained by CMS, and ensure that it does not employ or contract with individuals or entities which Participant knows or should know are or become excluded from participation in federal health care programs under § 1128 or § 1128A of the Social Security Act or that appear on the Preclusion List. If any contracted provider, subcontractor, employee or owner becomes excluded or appears on the Preclusion List, Participant shall take corrective action and make a report to UCare within 24 hours of learning of the exclusion or appearance on the Preclusion List. Participant agrees to not employ or contract with any entity or individual who is excluded or appears on the Preclusion List, subsequently becomes excluded or appears on the Preclusion List, or, to the best of Participant's knowledge, is in the process of becoming excluded, from participation in any federal health care benefit or government procurement program, including but not limited to federal health care programs under § 1128 or § 1128A of the Social Security Act or that appear on the Preclusion List. Participant agrees not to employ or contract with any individual who has been convicted of a criminal offense related to their involvement in Medicaid, Medicare, or social service programs under Title XX of the Social Security Act or who is listed on the Office of Foreign Assets Control Specially Designated Nationals List.

Participant agrees to search monthly the OIG List of Excluded Individuals Entities (LEIE), the Excluded Parties List System (EPLS, within the HHS System for Awards Management) database, the Office of Foreign Assets Control Specially Designated Nationals List, the Minnesota Department of Human Services Excluded Providers List, as well as the Preclusion List maintained by CMS and the UCare list of prohibited individuals, to determine the status of any person with an ownership or control interest and all officers, directors, employees, contractors and Subcontractors of Participant. If the foregoing databases indicate an individual or entity described above is excluded or appears on the Preclusion List, Participant shall immediately inform UCare and ensure that such individual or entity is not providing Services under this Agreement. Participant shall report to UCare immediately any information that Participant knows or should know regarding individuals or entities specified above or who have been convicted of a criminal offense related to their involvement with any federal program or who have been excluded or precluded from participation in Medicare or Medicaid under § 1128 or § 1128A of the Social Security Act or from participation in Minnesota state health care programs or who otherwise appear on the above-referenced lists. Participant shall immediately inform UCare in the event that Participant is sanctioned by a state or federal agency in connection with participation in any such program or in the event of a change in its participation status. Participant represents and warrants that neither Participant nor any of its Interpreters have ever been convicted of fraud in regard to the United States Internal Revenue Service or any state tax agency.

8.9 Lobbying Disclosure. Participant certifies that federally appropriated funds are not and have not been expended by or on behalf of Participant to pay for any person for influencing or attempting to influence an officer or employee of any federal agency or any member or employee of the U.S. Congress in connection with the awarding of a federal contract, grant, loan, or cooperative agreement, or the renewal or modification thereof. If funds other than federally appropriated funds have been or will be paid for any activity described by the preceding sentence, Participant shall complete and submit the Standard Form LLL "Disclosure of Lobbying Activities" in accordance with its instructions.

8.10 Attestation of Compliance with CMS Requirements for "Downstream" Contracts. If Participant subcontracts with providers and entities ("Subcontractors") to provide services to Medicare Advantage Plan Enrollees, such subcontracts must contain provisions that are consistent with the below CMS requirements. Participant shall provide UCare with copies of the subcontracts upon UCare's request, to confirm compliance, as follows:

a) Subcontractor agrees to safeguard an Enrollee's privacy and confidentiality, consistent with all State and Federal laws (including requirements from UCare necessary for compliance), and to assure the accuracy of an Enrollee's medical, health and enrollment information; and records, as applicable;
b) Subcontractor shall hold Enrollees harmless for payment of fees that are the legal obligation of UCare. In addition, provided this Agreement has not been terminated, Subcontractor shall continue to provide any Medicare Advantage Enrollee with Covered Services through the duration of the contract period for which CMS premium payment has been made to UCare. Furthermore, in the event an Enrollee is hospitalized on the date of termination of UCare's contract with CMS or in the event of UCare's insolvency, Subcontractor shall continue to provide the Enrollee Covered Services until the Enrollee is discharged;
c) Subcontractor agrees to maintain records pertaining to Covered Services provided under the

agreement for a period of at least ten (10) years following provision of services, and agrees to allow the U.S. Department of Health and Human Services, the Comptroller General, or their designees the right to audit, evaluate, and inspect any books, contracts, and records, including medical records, of the Subcontractor involving any transactions related to CMS' contract(s) with UCare for Medicare Advantage plans including special needs plans, during the Agreement and for a period of ten (10) years following its termination or from the date of completion of any audit, whichever is later;

d) Subcontractor acknowledges that UCare oversees and is accountable to CMS for any functions and responsibilities described in Medicare Advantage regulations, and Subcontractor agrees to comply with Medicare laws, regulations, and CMS instructions, as well as provide services consistent with and comply with UCare's contractual obligations with CMS;

e) Subcontractor shall comply with all protocols and procedures established or modified from time to time by UCare with respect to Covered Services provided to Enrollees, including but not limited to the UCare Provider Manual;

f) Any function delegated by UCare to Participant under this Agreement that is further delegated by Subcontractor to another person or entity must be pursuant to a written agreement that complies with 42 C.F.R. § 422.504(i)(4); and

g) Subcontractor acknowledges that UCare or its Agent agrees to make reimbursement within thirty (30) days after receipt of a Clean Claim, using any forms approved by UCare.

8.11 Ownership Disclosures. Participant shall disclose to UCare ownership information in accordance with 42 C.F.R. § 455.104 and as required by DHS, and in a manner and frequency as required by UCare.

ARTICLE 9: INSURANCE AND INDEMNIFICATION

9.1 Participant Insurance. Participant shall procure and maintain throughout the term of this Agreement, at Participant's sole cost and expense, liability insurance as described herein. The coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Service is provided. Liability insurance shall be, at minimum, of the types and in the amounts set forth in the table below. Medical malpractice insurance shall be either occurrence or claims made with an extended period reporting option. Participant shall provide to UCare within ten (10) days of UCare's request evidence of initial and continued compliance with the provisions of this section.

To the extent Participant's insurance policies are issued on a claims-made basis, Participant agrees to maintain the insurance policies described in this section for six (6) years following termination of this Agreement.

Type of Insurance	**Minimum Limits**
Medical malpractice and/ or professional liability insurance	One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate
Commercial general and/or umbrella liability insurance	One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate

9.2 Participant Hold Harmless. Participant shall indemnify, defend and hold UCare harmless from any third-party claims, liabilities, losses, demands and costs and expenses of any kind, including reasonable attorney's fees, regulatory penalties, and payment recoveries by government agencies, which UCare may hereafter incur, sustain or be required to pay by reason of any negligent act or omission, breach of this Agreement, violation of third-party intellectual property rights, violation of any applicable law or regulation, or any intentional misconduct of Participant or of any servant, agent, physician, employee, contractor or staff member of Participant.

ARTICLE 10: TERM AND TERMINATION

10.1 Term. The term of this Agreement shall commence on the Effective Date of this Agreement and shall continue until terminated in accordance with the terms of this Agreement.

10.2 Termination. This Agreement may be terminated by the mutual agreement of the Parties or as follows:

10.2.1 Termination by UCare Upon Event of Default. This Agreement may be terminated by UCare upon written notice to Participant, with such termination effective as described in this section, upon the occurrence of an Event of Default by Participant hereunder. Each of the following shall constitute an Event of Default by Participant and termination may occur as follows:

a) Effective immediately, upon Participant's suspension or exclusion from participation in federal or state health care programs (including appearance on the CMS Preclusion List);
b) Effective immediately, upon a determination by UCare that the health, safety, or welfare of one or more Enrollees is in immediate jeopardy if the Agreement is continued;
c) Effective immediately, upon any material impairment of Participant's ability to perform under this Agreement;
d) Effective immediately, if Participant fails to comply with any term of Article 8 (Licensure Status, Credentialing, and Compliance), fails to maintain an insurance program as described in Section 9.1 (Participant Insurance) or fails to make required ownership disclosures as described in Section 8.11 (Ownership Disclosures);
e) Effective immediately, if Participant fails to comply with any federal or state law;
f) Effective immediately, if Participant becomes insolvent, is adjudicated as bankrupt or has a receiver appointed or makes a general assignment for the benefit of creditors;
g) Effective immediately, upon a determination by UCare based on reliable evidence that Participant has made any untrue statements of material fact or any intentional misrepresentation of any fact, whether or not material, in any claim for payment, or any application form, survey, questionnaire or statement provided to UCare;
h) Effective immediately, upon a reasonable belief by UCare that Participant is engaged in fraud or abuse with regard to the provision of Covered Services under

this Agreement. This reasonable belief may be, but is not required to be, based upon the finding of a state or federal government agency, the Medicaid Fraud Control Unit, a court of law, or other legal entity that Participant is or has been engaged in fraud or abuse with regard to Covered Services provided under this Agreement or similar services;

i) Effective no less than thirty (30) days following notice, if a change occurs in Participant's affiliations, staff privileges, or specialty status in such a way as to substantially limit Participant's range of services or access to participating hospitals;

j) Effective no less than thirty (30) days following notice, if one or more of Participant's Professionals or other personnel is (i) suspended or excluded from the federal or state health care programs (including appearance on the Preclusion List), (ii) indicted or convicted for a felony or any criminal charge relating to the practice of medicine or to providing health care services or other services covered by government programs, or (iii) the subject of disciplinary action by an applicable board, another health plan, insurance company, government entity, or a hospital (including any limitations on the Professional's registration, license, participation status or staff privileges), provided that UCare may, in addition to or in lieu of terminating this Agreement, terminate such Professional's authority to provide Covered Services under this Agreement, effective immediately upon notice thereof; or

k) Effective on the timelines set forth above, if UCare's participation or services agreement with any entity related to Participant (defined as an entity sharing a managing employee, owner, officer or director with Participant) is subject to contract termination by UCare on any of the above bases or for breach in accordance with Section 10.2.3 below.

10.2.2 Termination by Participant upon Event of Default. This Agreement may be terminated by Participant immediately upon written notice to UCare upon the occurrence of an Event of Default by UCare hereunder. Each of the following shall constitute an Event of Default by UCare:

a) Revocation of any certification or license of UCare necessary for performance of this Agreement; or

b) UCare becomes insolvent, is adjudicated as bankrupt or has a receiver appointed or makes a general assignment for the benefit of creditors.

10.2.3 Breach. Except as otherwise permitted upon an Event of Default as defined above, either Party shall have the right to terminate this Agreement in the event of the other Party's material breach of a provision of this Agreement or the terms of the Provider Manual, which are incorporated herein by reference, in accordance with this section. The Party alleging the breach shall provide the other Party with detailed notice of the alleged breach and of its intent to terminate the Agreement in the event the breach is not cured within a specified reasonable time period, which shall not be less than thirty (30) days. In the event that the breach is not cured within such time frame, then this Agreement shall terminate as provided in the notice provided by the terminating Party. The non-breaching Party may terminate this Agreement immediately upon written notice, without providing the breaching Party an opportunity to cure the material breach, if the material breach is of the same type as described in a prior written notice sent, pursuant to this section and within the twelve (12) months prior to the current breach, by the non-breaching Party to

the breaching Party regarding a breach that was previously cured.

10.2.4 Termination Without Cause. This Agreement may be terminated by UCare or Participant, without cause in accordance with this paragraph, by providing the other Party with written notice of its intent to terminate. Such notice must specify the termination date. The termination date must be the last day of a month and must be a date that is at least one hundred twenty-five (125) days after written notice is given. Unless otherwise terminated pursuant to this Section 10.2, such termination shall be effective only on the termination date.

10.2.5 Termination of Subcontracts. In the event Participant has subcontracted with other providers or entities to provide Covered Services under this Agreement, any termination of this Agreement shall also apply to those providers or entities for Covered Services provided under this Agreement.

10.3 Rights and Obligations. The rights and obligations of each Party to this Agreement shall continue through the termination date hereof. Each Party will remain liable for any obligations or liabilities arising from activities undertaken prior to the effective date of termination.

10.3.1 Notice to Enrollees. Upon notice of termination of this Agreement, UCare and Participant each shall have the right to give notice of that termination to Enrollees to the extent and in the manner required by applicable law and the Provider Manual. UCare and Participant each shall cooperate with the other in providing such notification, and Participant shall cooperate with UCare in transferring to other Participating Providers all Enrollees then under Participant's care, effective no later than the termination of this Agreement.

10.3.2 Continuation of Covered Services. Upon termination of this Agreement, Participant shall, as required by 42 C.F.R. § 422.504(g)(2), continue to provide Covered Services for Enrollees for the duration of the contract period for which CMS had made payments to UCare. For Enrollees who are hospitalized on the date the CMS contract terminates, or in the event of UCare's insolvency, Participant shall provide Covered Services through the date of discharge of the Enrollee. In certain cases, Participant may be required to continue providing Covered Services to Enrollees for up to one hundred and twenty (120) days or for a longer period of time, in accordance with Minnesota Statutes § 62Q.56, subd. 1(a). For such continued care, UCare shall compensate Participant under the terms of this Agreement with respect to otherwise Covered Services rendered by Participant to the Enrollee.

10.3.3 Upon termination of this Agreement, Participant will immediately discontinue use of any and all signs, plaques, letterheads, forms, or other materials identifying Participant as a UCare Participating Provider.

10.4 Dispute Resolution. Any dispute arising out of or related to this Agreement shall be settled in accordance with this section or as otherwise required by law. Nothing in this section shall prohibit a Party from terminating this Agreement pursuant to its terms.

10.4.1 If any dispute develops that is subject to UCare's credentialing plan, policies and procedures, it will be handled in accordance with UCare's credentialing plan, policies and procedures. If any other dispute develops between the Parties relating to this Agreement, the Parties shall each appoint a key contact to meet and negotiate in good faith in an attempt to resolve it. If the dispute remains unresolved for thirty (30) days, either party may bring litigation against the other, or the parties may mutually agree to any form of binding or non-binding alternative dispute resolution.

10.4.2 Nothing in this section will limit a Party from bringing an action in any court of competent jurisdiction for injunctive or other equitable relief as a Party deems necessary or appropriate to stop the conduct or threatened conduct of the other Party. In addition, if a Party to this Agreement is named as a defendant in a third-party lawsuit, claims for contribution or indemnification against the other Party hereto may be brought in the third-party litigation.

ARTICLE 11: MISCELLANEOUS

11.1 Notice. All notices, communications, payments, and other documents required or permitted hereunder shall be in writing. Such notices shall be given: (i) by delivery in person; (ii) by courier service; (iii) by certified mail, postage prepaid, return receipt requested; (iv) by facsimile; or (v) by electronic mail addressed to the recipient at the address shown in the signature block to this Agreement, or to such other addresses as may be provided by either Party to the other.

Notices given shall be effective upon (i) receipt by the Party to which notice is given, or (ii) three (3) days following mailing, whichever occurs first.

11.2 Relationship of Parties. The relationship between the Parties hereto is that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither of the Parties hereto, nor any of their respective employees, shall be construed to be the agent, employee or representative of the other. Further, this Agreement shall not be construed to create a partnership, joint venture or like relationship between the Parties hereto.

11.3 Advertisement. Participant agrees that UCare may list Participant's name, address, telephone number, website, specialty or other area of concentration, and other publicly available information such as special services offered by Participant in such listings, directories, brochures and other writings as may be determined by UCare. Except as otherwise described herein or required by applicable law, Participant shall not use UCare's name, symbol or service mark without prior written approval.

11.4 Amendment. This Agreement may be amended by UCare by providing written notice to Participant specifying the effective date, in accordance with and subject to the limitations of this section, for purposes of bringing this Agreement into compliance with a federal or state law, rule, regulation, or agency mandate. Such amendment shall become effective on the effective date or the compliance date (if later) of the law, regulation, or agency mandate that gave rise to the need to amend this Agreement for purposes of conforming to such requirement. UCare shall also have the right to amend this Agreement upon forty-five (45) days' written notice to Participant; provided, however, that an amendment that is not required by law and that alters

the fee schedule hereunder or otherwise materially alters this Agreement will not take effect if Participant elects to terminate this Agreement without cause, as permitted hereunder. Except as otherwise provided herein, any other amendments or modifications to this Agreement must be mutually agreed to by the Parties, in writing, and signed by both Parties.

11.5 Governing Law. This Agreement is made and entered into in the State of Minnesota and shall be governed in all respects by the laws of the State of Minnesota. Any litigation related to this Agreement that is permitted to be brought in accordance with the dispute resolution provisions hereof shall be venued in Minnesota.

11.6 Conflict. In the event of a conflict between the Provider Manual and this Agreement, then (a) if the conflicting language in the Provider Manual was published by UCare on or before the Effective Date, the Agreement shall govern and (b) if the conflicting language in the Provider Manual was published by UCare after the Effective Date, the Provider Manual shall govern,

11.7 Benefit and Assignment; Change of Control. Participant's rights, duties, obligations and undertakings under this Agreement are binding upon Participant and are not assignable in whole or in part without the prior written approval of UCare, which consent shall not be unreasonably withheld. This Agreement, and all Exhibits, shall be binding upon, and shall inure to the benefit of the Parties hereto and their respective successors and assigns. Assignments subject to this limitation shall include assignment to an entity affiliated with Participant, and assignments by Participant to a successor in interest as a result of a merger, acquisition, or reorganization or sale of substantially all of Participant's assets. Any attempted assignment without UCare's consent shall be void. Upon receiving a written request to consent to an assignment or notification of a Change of Control (as that term is defined below), UCare may terminate this Agreement after at least thirty (30) days' prior written notice to Participant. In the event that UCare approves of an assignment of this Agreement, and the approved assignee is already a Participating Provider under an agreement with UCare, UCare shall have the option of paying the approved assignee under its existing agreement with UCare or under this Agreement. UCare shall have the absolute right, in its sole discretion, to assign all or any of its rights and obligations hereunder to an entity that controls or is controlled by UCare, or to add another affiliate of UCare as an additional party to this Agreement. Participant shall notify UCare in writing prior to any change in the identity of the person or persons holding fifty percent (50%) or more of the total financial or governance rights in Participant (a "Change of Control"). In the event of a Change of Control resulting in fifty percent (50%) of the financial or governance rights in Participant being held by a person that is already a Participating Provider under an agreement with UCare, UCare shall have the option of paying Participant under such person's existing agreement with UCare or under this Agreement.

11.8 Entire Agreement. Except as otherwise expressly provided herein, this Agreement as it may be amended pursuant to Section 11.4 embodies the entire agreement between UCare and Participant concerning the subject matter of this Agreement. This Agreement supersedes and replaces all other previous oral or written agreements concerning all or any part of the subject matter of this Agreement, and no such prior representations or agreements between the parties relating to the same subject matter shall have any force or effect.

11.9 Severability. If any part of this Agreement should be determined to be invalid, unenforceable, or contrary to law, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

11.10 Survival. Any section of this Agreement that by its terms contemplates or requires continuing effect following termination of this Agreement shall survive such termination. Specifically, and without limitation, Article 5 (Confidentiality and Records), Section 6.2 (Enrollee Protection Provisions), Article 9 (Insurance and Indemnification), Section 10.3 (Rights and Obligations), Section 10.4 (Dispute Resolution) and Section 11.5 (Governing Law) shall survive termination of this Agreement.

11.11 Approvals of this Agreement. The effectiveness of this Agreement is subject to the approval of this Agreement by the Minnesota Department of Health.

11.12 Waiver. The failure of any Party at any time to require performance of any provision or to resort to any remedy provided under this Agreement shall in no way affect the right of that Party to require performance or to resort to a remedy at any time thereafter, nor shall the waiver by any Party of a breach be deemed to be a waiver of any subsequent breach. A waiver shall not be effective unless it is in writing and signed by the Party against whom the waiver is being enforced. No course of dealing, nor any failure to exercise, nor any delay in exercising any right, power or privilege hereunder shall operate as a waiver thereof.

11.13 Compliance with Laws. Participant agrees to comply with (1) all applicable Medicare and Medicaid laws and regulations, and applicable CMS instructions, (2) all applicable Minnesota laws, regulations and guidance applicable to Minnesota state health care programs; (3) the applicable provisions of the contracts between UCare and DHS, CMS, and MNsure, which are hereby incorporated by reference; (4) all state and federal laws applicable to entities which receive federal funds; (5) provisions of Minnesota law applicable to the commercial products offered by UCare, including but not limited to Minnesota Statutes Chapter 62V; and (6) all applicable state and federal laws, regulations and Executive Orders regarding prohibited discrimination, including Title VI of the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

11.14 DHS-Required Language. In the event the Medicare contract between CMS and UCare is terminated or non-renewed, the contract between DHS and UCare shall be terminated unless CMS and DHS agree to the contrary. Such termination shall be carried out in accordance with the termination requirement stated in 42 C.F.R. § 422.506 and § 422.512.

11.15 Force Majeure. Neither UCare nor Participant shall be responsible for any resulting loss if the fulfillment of any of the terms or provisions of this Agreement is delayed, prevented, or rendered impossible by revolutions, insurrections, riots, wars, acts of enemies, floods, fires, or other acts of God.

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IN WITNESS WHEREOF, each Party has caused this Agreement to be signed on its behalf by its duly authorized representative as of the Effective Date.

UCare Minnesota PO Box 52 500 Stinson Blvd NE Minneapolis, MN 55440-8551	**Kanabec County Family Services** 905 Forest Ave. E. Suite 150 Mora, MN 55051
_____	_____
Ghita Worcester Executive Vice President of Public Affairs and Chief Growth Officer prccontractadmin@ucare.org	*Signature* Printed Name: _____ Title_____ Email: _____
_____	_____
Date	Date

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EXHIBIT A
to the
PROVIDER PARTICIPATION AGREEMENT

PRODUCTS COVERED UNDER THIS AGREEMENT

- Minnesota Health Care Programs products, including but not limited to:
  - Medical Assistance
  - MinnesotaCare (including any program funded by the Basic Health Program)
  - Minnesota Senior Care Plus (MSC+), non-dually eligible
  - Minnesota Special Needs Basic Care, non-dually eligible

- Dual Eligibles, including but not limited to:
  - Minnesota Senior Health Options (MSHO)
  - Minnesota Senior Care Plus (MSC+), dually eligible (MHCP portion only)
  - Minnesota Special Needs Basic Care, dually eligible, non-integrated (MHCP portion only)
  - Minnesota Special Needs Basic Care, dually eligible, integrated

- Medicare Products, including but not limited to:
  - Medicare Advantage products / UCare Medicare Plans
  - Medicare Advantage products / *EssentiaCare* (Medicare PPO) ONLY IF APPROVED
  - Medicare Advantage products / UCare Medicare with M Health Fairview & North Memorial ONLY IF APPROVED
  - Medicare Select / *UCare SeniorSelect*

- Qualified Health Plan Products, including but not limited to:
  - UCare Individual & Family Plans
  - UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

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EXHIBIT B
to the
PROVIDER PARTICIPATION AGREEMENT

SERVICES PROVIDED UNDER THIS AGREEMENT

Mental Health Services (including Targeted Case Management Services)
Care Coordination

Case Management

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EXHIBIT C
to the
PROVIDER PARTICIPATION AGREEMENT

SITE LISTING

Use this one for more than 3 sites.

The Site Listing for this Agreement shall be contained in a separate document to be agreed upon by the Parties and incorporated herein by reference

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Use this one for 3 sites or less.

Practice Name and Address	**Fed ID / NPI**	**Billing Name and Address**
Kanabec County Family Services 905 Forest Ave. E. Suite 150 «Mora, MN 55051 Phone: 320-679-6350	Tax ID #: 416005815 NPI #: 1396819108	Kanabec County Family Services 905 Forest Ave. E. Suite 150 Mora, MN 55051
Practice Name and Address	**Fed ID / Type II NPI**	**Billing Name and Address**
«ExhibitC_PvdrNameLoc2» «AddrLoc2» «AddrLoc2a» «CityStateZipLoc2» Phone: «PhoneLoc2» Practice County: «CountyLoc2»	Tax ID #: «TaxIDLoc2» NPI #: «NPILoc2»	«BillingNameLoc2» «BillingAddrLoc2» «BillingAddrLoc2a» «BillingCityStateZipLoc2»
Practice Name and Address	**Fed ID / Type II NPI**	**Billing Name and Address**
«ExhibitC_PvdrNameLoc3» «AddrLoc3» «AddrLoc3a» «BillingCityStateZipLoc3» Phone: «PhoneLoc3» Practice County: «CountyLoc2»	Tax ID #: «TaxIDLoc3» NPI #: «NPILoc3»	«BillingNameLoc3» «BillingAddrLoc3» «BillingAddrLoc3a» «BillingCityStateZipLoc3»

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EXHIBIT D
to the
PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

CAR SEAT EDUCATION

Products:

- Medical Assistance
- MinnesotaCare (including any program funded by the Basic Health Program)
- Minnesota Special Needs Basic Care, non-dually eligible
- Minnesota Special Needs Basic Care, dually eligible, non-integrated (MHCP portion only)
- Minnesota Special Needs Basic Care, dually eligible, integrated

Car Seat Education Individual Services

- Individual Car Seat Safety Education is reimbursed at $80 per household per same date of service:
    - One member of the household receiving a car seat - $80
    - More than one member of the household receiving seats on same date of service – divide $80 by the number of seats being given to members in the household (ill each member separately):
      Examples:
      2 members = $40 each
      3 members = $27*each (*round up to the nearest whole dollar)
      4 members = $20 each
- Reimbursement is for the education provided to members, each person receiving education must be a UCare member and is not based on the number of car seats being provided during the session (UCare pays for the car seats separately).
- Billing:
    - Diagnosis Code: Z71.89 (injury prevention)
    - Procedure Code: S9445 (Patient education – individual)
    - Place of Service: A valid place of service must be included on the claim
- Interpretation services related to car seat education are not a reimbursable service.
- Car seat storage and handling by Public Health or partnering agency is not reimbursable service.

Car Seat Education Group Classes

- Group (Class) Car Seat Safety Education is reimbursed at $57 per household per same date of service.
    - One member of the household receiving a car seat - $57
    - More than one member of the household receiving seats on same date of service– divide $57 by the number of seats being given to members in the household. Bill each member separately.
      Examples:

2 members = $29* each (*round up to nearest whole dollar)
3 members = $19 each
4 members = $15* each (*round up to nearest whole dollar)

- Reimbursement is based on a "per session" rate and is not based on the length of the session or the number of seats being given to members in the same household. Reimbursement is for the education provided to UCare members, each person receiving education must be a UCare member.
- Billing:
  - Diagnosis Code: Z71.89 (injury prevention)
  - Procedure Code: S9446 (Patient education - group)
  - Place of Service: A valid place of service must be included on the claim
- Interpretation services related to car seat education are not a reimbursable service.
- Car seat storage and handling by Public Health or partnering agency is not reimbursable service.

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EXHIBIT D1
to the
PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

ARTICLE I: HOSPICE

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge. If there is no rate in the Payment Methodology / Reimbursement fee schedule, then UCare will pay based on the rates in Default 1 and if there is no rate available in the Default 1 fee schedule, payment will revert to the payment rates in Default 2 and finally, if there is no rate available in Default 2, payment will revert to the payment rates in Default 3. Referenced fee schedules are those in effect at the time of the service. Claims are paid in accordance with UCare's payment policies and procedures.

Products:
- Medical Assistance
- MinnesotaCare (including any program funded by the Basic Health Program)
- Minnesota Senior Care Plus (MSC+), non-dually eligible
- Minnesota Special Needs Basic Care, non-dually eligible

Payment Methodology / Reimbursement	Default – 1	Default- 2	Default – 3
100% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Products:
Qualified Health Plan Products, including but not limited to:
- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

Revenue Code / Description	Hospice Reimbursement	Default – 1	Default- 2
Revenue Code 0651 Routine Home Care	100% of the Wage Adjusted CMS Routine Home Care Per Diem	100% of the UCare Standard fee schedule	50% of eligible billed charges
Revenue Code 0652 Continuous Home Care	100% of the Wage Adjusted CMS Continuous Home Care Per Diem	100% of the UCare Standard fee schedule	50% of eligible billed charges

Revenue Code 0655 Inpatient Respite Care	100% of the Wage Adjusted CMS Inpatient Respite Care Per Diem	100% of the UCare Standard fee schedule	50% of eligible billed charges
Revenue Code 0656 General Inpatient Care	100% of the Wage Adjusted CMS General Inpatient Care Per Diem	100% of the UCare Standard fee schedule	50% of eligible billed charges

UCare Minnesota Health Care Programs (MHCP) fee schedule. The UCare MHCP fee schedule is based on the State of Minnesota Health Care Programs fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Standard fee schedule. The UCare Standard fee schedule is a fee schedule developed by UCare. This fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare fee schedule. The UCare Medicare fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) professional fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

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EXHIBIT D2
to the
PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

ARTICLE I: MEDICARE CERTIFIED HOME HEALTH CARE SERVICES

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge. If there is no rate in the Payment Methodology / Reimbursement fee schedule, then UCare will pay based on the rates in Default 1 and if there is no rate available in the Default 1 fee schedule, payment will revert to the payment rates in Default 2, if there is no rate available in Default 2, payment will revert to the payment rates in Default 3. If there is no rate available in Default 3, payment will revert to the payment rates in Default 4. Referenced fee schedules are those in effect at the time of the service. Claims are paid in accordance with UCare's payment policies and procedures.

Products:
Non-Dually Eligible
- Medical Assistance
- MinnesotaCare
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care

Payment Methodology / Reimbursement	Default - 1	Default- 2	Default - 3
100% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Products:
Dually Eligible:
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care, dually eligible, non-integrated

Payment Methodology / Reimbursement	Default - 1	Default- 2	Default - 3
In accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 100% of the UCare MHCP fee schedule allowable rate where a Medicare coinsurance and/or deductible has been applied. UCare payment will be the difference between the Medicare payment and the UCare MHCP calculated allowable rate where the difference is greater than zero. If the difference is less than or equal to zero, the UCare payment will be zero. For services not in accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Participant for practitioner services at 100% of the UCare MHCP fee schedule.			

Product:

- Minnesota Senior Health Options (MSHO)

Payment Methodology / Reimbursement	Default - 1	Default - 2	Default - 3
100% of the UCare CMS Low Utilization payment Adjustment (LUPA) per visit rate	Not Applicable	Not Applicable	Not Applicable
All Other Services: 100% of the UCare MSHO fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Product:

- Minnesota Special Needs Basic Care, dually eligible, integrated

Payment Methodology / Reimbursement	Default - 1	Default - 2	Default - 3
100% of the UCare CMS Low Utilization payment Adjustment (LUPA) per visit rate	Not Applicable	Not Applicable	Not Applicable
All Other Services: 100% of the UCare SNBC fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Products:

Medicare Products, including but not limited to:

- Medicare Advantage products / UCare Medicare Plans
- Medicare Advantage products / *EssentiaCare* (Medicare PPO) ONLY IF APPROVED
- Medicare Advantage products / UCare Medicare with M Health Fairview & North Memorial ONLY IF APPROVED

Payment Methodology / Reimbursement	Default - 1	Default - 2	Default - 3
100% of the UCare CMS Low Utilization payment Adjustment (LUPA) per visit rate	Not Applicable	Not Applicable	Not Applicable
All Other Services: 100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Product:

- Medicare Select

Payment Methodology / Reimbursement	Default - 1	Default - 2	Default - 3	Default – 4
Subsequent to the Medicare Fiscal Intermediary's payment; 100% of the Enrollee's Copayments, Coinsurance, and Deductibles.	100% of the UCare CMS Low Utilization payment Adjustment (LUPA) per visit rate	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Products:

Qualified Health Plan Products, including but not limited to:

- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

UCare Minnesota Health Care Programs (MHCP) fee schedule. The UCare MHCP fee schedule is based on the State of Minnesota Health Care Programs fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Standard fee schedule. The UCare Standard fee schedule is a fee schedule developed by UCare. This fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Minnesota Senior Health Options (MSHO) fee schedule. The UCare MSHO fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare MSHO fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare MSHO fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Special Needs Basic Care (SNBC) fee schedule. The UCare SNBC fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare SNBC fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare SNBC fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare fee schedule. The UCare Medicare fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) professional fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare CMS Low Utilization Payment Adjustment (LUPA). For purpose of the above fee schedule relating to home health care, "CMS LUPA" rate is based upon the rate as determined by the Centers

for Medicare and Medicaid Services (CMS) LUPA national standardized per visit rates instead of the Home Health PPS case-mix system.

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EXHIBIT D3
to the

PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

ARTICLE I: PROFESSIONAL SERVICES (Includes all professional services, with the exception of RHC and FQHC. Includes Public Health Nursing Services)

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge. If there is no rate in the Payment Methodology fee schedule, then UCare will pay based on the rates in Default 1 and if there is no rate available in the Default 1 fee schedule, payment will revert to the payment rates in Default 2 and finally, if there is no rate available in Default 2, payment will revert to the payment rates in Default 3. Referenced fee schedules are those in effect at the time of the service. Claims are paid in accordance with UCare's payment policies and procedures.

Professional Services:

Products:
Non-Dually Eligible
- Medical Assistance
- MinnesotaCare
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care

Payment Methodology / Reimbursement	Default - 1	Default- 2	Default - 3
100% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Certified Health Care Home Program. If designated by Minnesota Department of Health (MDH) UCare shall reimburse Participant for Covered HCH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Health Care Home	100% of the Minnesota Health Care Home Fee Schedule

Products:
Dually Eligible
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care, dually eligible, non-integrated

Payment Methodology / Reimbursement	Default - 1	Default- 2	Default - 3

In accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for services up to 100% of the UCare MHCP fee schedule allowable rate where a Medicare coinsurance and/or deductible has been applied. UCare payment will be the difference between the Medicare payment and the UCare MHCP calculated allowable rate where the difference is greater than zero. If the difference is less than or equal to zero, the UCare payment will be zero. For services not in accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for services up to 100% of the UCare MHCP fee schedule.	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Health Care Home Program. If designated by Minnesota Department of Health (MDH) UCare shall reimburse Participant for Covered HCH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Health Care Home	100% of the Minnesota Health Care Home Fee Schedule

Product:

- Minnesota Senior Health Options (MSHO)

Payment Methodology / Reimbursement	Default - 1	Default- 2	Default - 3
100% of the UCare MSHO fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Health Care Home Program. If designated by Minnesota Department of Health (MDH) UCare shall reimburse Participant for Covered HCH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Health Care Home	100% of the Minnesota Health Care Home Fee Schedule

Product:

- Minnesota Special Needs Basic Care, dually eligible, integrated

Payment Methodology / Reimbursement	Default - 1	Default – 2	Default - 3
100% of the UCare SNBC fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Health Care Home Program. If designated by Minnesota Department of Health (MDH) UCare shall reimburse Participant for Covered HCH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Health Care Home	100% of the Minnesota Health Care Home Fee Schedule

Products:

Medicare Products, including but not limited to:

- Medicare Advantage products / UCare Medicare Plans
- Medicare Advantage products / *EssentiaCare* (Medicare PPO) ONLY IF APPROVED
- Medicare Advantage products / UCare Medicare with M Health Fairview & North Memorial ONLY IF APPROVED

Professional Services Payment Methodology / Reimbursement	**Default - 1**	**Default – 2**	**Default - 3**
100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable
DMEPOS Payment Methodology / Reimbursement	**Default - 1**	**Default – 2**	**Default - 3**
100% of the UCare Medicare DMEPOS fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

Clinical Laboratory Payment Methodology / Reimbursement	**Default - 1**	**Default – 2**	**Default - 3**
100% of the UCare Medicare Clinical Lab fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

Drugs and Biologicals Payment Methodology / Reimbursement	**Default - 1**	**Default – 2**	**Default - 3**
100% of the UCare Medicare ASP fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

Product:

- Medicare Select

Payment Methodology / Reimbursement	Default - 1	Default – 2	Default - 3
Subsequent to the Medicare Fiscal Intermediary's payment; 100% of the Enrollee's Copayments, Coinsurance, and Deductibles.	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Products:

Qualified Health Plan Products, including but not limited to:

- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
160% of the applicable UCare Medicare Fee Schedule rate	160% of the UCare Standard fee schedule	65% of eligible charges	Not Applicable

DMEPOS Payment Methodology / Reimbursement	Default - 1	Default – 2	Default - 3
100% of the UCare Medicare DMEPOS fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

Clinical Laboratory Payment Methodology / Reimbursement	Default – 1	Default – 2	Default - 3
155% of the UCare Medicare Clinical Lab fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

Drugs and Biologicals Payment Methodology / Reimbursement (non-Vaccine)	Default - 1	Default – 2	Default - 3
100% of the UCare ASP Pricing File rate	AWP minus 17%	Not Applicable	Not Applicable

Drugs and Biologicals Payment Methodology / Reimbursement (Vaccines)	Default - 1	Default – 2	Default - 3

100% of the UCare Vaccination fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

UCare Minnesota Health Care Programs (MHCP) fee schedule. The UCare MHCP fee schedule is based on the State of Minnesota Health Care Programs fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Minnesota Senior Health Options (MSHO) fee schedule. The UCare MSHO fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare MSHO Fee Schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare MSHO fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Minnesota Special Needs Basic Care (SNBC) fee schedule. The UCare SNBC fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare SNBC Fee Schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare SNBC fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare fee schedule. The UCare Medicare fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) professional fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Standard fee schedule. The UCare Standard fee schedule is a fee schedule developed by UCare. The fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare Clinical Lab fee schedule: Fee schedule reimbursement rate as determined by the Centers for Medicare and Medicaid Services (CMS) Clinical Lab Fee Schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

CMS Average Sales Price (ASP). Reimbursement rates as determined by the Centers for Medicare and Medicaid Services (CMS) Average Sales Price (ASP) Drug Pricing Files; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare DMEPOS fee schedule. The UCare Medicare DMEPOS fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) DMEPOS fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Vaccination fee schedule. The UCare Vaccination fee schedule is based on the State of Minnesota Health Care Programs fee schedule specific to vaccination codes.

Average Wholesale Price (AWP). Reimbursement rates as determined by First Databank AWP pricing files.

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EXHIBIT D4
to the
PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

PUBLIC HEALTH NURSE HOME VISITS

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge.

• Medical Assistance • MinnesotaCare • Minnesota Senior Care Plus (MSC+) • Minnesota Special Needs Basic Care (*UCare Connect*) • Minnesota Senior Health Options (MSHO) • Minnesota Special Needs Basic Care, integrated (*UCare Connect + Medicare*)	S9123 - $180.00 S9123-U8- $180.00 *Provider will file claims to UCare with the U8 modifier, when applicable, in accordance with DHS guidelines.*

Public Health Nurse Home Visits billed with codes other than S9123 will be reimbursed in accordance with the Professional Services Reimbursement Schedule.

EXHIBIT D5
to the
PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

ARTICLE 1: MENTAL HEALTH SERVICES

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge. If there is no rate in the Payment Methodology/ Reimbursement fee schedule, then UCare will pay based on the rates in Default 1 and if there is no rate available in the Default 1 fee schedule, payment will revert to the payment rates in Default 2 and finally, if there is no rate available in Default 2, payment will revert to the payment rates in Default 3. Referenced fee schedules are those in effect at the time of the service. Claims are paid in accordance with UCare's payment policies and procedures.

Products:
Non-Dually Eligible:

- Medical Assistance
- MinnesotaCare
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
ACT, CCBHC, CRT, IRMHS, IRTS, PRTF, RCS and TCM services rendered by state approved providers only: 100% of the MHCP provider-specific rate or contracted county host rate. Providers billing MH-TCM services should file claims to UCare with charge amounts listed at 100% of the then-current established rate.	Not Applicable	Not Applicable	Not Applicable
ARMHS and DBT services rendered by state approved providers only: 100% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges
All Other Services: 110% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Certified Behavioral Health Home Program. If designated by Minnesota Department of Human Services (DHS) UCare shall reimburse Participant for Covered BHH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Behavioral Health Home	100% of the UCare MHCP Behavioral Health Home fee schedule

As directed by DHS, UCare will not reimburse Participant for duplicative services associated with treatment similar to the Behavioral Health Home model. The services deemed as duplicative include Mental Health Targeted Case Management (TCM) and Assertive Community Treatment (ACT) or any additional services designated by DHS. UCare will only reimburse Participant for the first claim submitted of this service type and recover any duplicative services through post-payment claim review.

Products:

Dually Eligible:

- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care, dually eligible, non-integrated

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
ACT, CCBHC, CRT, IRMHS, IRTS, PRTF, RCS and TCM services rendered by state approved providers only: 100% of the MHCP provider-specific rate or contracted county host rate. Providers billing MH-TCM services should file claims to UCare with charge amounts listed at 100% of the then-current established rate.	Not Applicable	Not Applicable	Not Applicable
ARMHS and DBT services rendered by state approved providers only: In accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 100% of the UCare MHCP fee schedule allowable rate where a Medicare coinsurance and/or deductible has been applied. UCare payment will be the difference between the Medicare payment and the UCare MHCP calculated allowable rate where the difference is greater than zero. If the difference is less than or equal to zero, the UCare payment will be zero. For services not in accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 100% of the UCare MHCP fee schedule.	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

All Other Services: In accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 110% of the UCare MHCP fee schedule allowable rate where a Medicare coinsurance and/or deductible has been applied. UCare payment will be the difference between the Medicare payment and the UCare MHCP calculated allowable rate where the difference is greater than zero. If the difference is less than or equal to zero, the UCare payment will be zero. For services not in accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 110% of the UCare MHCP fee schedule.	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Behavioral Health Home Program. If designated by Minnesota Department of Human Services (DHS) UCare shall reimburse Participant for Covered BHH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Behavioral Health Home	100% of the UCare MHCP Behavioral Health Home fee schedule

As directed by DHS, UCare will not reimburse Participant for duplicative services associated with treatment similar to the Behavioral Health Home model. The services deemed as duplicative include Mental Health Targeted Case Management (TCM) and Assertive Community Treatment (ACT) or any additional services designated by DHS. UCare will only reimburse Participant for the first claim submitted of this service type and recover any duplicative services through post-payment claim review.

Product:

- Minnesota Senior Health Options (MSHO)

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
ACT, CCBHC, CRT, IRMHS, IRTS, PRTF, RCS and TCM services rendered by state approved providers only: 100% of the MHCP provider-specific rate or contracted county host rate. Providers billing MH-TCM services should file claims to UCare with charge amounts listed at 100% of the then-current established rate.	Not Applicable	Not Applicable	Not Applicable

ARMHS and DBT services rendered by state approved providers only: 100% of the UCare MSHO fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable
All Other Services: 105% of the UCare MSHO fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Behavioral Health Home Program. If designated by Minnesota Department of Human Services (DHS) UCare shall reimburse Participant for Covered BHH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Behavioral Health Home	100% of the UCare MHCP Behavioral Health Home fee schedule

As directed by DHS, UCare will not reimburse Participant for duplicative services associated with treatment similar to the Behavioral Health Home model. The services deemed as duplicative include Mental Health Targeted Case Management (TCM) and Assertive Community Treatment (ACT) or any additional services designated by DHS. UCare will only reimburse Participant for the first claim submitted of this service type and recover any duplicative services through post-payment claim review.

Product:

- Special Needs Basic Care, dually eligible, integrated

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
ACT, CCBHC, CRT, IRMHS, IRTS, PRTF, RCS and TCM services rendered by state approved providers only: 100% of the MHCP provider-specific rate or contracted county host rate. Providers billing MH-TCM services should file claims to UCare with charge amounts listed at 100% of the then-current established rate.	Not Applicable	Not Applicable	Not Applicable
ARMHS and DBT services rendered by state approved providers only: 100% of the UCare SNBC fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable
All Other Services: 105% of the UCare SNBC fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Behavioral Health Home Program. If designated by Minnesota Department of Human

Services (DHS) UCare shall reimburse Participant for Covered BHH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Behavioral Health Home	100% of the UCare MHCP Behavioral Health Home fee schedule

As directed by DHS, UCare will not reimburse Participant for duplicative services associated with treatment similar to the Behavioral Health Home model. The services deemed as duplicative include Mental Health Targeted Case Management (TCM) and Assertive Community Treatment (ACT) or any additional services designated by DHS. UCare will only reimburse Participant for the first claim submitted of this service type and recover any duplicative services through post-payment claim review.

Product:

Medicare Products, including but not limited to:

- Medicare Advantage products / UCare Medicare Plans
- Medicare Advantage products / *EssentiaCare* (Medicare PPO) ONLY IF APPROVED
- Medicare Advantage products / UCare Medicare with M Health Fairview & North Memorial ONLY IF APPROVED

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
105% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Product:

- Medicare Select

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
Subsequent to the Medicare Fiscal Intermediary's payment; 100% of the Enrollee's Copayments, Coinsurance, and Deductibles.	UCare shall reimburse Participant for Covered Services listed in the Certificate of Coverage which are not eligible for coverage by fee-for-service Medicare at the UCare Standard fee schedule	Not Applicable	Not Applicable

Product(s):

Qualified Health Plan Products, including but not limited to:

- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3

CRT or IRTS services rendered by state approved providers only: 100% of the MHCP provider-specific rate or contracted county host rate.	Not Applicable	Not Applicable	Not Applicable
DBT services rendered by state approved providers only: 100% of the UCare MHCP fee schedule	160% of the UCare Medicare fee schedule	160% of the UCare Standard fee schedule	65% of eligible billed charges
All Other Services: 160% of the UCare Medicare fee schedule	160% of the UCare Standard fee schedule	65% of eligible billed charges	Not Applicable

UCare Minnesota Health Care Programs (MHCP) fee schedule. The UCare MHCP fee schedule is based on the State of Minnesota Health Care Programs fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Standard fee schedule. The UCare Standard fee schedule is a fee schedule developed by UCare. The UCare Standard fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Minnesota Senior Health Options (MSHO) fee schedule. The UCare MSHO fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare MSHO fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare MSHO fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Special Needs Basic Care (SNBC) fee schedule. The UCare SNBC fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare SNBC fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare SNBC fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare fee schedule. The UCare Medicare fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) professional fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

ARTICLE 2: SUBSTANCE USE DISORDER HEALTH SERVICES

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge. If there is no rate in the Payment Methodology/ Reimbursement fee schedule, then UCare will pay based on the rates in Default 1 and if there is no rate available in the Default 1 fee schedule, payment will revert to the payment rates in Default 2 and finally, if there is no rate available in Default 2, payment will revert to the payment rates in Default 3. Referenced fee schedules are those in effect at the time of the service. Claims are paid in accordance with UCare's payment policies and procedures.

Products:

Non-Dually Eligible:

- Medical Assistance
- MinnesotaCare
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
BHF Services: 100% of the BHF rates	Not Applicable	Not Applicable	Not Applicable
All Other Services: 110% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Products:

Dually Eligible:

- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care, dually eligible, non-integrated

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
BHF Services: 100% of the BHF rates	Not Applicable	Not Applicable	Not Applicable
All Other Services: In accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 110% of the UCare MHCP fee schedule allowable rate where a Medicare coinsurance and/or deductible has been applied. UCare payment will be the difference between the Medicare payment and the UCare MHCP calculated allowable rate where the difference is greater than zero. If the difference is less than or equal to zero, the UCare payment will be zero. For services not in accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 110% of the UCare MHCP fee schedule.	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Product:

- Minnesota Senior Health Options (MSHO)

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
BHF Services: 100% of the BHF rates	Not Applicable	Not Applicable	Not Applicable
All Other Services: 105% of the UCare MSHO fee schedule	100% of the UCare	50% of eligible billed	Not Applicable

	Standard fee schedule	charges	

Product:

- Minnesota Special Needs Basic Care, dually eligible, integrated

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
BHF Services: 100% of the BHF rates	Not Applicable	Not Applicable	Not Applicable
All Other Services: 105% of the UCare SNBC fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Products:

Medicare Products, including but not limited to:

- Medicare Advantage products / UCare Medicare Plans
- Medicare Advantage products / *EssentiaCare* (Medicare PPO) ONLY IF APPROVED
- Medicare Advantage products / UCare Medicare with M Health Fairview & North Memorial ONLY IF APPROVED

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
105% of the UCare Medicare fee schedule	100 % of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Product:

- Medicare Select

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
Subsequent to the Medicare Fiscal Intermediary's payment; 100% of the Enrollee's Copayments, Coinsurance, and Deductibles.	UCare shall reimburse Participant for Covered Services listed in the Certificate of Coverage which are not eligible for coverage by fee-for-service Medicare at the UCare Standard fee schedule	Not Applicable	Not Applicable

Products:

Qualified Health Plan Products, including but not limited to:

- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3

BHF Services: 100% of the BHF rates	Not Applicable	Not Applicable	Not Applicable
All Other Services: 160% of the UCare MHCP fee schedule	160% of the UCare Standard Fee Schedule	65% of eligible billed charges	Not Applicable

BHF Rates. Fee schedule reimbursement rate as determined by the Minnesota Department of Human Services for Behavioral Health Fund (BHF).

UCare Minnesota Health Care Programs (MHCP) fee schedule. The UCare MHCP fee schedule is based on the State of Minnesota Health Care Programs fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Standard fee schedule. The UCare Standard fee schedule is a fee schedule developed by UCare. The UCare Standard fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Minnesota Senior Health Options (MSHO) fee schedule. The UCare MSHO fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare MSHO fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare MSHO fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Special Needs Basic Care (SNBC) fee schedule. The UCare SNBC fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare SNBC fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare SNBC fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare fee schedule. The UCare Medicare fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) professional fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

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EXHIBIT D6
to the
PROVIDER PARTICIPATION AGREEMENT

DELEGATED CARE COORDINATION SERVICES

REIMBURSEMENT SCHEDULE

UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedule:

Product	Enrollee Status	Reimbursement
Minnesota Special Needs Basic Care, dually eligible, integrated Minnesota Special Needs Basic Care	Enrollees newly enrolled in UCare's Minnesota Special Needs Basic Care, dually eligible, integrated or Minnesota Special Needs Basic Care products	$XX Per Member Per Month (PMPM), up to two months
	Enrollee declined to complete a Health Risk Assessment and subsequent care coordination, or Enrollee requested to be closed to care coordination services after previously being opened to care coordination services	$XX Per Member Per Month (PMPM)
	Enrollee unable to be reached by Participant	$XX Per Member Per Month (PMPM)
	Enrollee open to care coordination and receiving the following services: • Initial Health Risk Assessment & required reassessment(s) • Comprehensive support plan • Coordination of medical and mental health services, social drivers of health, or any additional needs for which the Enrollee requests or requires assistance.	$XX Per Member Per Month (PMPM)

UCare will make payment only for eligible Enrollees based on status of Enrollee during the applicable month.

Participant does not need to bill UCare for care coordination services. UCare reserves the right to implement alternative billing requirements at a later date.

Enrollees are assigned to Participant via the monthly enrollment roster.

Enrollees assigned to Participant will reside in the following locations:

List county service area or other information here—

Scope of Services. Participant will perform services according to the Special Needs Basic Care, Care Coordination Requirements Grids.

Such standards may include:

- Appointment timeliness and access to care standards
- Demonstrating cultural and disability sensitivity in member interactions
- Timely communication of clinical information to member
- Communication of information among providers when referrals are made
- Member input to treatment plan
- Health record standards such as member identifiers, problem list, medications, advance directives, allergies, etc.
- Communication of information among providers when referrals are made
- Members are provided with continuity of care and appropriate community and social services
- Member information is protected and handled in a confidential manner Members are not discriminated against based on their gender, ability to pay, etc.
- Written policies and procedures specifying the elements identified above as existing care coordination standards. The policies and procedures will be on file, current, and available for audit by UCare
- Access to medical records and personal interviews to substantiate conformity to the policies and procedures
- Timely submission of prior authorization requests with necessary supporting information
- Response to regulatory changes on a timely basis

Additional details concerning the program specifications and definitions can be accessed in a Companion Guide, which UCare may edit as necessary.

EXHIBIT D7
to the
PROVIDER PARTICIPATION AGREEMENT

CASE MANAGEMENT SERVICES

REIMBURSEMENT SCHEDULE

UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedule:

Product	**Reimbursement**
Minnesota Senior Health Options (MSHO) Case Management services including: • Initial Health Risk Assessment & required reassessment(s) • Comprehensive support plan • Coordination of medical and mental health services, social drivers of health, or any additional needs for which the Enrollee requests or requires assistance	Community Based, without EW Services $ Per Member Per Month (PMPM) Community Based, with EW Services $ Per Member Per Month (PMPM) Institutional $ Per Member Per Month (PMPM)
Initial Health Risk Assessment	$

Product	**Reimbursement**
Minnesota Senior Care Plus (MSC+) Case Management services including: • Initial Health Risk Assessment & required reassessment(s) • Comprehensive support plan	Community Based, without EW Services $ Per Member Per Month (PMPM) Community Based, with EW Services $ Per Member Per Month (PMPM) Institutional

• Coordination of medical and mental health services, social drivers of health, or any additional needs for which the Enrollee requests or requires assistance	$ Per Member Per Month (PMPM)
Initial Health Risk Assessment	$

UCare will make payment only for eligible Enrollees.

Participant does not need to bill UCare for case management services. UCare reserves the right to implement alternative billing requirements at a later date.

Enrollees are assigned to Participant via the monthly enrollment roster.

The Enrollees included under this agreement will be listed on the monthly roster and may include the following, as assigned by UCare.

List service area here—for example, list of primary care clinics, county assignments, etc.

Scope of Services. Participant will perform services according to community standards.

Such standards may include:

- Appointment timeliness and access to care standards
- Demonstrating cultural and disability sensitivity in member interactions
- Timely communication of clinical information to member
- Communication of information among providers when referrals are made
- Member input to treatment plan
- Health record standards such as member identifiers, problem list, medications, advance directives, allergies, etc.
- Communication of information among providers when referrals are made
- Members are provided with continuity of care and appropriate community and social services
- Member information is protected and handled in a confidential manner Members are not discriminated against based on their gender, ability to pay, etc.
- Written policies and procedures specifying the elements identified above as existing community standards. The policies and procedures will be on file, current, and available for audit by UCare.
- Access to medical records and personal interviews to substantiate conformity to the policies and procedures
- Timely submission of prior authorization requests with necessary supporting information
- Response to regulatory changes on a timely basis

Resolution # KCFS - 11/15/2022

Health Plans Care Coordination Agreement Resolution

WHEREAS, the Minnesota Department of Human Services has determined that it is in the best interest of counties and their residents to have a choice in the health plans available to them for public programs, and

WHEREAS, Kanabec County was notified that Blue Cross Blue Shield, Medica and U Care will be added along with South Country Health Alliance as the health plans providing service in the County, and

WHEREAS, the Family Services Director has met with the three new health plans and their request is that Kanabec County would provide the care coordination services/case management for Kanabec County residents to foster communication and coordinate care and services among members, providers, staff and other organizations, and

WHEREAS, Kanabec County desires to provide the delegated services in accordance with the health plans' policies and procedures and in compliance with applicable federal and state laws and regulations and the National Committee for Quality Assurance accreditation standards, and

WHEREAS, the Kanabec County Attorney has reviewed and approved the aforementioned contracts with liability language changes to be made by UCare.

THEREFORE BE IT RESOLVED the Kanabec County Human Service Board approves the Family Services Director signing contracts with Blue Cross Blue Shield, Medica and U Care to provide public programs care coordination /case management for County residents for the contracted period and per the health plans' rate schedules.

2023 Annual Contracts Consent Agenda

1. Kanabec County Family Services and Dr. Paul Richardson for psych services.

2. Kanabec County Family Services and Karissa Igneszewski for psych evaluations and medication management.

3. Kanabec County Family Services and Mille Lacs County for psychiatric services.

4. Kanabec County Family Services and Jessica Stokes for psych evaluations and individual counseling.

5. Kanabec County Family Services and Pine County for psychiatric services.

6. Kanabec County Family Services and Region 7E for Regional Adult Mental Health Outpatient Medication Management services.

7. Kanabec County Family Services and Central MN Mental Health Center for detox services.

8. Sue's Bus Service for non-emergency medical transportation.

9. Kanabec County Family Services and Central MN Jobs & Training for MFIP and DWP services.

Consent Agenda Resolutions

Resolution # FS - 11/15/2022

Psychiatric Services Contract – Dr. Paul Richardson

WHEREAS, the Family Services Agency does contract for psychiatric services, and

WHEREAS, such a contract has been presented to the Kanabec County Board of Commissioners for the year 2023;

THEREFORE BE IT RESOLVED to approve an agreement for psychiatric services for the year 2023 with Dr. Paul Richardson for 4 hours per week at $250 per hour for the time period January 1, 2023 through December 31, 2023.

Resolution # FS -11/15/2022

Psychological Services Contract –Karissa Ignaszewski

WHEREAS, the Family Services Agency does contract for psychiatric evaluations and counseling services for the Region 7E Mental Health Project, and

WHEREAS, such a contract has been presented to the Kanabec County Board of Commissioners for a period beginning January 1, 2023 and ending December 31, 2023, and

WHEREAS, this position is fully funded by the Regional Adult Mental Health Initiative Funds;

THEREFORE BE IT RESOLVED to approve an agreement for psychiatric services for the period beginning January 1, 2023 and ending December 31, 2023 with Karissa Ignaszewski.at the rate of $92.65 not to exceed 416 hours quarterly.

Resolution # FS – 11/15/2022

Mille Lacs County Psychiatric Services Resolution

WHEREAS, Minn. Stat. §§235.461 through 235.486 and Minn. Stat. §§235.487 through 235.488 establishes the Minnesota Comprehensive Adult Mental Health Act and the Minnesota Comprehensive Children's Mental Health Act, respectively; and

WHEREAS, Mille Lacs County Community and Veterans Services wishes to secure the provision of Psychiatric Services from Kanabec County Family Services, and

WHEREAS, Kanabec County Family Services is suitably qualified and desires to provide Psychiatric services for Mille Lacs County.

NOW, THEREFORE BE IT RESOLVED that the Kanabec County Human Services Board approves Kanabec County Family Services entering into an agreement for Psychiatric Services to commence January 1, 2023 through December 31, 2023 with Mille Lacs County.

Resolution # FS - 11/15/2022

Psychiatric Services Contract Jessica Stokes– resolution

WHEREAS, the Family Services Agency does contract for psychiatric evaluations and counseling services for the Region 7E Mental Health Project, and

WHEREAS, such a contract has been presented to the Kanabec County Board of Commissioners for a period beginning January 1, 2023 and ending December 31, 2023, and

WHEREAS, this position is fully funded by the Regional Adult Mental Health Initiative Funds;

THEREFORE BE IT RESOLVED to approve an agreement for psychiatric services for the period beginning January 1, 2023 and ending December 31, 2023 with Jessica Stokes at a rate of $87.50 per hour not to exceed 390 hours per quarter.

Resolution # FS – 11/15/2022

Pine County Psychiatric Services Resolution

WHEREAS, Minn. Stat. §§235.461 through 235.486 and Minn. Stat. §§235.487 through 235.488 establishes the Minnesota Comprehensive Adult Mental Health Act and the Minnesota Comprehensive Children's Mental Health Act, respectively; and

WHEREAS, Pine County health and Human Services wishes to secure the provision of Psychiatric Services from Kanabec County Family Services, and

WHEREAS, Kanabec County Family Services is suitably qualified and desires to provide Psychiatric services for Pine County.

NOW, THEREFORE BE IT RESOLVED that the Kanabec County Human Services Board approves Kanabec County Family Services entering into an agreement for Psychiatric Services to commence January 1, 2023 through December 31, 2023 with Pine County.

Consent Agenda Resolutions

Resolution # FS – 11/15/2022

Regional AMHI Medication Management Resolution

WHEREAS, the Region7E Adult Mental Health Initiative has funds available to provide regional adult mental health outpatient medication management and client outreach services through management of the Region 7E mental health website, and

WHEREAS, Isanti County, as fiscal agent for the Regional Adult Mental Health Initiative (AMHI) is also the contracting entity and wishes to contract with Kanabec County, through its Family Services Agency to provide said medication management services and client outreach services through management of the Region 7E mental health website, and

WHEREAS, Kanabec County Family Services is willing and able to provide said medication management services and client outreach services through management of the Region 7E mental health website.

THEREFORE BE IT RESOLVED that the Kanabec County Family Services Board approves entering into an agreement with Isanti County, on behalf of the Region 7E Adult Mental Health Initiative for regional adult mental health outpatient medication management and client outreach services through management of the Region 7E mental health website for the period January 1, 2023 through December 31, 2023.

Resolution # FS -11/15/2022

Detoxification Services – Central MN Mental Health Center

WHEREAS, Kanabec County Family Services contracts for detoxification services, and

WHEREAS, Central Minnesota Mental Health Center agrees to accept appropriate referrals from Kanabec County for the purpose of providing detoxification services, and

WHEREAS, such an agreement has been presented to the Kanabec County Board of Commissioners, for the year 2023**;**

THEREFORE BE IT RESOLVED to approve an agreement for detoxification services for the year 2023 at a daily rate of $500.00 per client, with Central Minnesota Mental Health Center for the time period January 1, 2023 through December 31, 2023 and for the Health & Human Services Director to sign such Agreement.

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Resolution # FS -11/15/22

Sue's Bus Service Agreement Resolution

WHEREAS, Kanabec County Family Services is in need of transportation daily for clients between home and school, and

WHEREAS, Sue's Bus Service is transporting said clients to school at this time and are willing and able to continue to transport them daily between home and school.

THEREFORE BE IT RESOLVED the Kanabec County Human Services Board approves the Agreement with Sue's Bus Service for transporting clients' to and from school daily until further notice and billed at the current DHS Non-emergency Medical Transportation rate.

Resolution # FS -11/15/22

Central MN Jobs and Training
Agreement and Budget Resolution

WHEREAS, Kanabec County Family Services has contracted with Central Minnesota Jobs and Training (CMJTS) for employment and training services for cash and assistance clientele, and

WHEREAS, Central Minnesota Jobs and Training has submitted an annual budget and Agreement for 2023; and

WHEREAS, the Kanabec County Human Services Director is recommending approving contracting with Central Minnesota Jobs and Training in 2023 for employment and training services and approving the budget and Agreement they have submitted;

THEREFORE BE IT RESOLVED the Kanabec County Human Services Board approves contracting with Central Minnesota Jobs and Training for employment and training services and approves the 2023 budget and Agreement submitted.

FINANCIAL ASSISTANCE

Preparer: Tim Dahlberg

A. Major Highlights

- This past quarter, in August and September in particular, there were sizable increases in applications received and application/renewal interviews. Our team handled this adjustment well. It is thought that a contributor to this was the SNAP income limit switch that occurred on 9/1/22.

B. Challenges/Concerns

- It is unknown when issuances of E-SNAP, an additional benefit being issued to SNAP recipients during the PHE (public health emergency), will end. When this occurs, we anticipate receiving an influx of calls.
- We continue to monitor for other PHE program changes. Certain program waivers have been lifted, but others have been extended.

C. Looking Ahead

- We have upcoming trainings in October that will be very helpful in navigating program rules as we transition out of the PHE

Program Totals as of 9/30/22		
Program	**Active Cases**	**# of Persons Active**
MN Family Investment Program (MFIP)	70	171
Diversionary Work Program (DWP)	3	10
General Assistance	83	83
MN Supplemental Assistance (MSA)	75	77
Housing Supports (Formerly GRH)	80	80
Food Support (SNAP)	854	1417
Medical Assistance and/or Medicare Savings Programs (MAXIS)	892	922
Medical Assistance (METS) *as of 10/06/2022	1958	3910
MinnesotaCare (County Serviced) * as of 10/06/2022	104	144

CHILD SUPPORT

Preparer: Tammy Owens and Tim Dahlberg

A. Major Highlights

- Lisa has completed all of the initial DHS trainings for her role as Child Support and Collections Officer/Fraud Prevention Specialist. She is taking on more and more responsibilities when it comes to her Child Support caseload. Lisa has been learning well.
- The Child Support team has done a phenomenal job in working with and supporting Lisa as she's been developing.

B. Challenges/Concerns

- Child support guidelines change effective 01/01/2023. We will have trainings on the new worksheets and changes to the court pleadings. For the remainder of the year, we will likely have to complete worksheets with current and future guidelines for our Magistrate to have as much information as possible in her decision-making.

C. Looking Ahead

- Lisa will continue her training through additional topic-specific DHS trainings along with continued hands-on learning with her team.
- MFSRC Virtual Conference. This is our main training opportunity for the year.

CHILD SUPPORT ENFORCEMENT STATISTICS					
	QUARTER ENDING				
AREA					Year to
	3/31/2022	6/30/2022	9/30/2022	12/31/2022	Date
Caseload By Type					
Non-Public Assistance	187	187	176		
Arrears Only	216	219	220		
Public Assistance	301	300	293		
Foster Care	8	7	2		
Spousal Maintenance Only	5	5	5		
Total	**717**	**718**	**696**		
Collections Report					
Total Collected	**$489,304.64**	**$519,522.80**	**$486,890.07**		**$1,495,717.51**
PA Collections					
Current	$203,575.89	$193,533.62	$202,919.48		**$600,028.99**
Arrears	$45,199.81	$47,586.06	$28,646.36		**$121,432.23**
Spousal Maintenance					**$0.00**
Total	**$248,775.70**	**$241,119.68**	**$231,565.84**		**$721,461.22**
NPA Collections					
Current	$164,485.64	$180,243.66	$169,805.84		**$514,535.14**
Arrears	$72,774.92	$95,066.46	$82,253.39		**$250,094.77**
Spousal Maintenance	$3,268.38	$3,093.00	$3,265.00		**$9,626.38**

Total	**$240,528.94**	**$278,403.12**	**$255,324.23**		**$774,256.29**
Current Support due	$495,710.23	$510,630.68	$509,397.22		**$1,515,738.13**
Current Distributed	$370,429.91	$375,910.28	$374,659.82		**$1,121,000.01**
% of Distribution of Current	74.73%	73.62%	73.55%		**73.96%**
Cases with Arrears due	409	408	406		
Cases with Arrears Distributed	198	173	178		
% of Cases w/Arrears Payment	48.41%	42.40%	43.84%		

ACCOUNTING UNIT

Reporter: Jessica Gravich

A. Major Highlights

- All annual and quarterly reports were completed by the due dates.
- The 2022 Family Services Budget remains within expectations.

B. Challenges and Concerns

- We are still tracking the IV-E Children's Residential Facility payments that are currently not reimbursed.
- Continue to keep an eye on our fund balance. It remains positive to the previous year.

C. Looking Ahead

- Completed the 2023 budget for Family Service Dept.
- Looking at new processes for upcoming changes to the billing process.

D. Fiscal Fraud/Collections

- Fraud and collection are moving to Financial/Child Support Unit.
- For this quarter the following amounts were collected:

Type	Amount	County Portion	Number of Cases
Fraud	$0	$0	7
Estate (MA)	$4,906.96	$1,226.74	3
Estate (GA)	$0	$0	0

Kanabec County Family Services
3rd Quarter 2022 Report

ADMINISTRATIVE STATISTICS

AREA	1/1/2022 to 3/31/2022	4/1/2022 to 6/30/2022	7/1/2022 to 9/30/2022	10/1/2022 to 12/31/2022	Year to Date Data	2022 Approved Budget
Revenues - Income Maintenance						
State Sources	51,412	35,468	86,410		173,290	185,021
Federal Sources	243,456	223,175	221,580		688,211	1,074,843
Other Sources	68,113	58,881	6,964		133,958	137,661
Fund Balance-Planned Use					-	
Total	362,981	317,524	314,953	-	995,459	1,397,525
Expenditures - Income Maintenance						
Public Aid	99,105	136,108	109,508		344,721	490,100
Personel Services	306,436	315,761	359,823		982,020	1,390,172
	82,021	35,209	31,748		148,978	204,365
Direct Materials	668	1,761	660		3,089	4,850
Other Expenses					-	
Total	488,230	488,838	501,738	-	1,478,807	2,089,487
Revenues - Social Services						
State Sources	112,035	240,025	415,542		767,602	981,971
Federal Sources	327,356	298,609	279,934		905,899	1,159,904
Fees for Services	85,962	68,813	55,433		210,208	127,000
Other Sources	115,304	143,730	96,834		355,868	414,500
Fund Balance-Planned Use					-	
Total	640,657	751,177	847,743	-	2,239,577	2,683,375
Expenditures - Social Services						
Public Aid	352,142	426,247	439,604		1,217,992	1,691,847
Personel Services	534,768	537,238	600,621		1,672,627	2,321,727

Services & Charges	55,360	47,872	45,285		148,517	237,244
Direct Materials	2,173	3,181	1,269		6,623	14,903
Other Expenses			745		745	
Total	944,443	1,014,538	1,087,524	-	3,046,504	4,265,721
Revenues - IM & SS						
State Sources	163,447	275,494	501,952	-	940,893	1,166,992
Federal Sources	570,812	521,784	501,514	-	1,594,110	2,234,747
Fees for Services	85,962	68,813	55,433	-	210,208	127,000
Other Sources	183,417	202,610	103,798	-	489,825	552,161
Fund Balance-Planned Use					-	
Total	1,003,638	1,068,701	1,162,696	-	3,235,036	4,080,900
Expenditures - IM & SS						
Public Aid	451,247	562,355	549,112	-	1,562,713	2,181,947
Personal Services	841,204	852,999	960,444	-	2,654,647	3,711,899
Services & Charges	137,381	83,081	77,033	-	297,494	441,609
Direct Materials	2,841	4,942	1,929	-	9,712	19,753
Other Expenses					-	
Total	1,432,673	1,503,376	1,588,517	-	4,524,566	6,355,208

CHILD PROTECTION

A. Major Highlights:

- Sharon Wright retired after more than 15 years of service to our families, providing her comprehensive knowledge in parenting to improve families.
- Family support team meetings resumed in September and are an asset to connecting the agency with the community and school.
- School is back in session and students are going full time in person. We remain hopeful that this will continue to reduce the number of truancy and educational neglect cases as we continue to navigate COVID.
- Kid's groups were a success in smaller groups and included hiking, geocaching, swimming and fishing.
- Back to school supply give away was a success.

B. Trainings:

- Staff has participated in the following trainings:
  - Better together, IV-E, Legal Processes, Forensic Interviewing, Virtual Meetings, Safety Trainings

C. Challenges/Concerns:

- Limited resources and waiting lists present a challenge to address the needs of clients.
- Chronic chemical use/abuse in the county and its exposure to children.
- Ongoing challenges to court hearing as part of the 10th PICK. Virtual hearings and in person hearing scheduling confusion, long wait times for families, limited GAL advocates,
- Ongoing concerns for COVID exposure to social workers and the families. This has also been a challenge in ensuring on going face to face connections as there continues to be outbreaks.

D. Looking Ahead:

- Children's Activity Fundraising - AVON
- New hire to replace the Community Support Tech position after she retired.
- Fall Conference in St. Louis County.

CHILDREN'S MENTAL HEALTH

A. Major Highlights:

- One youth remained in foster placement.
- Three youth remained in residential placement.
- One youth discharged from residential placement.
- One youth entered residential placement.
- Katie V. (previously in Child Protection) will be the new Children's Mental Health Case Manger as Alissa has taken a new role within Family Services.

B. Trainings

- Alissa and Linda training highlights include DHS presentation on Mental Health funds, 988 webinar, and social media history training.

C. Challenges/Concerns:

- There were 2 Children's Mental Health intakes this quarter compared to 4 in the third quarter of 2021. 20 total intakes for 2022.
- Caseloads have continued being high. Due to ongoing cases being more intense and needing services for longer periods of time as well as ongoing intakes.
- Youth needing higher levels of care are having difficulty accessing this due to available resources for youth with semi-acute needs.

- Continuing to work through the process of the Family First Prevention Services Act. This adds many steps to the placement process for kids seeking residential placement.
- Additional options for kids needing higher levels of care are needed.
- We are still struggling to get required assessment instruments (Child and Adolescent Service Intensity Instrument and Strengths and Difficulties Questionnaire) from therapists.

D. Looking Ahead:

- Continued rising case numbers due to steady intakes and clients receiving services longer.

Children's Services Statistics	**October 2021 – December 2021**	**January 2022 – March 2022**	**April 2022 – June 2022**	**July 2022 – September 2022**
Child Protection (CP)/Child Welfare (CW)				
CP/CW intakes				
○ Opened for assessment	25	45	28	28
○ Screened out (CP only)	84	87	66	77
• Assessments & investigations	47	44	45	36
• Case management	28	45	42	33
• Open CHIPS court files (per child)	25	31	27	24
• Open Adoption Cases	3	3	3	5
• Completed Adoptions	0	0	0	3
Parent Support Outreach Program (PSOP)				
• PSOP intakes	1	2	0	7
• Opened for case management	0	0	0	0
Children's Mental Health (CMH)				
CMH intakes				
○ Opened for case management	6	5	11	4
○ Screened out	0	0	0	0
• Case management (per child)	53	58	51	48
❖ **Out of Home Placements**				
• Children's services placements	23	37	34	31
• Trial home visits	1	5	6	1
• Pre-adoptive/Pre-kinship home	4	6	7	10
• Extended foster care (Age 18-21)	1	1	0	0
• Probation placements	0	0	0	0

Kanabec County Family Services
3rd Quarter 2022 Report

AGING SERVICES

Reporter: Aliina Olson and Krista Eye

A. Major Highlights:

- Completing initial assessments and reassessments with clients in their homes and getting to see them in person. Connecting members with the resources they need when they are at the most critical point in their lives.

B. Training Attended:

- Annual OSHA training online, Aliina completed annual training for MMIS state system

C. Challenges and Concerns:

- Challenge remains the same with affordable housing in our community with the growing aging population. Continuation also of resources in our community for the aging population.

D. Trends:

- Continued growth of this case load and clients turning 65 in our county.

E. Looking Ahead:

- Implementing the new MNCHOICE model for our assessment/reassessment and care plan piece with SCHA. Hopes that Kanabec County can implement more housing choices for our growing elderly population. More activities for elderly in the community to help with getting this population out of their homes and staying active.

Case Load Total-184
New- 16

COMMUNITY SUPPORT PROGRAM

Reporter: Rhonda Bergstadt

A. Major Highlights

- We have held groups at the park again this year. This has been very beneficial to all who have attended. We worked on relaxation techniques to decrease anxiety which has become a major problem with the events of the past few years.

B. Training Attended

- I continue to complete research and training as needed to offer the best and most effective treatment to those I serve.

C. Challenges and Concerns

- Our Local Advisory Board on Mental health has identified a need to educate our community on Mental Health disorders. They have decided to hold a bake sale along with educational material in our community. They are hoping to share information with several people at that time.

D. Looking Ahead

- Fuel Assistance Applications have been completed for many of our people in hopes of decreasing the stressors that come with the heating season.
- We are reinforcing need for all to stay as healthy as possible this upcoming season of global illness.

E. Trends

- Inflation, fixed income, working poor, higher fuel and heating costs. This all equals stress, and increased mental health symptoms

DD CASE MANAGEMENT

Reporter: Kelly Mitchell, Chelsey Bottelson

A. Major Highlights

- Continued changes to the waiver system; many put on hold.
- Completion of waiver audit.

B. Training Attended

- Staff have attended various online trainings and are scheduled to attend a 2 day training next quarter.

C. Challenges and Concerns

- Continued lack of staffing in Community Residential Settings; some outside Kanabec County closing due to no staffing.
- Transportation continues to be a challenge for the individuals in our area. This is a big barrier for our individuals who are seeking employment.
- Audit completed.
- Continues to be long wait lists for day programs. Many are still not operating at full-capacity.
- Increase in caseloads. There has been a big increase in transfers from other counties.

D. Looking Ahead

- Finish any changes and recommendations from Audits.
- Preparing for continued changes to MNChoices and waivers.

E. Trends

- Continued increase of Housing Stabilization Services.
- Continued Increase in Environmental Accessibility Adaptation referrals and referrals to ConnectAbility.
- Continued need for respite, specifically children with disabilities.
- Seeing an increase for exception rates for services for In-home supports due to higher need clients.

- Seeing an increased need in psychiatric residential treatment placements in children. Lack of beds available in the state.
- Increased in hospitalizations of children.
- Increase in high needs cases

KCFS - LICENSING

Reporters: Tonya Burk, Danielle Linkert, Ashlee Lovaas

A. Major Highlights

	Family Child Care	Child Foster Care	Adult Foster Care
New Licenses		2	
Re-licensing	2	2	3
Off Year Visits	4		
Change of Premise			
Pending Applications	1		
Correction Orders		1	1
Negative Actions			
Extensions			
Investigations	2		
Closed Licenses	1 Kanabec 1 licensed by Pine	1	
Orientation provided for (number of persons)	3	1	0
Total Number of Providers in Kanabec County	24	10 – CFC 1 CRS CFC	7 – AFC 13 - CRS

B. Training Attended

- Monthly Licensor Call in Webex (FCC) –Danielle
- Monthly ELICI Trainings- Danielle
- FCC Roundtable Trainings- Danielle
- Monthly Foster Care Webinar –Ashlee
- 245 Roundtable discussions-Ashlee

C. Challenges and Concerns

- Family Child Care Rule 13 Audit Review will take place in October 2022
- Staff shortages in Community Residential Settings

D. Looking Ahead

- Several pending Family Child Care applicants

- Family Child Care Rule 13 Audit Review will take place in October 2022
- Several pending Child Foster Care applicants

E. Trends

- In person Child Foster Care Orientation held every 2 months (August 9th, upcoming October 11th)

ADULT MENTAL HEALTH

Reporter: Cassie Dahlberg, Abby Malecha

A. Major Highlights:

- A client being provided services through Adult Mental Health and civil commitment supervision died while in a treatment setting.

B. Training Attended:

- No conferences were attended during the third quarter. One worker attended a few miscellaneous individual training courses virtually.

C. Challenges and Concerns:

- More inpatient supports are needed than what MN has to offer. People are being quickly discharged from local hospital settings within days, sometimes hours, of voicing homicidal and/or suicidal intent.

D. Trends:

- New and worsening mental health symptoms are being reported by Kanabec residents.

E. Looking Ahead:

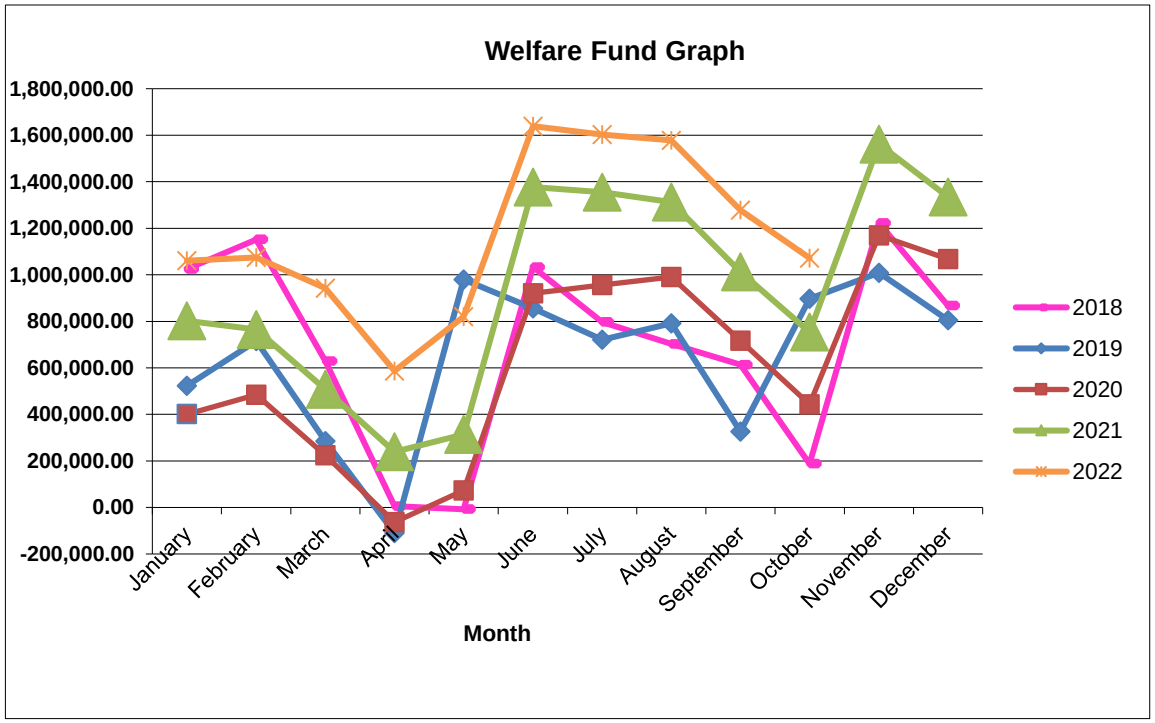
- Kanabec residents continue to struggle with obtaining and maintaining housing.
-

Program Area – Adult Services	01/01/2022 To 03/31/2022	04/01/2022 To 06/30/2022	07/01/2022 To 09/30/2022	10/01/2022 To 12/31/2022	Year To Date Data
702 Social Services					
MNChoices					
# New Assessments	14	15	22		
# Reassessments	53	66	45		
SCHA Community Well – New Enrollees					
# New Enrollees	13	11	16		
Total Members Served	157	168	184		
CADI Waiver					
# clients on waiver	103	104	115		

# adults	79	81	91		
# children	24	23	24		
# clients in residential setting	24	14	34		
# receiving employment services	22	21	23		
Relocation Services					
# receiving RSC	2	0	0		
710 Licensing					
Family Child Care					
# homes active	25	26	24		
# newly licensed	0	1	0		
# relicensed	5	5	2		
Child Foster Care					
# homes active	12	11	11		
# newly licensed	0	1	2		
# relicensed	0	0	2		
Adult Foster Care/Comm Resid Setting					
# homes active	21	20	20		
# newly licensed	0	0	0		
# relicensed	3	0	3		
730 Chemical Dependency					
# Rule 25 assessments	3	1	0		
# Detox paid	4	3	3		
Program Area – Adult Services	01/01/2022 To 03/31/2022	04/01/2022 To 06/30/2022	07/01/2022 To 09/30/2022	10/01/2022 To 12/31/2022	Year To Date Data
740 Mental Health – Adults					
Residential					
# persons in CBHHS	0	0	0		
# inpatient setting	3	6	2		
# IRTS setting	1	2	2		
# in residential setting	6	4	3		
Community Supports					
# CSP clients	26	24	25		
# Adult services	2	1	1		
Case Management					
# Rule 79 clients	29	35	39		
# general case management clients	2	0	0		
Court					
# pre-petition screenings	3	4	1		
# judicial hearings	8	3	4		
750 Developmental Disabilities					
# DD clients – adult	64	64	64		

# DD clients – child	31	34	35		
# clients on waiver	77	78	79		
# SILS clients	7	7	7		
# clients in residential setting	31	31	29		
# clients in ICF-DD	1	1	1		
# clients in nursing home	1	1	2		
# receiving employment support	28	25	26		
# receiving Family Support Grant	0	0	0		
760 Adult Services					
# Adult Protection reports	12	25	36		
# Adult Protection cases	5	8	11		
# Court Visitor cases	3	1	2		
# CSG Cases	4	4	4		
Overall Number of Workgroups	499	492	484		

	2018	2019	2020	2021	2022
January	1,024,705.97	523,556.70	401,131.39	802,602.99	1,060,669.83
February	1,151,821.98	715,738.74	483,781.08	764,375.81	1,074,400.99
March	629,190.77	285,341.21	225,078.17	507,711.89	942,838.71
April	5,607.36	-109,902.43	-63,141.11	239,129.82	586,755.76
May	-7,853.46	979,247.26	73,382.15	313,993.85	820,322.23
June	1,032,778.15	855,820.47	920,867.09	1,376,518.14	1,638,762.92
July	796,820.09	721,467.48	955,700.06	1,355,779.92	1,603,064.80
August	703,093.77	791,435.79	990,235.56	1,312,346.82	1,578,429.94
September	613,301.63	326,963.03	716,408.79	1,012,985.41	1,277,604.14
October	187,807.92	897,606.65	443,084.51	753,774.16	1,072,396.60
November	1,222,983.64	1,008,939.34	1,170,024.75	1,562,104.61	
December	867,114.62	804,618.63	1,067,709.00	1,335,030.43	
Totals	8,227,372.44	7,800,832.87	7,384,261.44	11,336,353.85	11,655,245.92
Averages	685,614.37	650,069.41	615,355.12	944,696.15	1,165,524.59
6 month Avg.	731,853.61	758,505.15	890,527.11	1,222,003.56	1,331,763.44
Rolling 12 month Avg	685,614.37	650,069.41	615,355.12	944,696.15	1,212,698.41



Kanabec County Family Services - Board Financial Report							Through October 2022						
	Total year to date/			8.33%	16.67%	25.00%	33.33%	41.67%	50.00%	58.33%	66.67%	75.00%	83.33%
Department	Budget	% of budget	Total	January	February	March	April	May	June	July	August	September	October
Income Main. Service													
Exp	717,387.00	79.86%	572,904.89	51,831.67	48,106.77	80,924.69	53,106.34	52,548.82	52,868.70	73,249.81	54,106.51	53,456.70	52,704.88
Rev	364,991.00	66.83%	243,939.18	7,767.70	60,202.65	10,634.90	9,823.22	57,730.12	9,823.22	10,055.92	58,070.33	9,950.80	9,880.32
Tax	345,232.48	51.33%	177,191.79	4,846.42					172,345.37				
State Shared Rev			17,214.17							14,518.14			2,696.03
Recoveries													
Exp	19,100.00	99.57%	19,017.06	1,368.08	2,734.61	236.82	8,189.75	0.00	0.00	4,054.65	0.00	2,433.15	0.00
Rev	21,100.00	95.73%	20,199.23	8,478.45	1,272.36	4,949.84	1,224.96	1,190.92	972.72	39.00	1,411.79	39.00	620.19
Tax	22,426.52	51.74%	11,602.62	406.95					11,195.67				0.00
State Shared Rev			1,118.25							943.11			175.14
Burials													
Exp	25,000.00	109.73%	27,433.13	5,400.00	5,076.69	3,089.50	3,504.92	0.00	3,062.20	3,177.11	1,500.00	1,664.00	958.71
Rev			0.00										
Tax			0.00										
Child Support													
Exp	367,603.00	78.80%	289,679.42	28,185.73	27,219.76	35,570.35	29,925.04	27,313.36	27,319.45	36,457.37	26,781.58	27,334.03	23,572.75
Rev	410,000.00	72.16%	295,846.31	1,766.08	77,547.00	17,547.55	16,174.48	61,633.51	16,420.64	29,562.23	42,584.64	16,297.66	16,312.52
Tax													
MA Services													
Exp	483,900.00	75.15%	363,647.72	36,658.39	36,290.38	17,701.02	72,826.52	19,329.61	38,645.07	31,681.21	51,151.15	23,418.93	35,945.44
Rev	418,000.00	80.80%	337,759.69	59,484.31	26,993.02	45,877.24	28,436.21	65,208.57	8,950.23	24,547.76	31,893.41	24,917.30	21,451.64
Tax	64,561.19	51.55%	33,280.62	1,050.67					32,229.95				
State Shared Rev			3,219.19							2,715.01			504.18
Child Care													
Exp	230,950.00	86.71%	200,254.33	36,031.78	93.00	18,896.48	24,495.11	38,761.74	14,138.85	22,728.20	20,024.71	9,330.64	15,753.82
Rev	224,025.00	99.73%	223,411.08	392.00	0.00	86,358.00	462.00	73,807.08	895.00	752.00	59,529.00	685.00	531.00
Tax	6,795.92	50.19%	3,411.13	18.50					3,392.63				
State Shared Rev			338.86							285.79			53.07
Fraud													
Exp	78,622.00	72.96%	57,363.36	5,508.04	5,429.00	5,430.06	5,655.37	5,428.98	5,636.81	7,609.46	5,429.00	5,807.67	5,428.97
Rev			0.00										
Tax	77,020.37	51.49%	39,659.51	1,209.75					38,449.76				
State Shared Rev			3,840.43							3,238.95			601.48
Adult Services													
Exp	4,000.00	38.50%	1,540.00	440.00	220.00	220.00	220.00	220.00	220.00	0.00	0.00	0.00	0.00
Rev	8,581.00	153.95%	13,210.55	18.41	36.40	18.20	18.20	3,190.88	18.20	9,306.66	18.20	567.20	18.20
Tax													
Dev. Disability													
Exp	94,389.00	50.86%	48,002.43	4,574.62	4,909.09	3,506.09	5,919.59	4,751.33	4,979.64	3,811.70	4,950.36	6,269.12	4,330.89
Rev	69,865.00	44.14%	30,840.00		0.00	10,771.00	0.00	9,153.00	0.00	0.00	10,916.00	0.00	0.00
Tax	24,012.23	51.08%	12,264.75	277.47					11,987.28				
State Shared Rev			1,197.31							1,009.79			187.52

Mental Health													
Exp	1,211,095.00	83.04%	1,005,674.05	99,533.69	87,914.73	79,526.55	99,411.21	84,887.65	117,900.40	117,092.80	122,399.42	100,378.74	96,628.86
Rev	740,269.00	99.94%	739,849.93	75,682.62	39,629.88	83,668.40	61,291.77	149,017.91	84,299.63	29,720.12	63,875.79	51,171.22	101,492.59
Tax	461,216.10	51.73%	238,588.70	8,342.49					230,246.21				
State Shared Rev			22,997.41							19,395.62			3,601.79
Chemical Dependancy													
Exp	117,000.00	18.95%	22,171.40	1,500.00	0.00	4,612.35	1,923.72	0.00	6,635.33	0.00	2,500.00	5,000.00	0.00
Rev	51,000.00	64.03%	32,655.44		15,181.89	1,000.60	2,124.15	4,476.00	1,292.40	0.00	5,409.93	1,728.65	1,441.82
Tax	64,561.19	51.55%	33,284.32	1,054.37					32,229.95				
State Shared Rev			3,219.19							2,715.01			504.18
Child Services													
Exp	586,512.00	84.14%	493,499.30	32,504.74	42,541.26	54,226.44	42,238.18	31,880.75	75,359.11	53,451.46	47,816.21	69,690.05	43,791.10
Rev	377,005.00	83.65%	315,380.80	6,341.12	49,382.16	10,351.13	5,926.90	67,710.07	26,068.22	65,045.64	52,165.05	9,719.28	22,671.23
Tax	205,236.63	51.68%	106,060.66	3,603.36					102,457.30				
State Shared Rev			10,233.62							8,630.86			1,602.76
Social Services													
Exp	1,324,304.00	79.28%	1,049,937.82	106,484.12	101,570.28	102,421.94	105,633.71	101,399.99	101,981.50	143,365.88	91,624.27	98,556.06	96,900.07
Rev	1,144,459.00	88.95%	1,018,010.00	35,569.68	140,631.39	69,293.91	58,141.60	136,048.36	52,275.60	295,752.26	117,253.44	60,999.86	52,043.90
Tax	176,240.73	51.89%	91,444.88	3,462.78					87,982.10				
State Shared Rev			8,787.81							7,411.49			1,376.32
Income Main. Admin													
Exp	92,014.00	79.93%	73,544.67	7,236.42	6,916.35	6,698.47	7,541.00	7,066.37	6,793.37	9,923.12	7,141.18	7,246.22	6,982.17
Rev	44,300.00	71.94%	31,868.25	908.20	8,858.52	1,129.75	1,098.78	8,452.19	1,098.78	1,017.51	7,068.98	1,122.63	1,112.91
Tax	46,665.28	51.14%	23,865.77	569.74					23,296.03				
State Shared Rev			2,326.84							1,962.43			364.41
Social Services Admin.													
Exp	252,170.00	79.20%	199,727.82	19,236.45	18,767.34	17,416.47	22,712.06	19,056.44	19,079.71	27,006.13	19,315.94	19,459.20	17,678.08
Rev	65,000.00	68.34%	44,418.00		16,331.00	0.00	0.00	14,960.00	0.00	0.00	13,127.00	0.00	0.00
Tax	183,716.24	51.98%	95,498.63	3,784.64					91,713.99				
State Shared Rev			9,160.56							7,725.86			1,434.70
FS Admin													
Exp	742,159.00	74.94%	556,143.86	74,095.17	57,510.68	46,459.92	60,541.19	47,976.79	44,566.61	66,259.52	52,464.84	52,145.00	54,124.14
Rev	142,305.00	62.48%	88,911.57	2,824.10	22,964.83	3,774.35	3,678.00	21,929.69	3,678.00	3,726.57	18,902.69	3,726.57	3,706.77
Tax	587,620.12	51.35%	301,717.44	8,368.39					293,349.05				
State Shared Rev			30,082.84							24,711.32	344.06	438.54	4,588.92
Agency Totals													
Exp	6,346,205.00	78.48%	4,980,541.26	510,588.90	445,299.94	476,937.15	543,843.71	440,621.83	519,186.75	599,868.42	507,205.17	482,189.51	454,799.88
Rev	4,080,900.00	84.20%	3,436,300.03	199,232.67	459,031.10	345,374.87	188,400.27	674,508.30	205,792.64	469,525.67	482,226.25	180,925.17	231,283.09
Tax	2,265,305.00	51.55%	1,167,870.82	36,995.53	0.00	0.00	0.00	0.00	1,130,875.29	0.00	0.00	0.00	0.00
State Shared Rev			113,736.48	0.00	0.00	0.00	0.00	0.00	0.00	95,263.38	344.06	438.54	17,690.50
Total Revenue	6,346,205.00	74.34%	4,604,170.85	236,228.20	459,031.10	345,374.87	188,400.27	674,508.30	1,336,667.93	564,789.05	482,570.31	181,363.71	248,973.59

Board Approval Report

SSIS pymt. batch #: 130473000

Paid Cnty Vendor				Total Payments	Total Amount
10k Realty, LLC, 000016929				1	1,450.00
Svc Description	**Svc Code**	**Payments**	**Amount**		
Housing Services	144	1	1,450.00		
ANOKA COUNTY NON SECURE, 000010476				1	1,305.00
Svc Description	**Svc Code**	**Payments**	**Amount**		
Health-Related Services	118	1	1,305.00		
Bartel/Phyllis, 000010615				2	240.00
Svc Description	**Svc Code**	**Payments**	**Amount**		
Child Respite Care	489	2	240.00		
Central Minnesota Jobs & Training, 000015800				2	20,003.60
Svc Description	**Svc Code**	**Payments**	**Amount**		
Statewide MFIP Employment Services	237	2	20,003.60		
Central Mn Mental Health Center, 000011298				1	1,000.00
Svc Description	**Svc Code**	**Payments**	**Amount**		
Detoxification	371	1	1,000.00		
Community Living Options, 000011478				2	794.22
Svc Description	**Svc Code**	**Payments**	**Amount**		
Semi-Independent Living Services (SILS)	534	2	794.22		
EAST CENTRAL REG. JUVENILE CTR., 000012085				4	30,800.00
Svc Description	**Svc Code**	**Payments**	**Amount**		
Correctional Facilities	185	4	30,800.00		
Families in Transition Services Inc, 000012296				1	420.00
Svc Description	**Svc Code**	**Payments**	**Amount**		
Family-Based Counseling Services	162	1	420.00		
Ignaszewski/Karissa, 000012959				2	13,293.95
Svc Description	**Svc Code**	**Payments**	**Amount**		
Adult Outpatient Psychotherapy	452	2	13,293.95		
Kanabec County Auditor-Treas, 000013260				1	72.42
Svc Description	**Svc Code**	**Payments**	**Amount**		
Adult Outpatient Psychotherapy	452	1	72.42		
Kanabec County Community Health, 000013263				1	9,308.20
Svc Description	**Svc Code**	**Payments**	**Amount**		
Adult Outpatient Psychotherapy	452	1	9,308.20		
Kelsay/Jennifer, 000013429				1	701.00
Svc Description	**Svc Code**	**Payments**	**Amount**		
Parent Support Outreach Services	167	1	701.00		
Lighthouse Child & Family Services LLC, 000000667				1	650.00
Svc Description	**Svc Code**	**Payments**	**Amount**		
Child Outpatient Diagnostic Assessment/Psychologica	405	1	650.00		
Little Sand Group Homes, 000013715				1	8,870.65
Svc Description	**Svc Code**	**Payments**	**Amount**		
Children's Group Residential Care	183	1	8,870.65		
Minnesota Monitoring, Inc., 000014649				1	207.00
Svc Description	**Svc Code**	**Payments**	**Amount**		
Health-Related Services	118	1	207.00		
Nexus-Gerard Family Healing , LLC, 000012394				1	4,955.04

Board Approval Report

Paid Cnty Vendor / Svc Description	Svc Code	Payments	Amount	Total Payments	Total Amount
Children's Residential Treatment	483	1	4,955.04		
Nexus-Mille Lacs Family Healing, 000014598				2	15,826.80
Children's Residential Treatment	483	2	15,826.80		
Options Residential, 000015334				1	1,469.71
Child Family Foster Care	181	1	1,469.71		
PHASE, Inc., 000015579				2	1,375.92
Day Training and Habilitation	566	1	926.64		
Transportation	516	1	449.28		
Prairie Lake Youth Programs, 000015767				2	8,934.85
Correctional Facilities	185	1	8,866.00		
Health-Related Services	118	1	68.85		
Premier Biotech Labs, LLC, 000015779				2	142.45
Health-Related Services	118	2	142.45		
Procentive.Com LLC, 000010757				2	313.00
Adult Outpatient Psychotherapy	452	2	313.00		
Richardson MD/Paul T, 000016136				2	5,045.00
Adult Outpatient Psychotherapy	452	2	5,045.00		
RSI, 000016246				2	272.88
Semi-Independent Living Services (SILS)	534	2	272.88		
Stokes, Jessica, 000016761				2	8,460.00
Adult Outpatient Psychotherapy	452	2	8,460.00		
The Heritage of Hannah Neil, 000017011				1	9,000.00
Children's Residential Treatment	483	1	9,000.00		
Volunteers Of America, 000017460				4	2,637.00
Semi-Independent Living Services (SILS)	534	4	2,637.00		
			Report Totals:	**45**	**147,548.69**

I hereby certify that the above amounts have been approved and allowed by the county Welfare Board for payment to the claimant as in each instance stated that said county Welfare Board authorizes and instructs the county Auditor and county Treasurer of said county to pay the same.

Signature **Title** **Date**

NOVEMBER 2022 BOARD REPORT (Revised)			
Vendor Name	Amount		
Crescent Tide (GA Burial)	$ 1,157.00		
Cassandra Dahlberg (Mental Health Travel)	$ 53.75		
DHS	$ 13,483.79		
Lisa Goranson (Fraud Travel)	$ 78.00		
Katie Heacock (SS Admin Travel)	$ 219.38		
Leah Hjort (Child Protection Travel)	$ 165.63		
Linda Hosley (Child Mental Health and Staff Development)	$ 932.52		
Innovativie Office Solutions (Office Supplies)	$ 671.93		
MaKala Johnson (Child Protection Travel)	$ 85.00		
Kanabec County Attorney	$ 10,535.40		
Kanabec County Aud Treasurer)	$ 29,581.01		
Kanabec County Aud Treasurer /Car Pool Vehicle Lease Agreement	$ 369.65		
Kanabec County Comm Health	$ 5,906.39		
Patty Kruse (Travel)	$ 32.50		
Kari Lindstrom (Child Protection Travel)	$ 496.88		
Ashlee Lovaas (DD Travel)	$ 136.56		
Abby Malecha (Mental Health Travael)	$ 280.00		
Marco Technologies LLC	$ 1,950.76		
Minn Dept of Health (Child Support Paperwork)	$ 40.00		
Kelly Mitchell (DD Travel)	$ 198.75		
Brainna Nikodym (Financial Travel)	$ 104.75		
Pine County Sheriff Office (Child Support Paperwork)	$ 75.00		
Kristen Struss	$ 183.15		
Timber Trails Public Transit	$ 955.41		
TOTAL IFS DOLLARS	**$ 67,693.21**	31	Total IFS Vendors
TOTAL SSIS DOLLARS	**$ 147,548.69**	25	Total SSIS Vendors
Total	**$ 215,241.90**		
Cost Effective Health Insuarnce & Medicare Part B Reimbursements	**$ 21,481.69**	55	Ins. Reimb.Vendors
MA Medical Mileage	**$ 3,825.64**	15	Med Mileage Vendors
Grand Total	**$ 240,549.23**		
		126	**Total Vendors**

9:25am Appointment

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: Public Programs Health Plans approval	**b. Origination**: K.C. Community Health/Timber Trails Public Transit
c. Estimated time: 5 minutes	**d. Presenter**(s): Renee Petersen

e. Board action requested: Approval to sign agreements with DHS designated health plans to provide care coordination/case management for county residents and non-emergency medical transportation by Timber Trails Public Transit.

f. Background: The Minnesota Department of Human Services has determined that it is in the best interest of counties and their residents to have a choice in the health plans available to them for public programs. Kanabec County was notified that Blue Cross Blue Shield, Medica and U Care will be added along with South Country Health Alliance as the health plans providing service in the County beginning January 1. The Community Health Director has met with the three health plans and their request is that Kanabec County Community Health would provide the care coordination services/case management for Kanabec County residents in order to foster communication and coordinate care and services among members, providers, staff and other organizations. K.C. Community Health already has a contract with Blue Cross so at this time we are requesting approval of contracts with Medica and U Care. K.C. Community Health prefers to provide these services to the county's residents so they have someone local who knows the resources available for them, as well as someone nearby with whom they can communicate. The contracts have been reviewed by the County Attorney.

Additionally Timber Trails Public Transit is the main transportation provider within Kanabec County and as such would like to contract with the 3 health plans to provide non-emergency medical rides for county residents.

Supporting Documents: **Contracts with Medica and U Care and (2) resolutions** **Attached:** **X**

Date Received in County Coordinator's Office:		

MEDICA HEALTH PLANS

KANABEC COUNTY

SNBC/SNBC D-SNP CASE MANAGEMENT PARTICIPATION AGREEMENT

This SNBC/SNBC D-SNP Case Management Participation Agreement ("Agreement"), effective on January 1, 2023 (the "Effective Date"), is made by and between Medica Health Plans, a health maintenance organization organized pursuant to the laws of the State of Minnesota ("Medica") and Kanabec County ("Agency") for the purpose of setting forth the terms and conditions under which Agency will render Case Management Services to Members who are enrolled for coverage under Medica AccessAbility Solution, also known as Minnesota Special Needs BasicCare ("SNBC"), and/or Medica AccessAbility Solution Enhanced ("SNBC D-SNP") (collectively, "SNBC") in accordance with this Agreement.

Article 1
Definitions

Section 1.1 Definitions. The following terms have the meanings given below:

Administrative Requirements:	Administrative requirements and protocols of Medica as set forth in Medica's Care Coordination Resources, Medica's Provider Administrative Manual, Credentialing Plan, Medical Policies and Clinical Guidelines (such as reimbursement, coverage, utilization management, and pharmacy policies), Provider Requirements for Medicare, Medicaid and other government program products, administrative guidelines, provider protocols, training manuals, state-specific addenda, and other manuals and provider requirements, each of which can be found at www.medica.com.
Benefit Contract:	A plan of health care coverage issued by Medica for its SNBC Program Members under the Medica & DHS SNBC Agreement that contains the terms and conditions of the Member's coverage, as set forth in the payment appendix to this Agreement.
Care Coordination Services:	Services that coordinate the provision of services under a Benefit Contract, including without limitation, Health Services, social services, dental services, mental health/substance abuse services, and long term care services for a Member among different health and social service professionals and across settings of care including, but not limited to: needs assessment, service authorization, care communication, care coordination and risk assessment.
Care Coordination Resources:	Care Coordination Resources and protocols are available on www.medica.com.

Care Coordinator:	An individual who provides Care Coordination Services. Care Coordinators must be a registered nurse, licensed social worker, county social worker evaluated by the Minnesota Merit System, physician assistant, nurse practitioner or physician. Alternatively, in lieu of the foregoing requirements, Care Coordinators must be supervised by a licensed social worker, county social worker evaluated by the Minnesota Merit System, registered nurse, physician assistant, nurse practitioner or physician and must meet the DHS requirements for the provision of case management by meeting the social work standards under the Minnesota Merit System. Care Coordinators must have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services and must complete all relevant training required by DHS.
Care System:	A network of health care providers, including primary care physicians, that assumes responsibility for managing and ensuring the provision, coordination, referral and delivery of Health Services for Care System Members who have designated the Care System as their primary care provider.
Case Management:	The assignment of an individual who coordinates Medicare, to the extent feasible, and Medicaid SNBC Services for a Member.
Case Management Fee:	The per Member per month amount to reimburse Agency for Case Management Services, administrative support and care coordination oversight.
Case Management Services:	Care Coordination Services provided under this Agreement in accordance with the Medica & DHS SNBC Agreement. The term "Case Management" is being used in this Agreement for consistency with use of the term in the Medica & DHS SNBC Agreement.
Case Management Subcontractor:	A properly licensed or certified individual, organization or agency that Medica may otherwise contract with (as determined by Medica from time to time) and that renders Case Management Services to a Member through an arrangement with Agency, including a professional services agreement, management services agreement and similar arrangements, when payment for such Case Management Services are included in Medica's payment to Agency. An employee of Agency is not a Case Management Subcontractor.
Case Manager:	An individual who provides Case Management Services and meets the definition of a Care Coordinator.
Certified Assessor	Certified Assessor means a person who completes training and obtains certification from DHS and performs Long Term Care Consultation

	assessments. For SNBC Members, if a lead agency staff person meets all of the training and education requirements of a Certified Assessor the Certified Assessor may perform multiple roles such as a Certified Assessor, waiver case manager and care coordinator.
CMS:	The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.
Copayment or Coinsurance:	The amount a Member is required to pay for certain Health Services in accordance with the Member's Benefit Contract.
Deductible:	The annual amount of charges for Health Services, as provided in the Member's Benefit Contract that the Member must satisfy before triggering any obligation to pay by Medica.
DHS:	The Minnesota Department of Human Services.
Health Risk Assessment ("HRA"):	The assessment of Members for the purpose of identifying health needs, health risks, and social determinants of health, and linking the Member with interventions to promote health, sustain function, and/or prevent disease.
Health Services:	The health care services and supplies provided to a Member and covered under the Member's Benefit Contract.
HIPAA:	The Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereby, as amended.
Home and Community Based Services ("HCBS"):	Services provided under a federal waiver under §1915(c) of the Social Security Act, 42 USC §1396n(c), and pursuant to Minnesota Statutes, § 256B.092, Subd. 4, § 256B.49, and Chapter 256S. These services are for Members who meet specific eligibility criteria including being at risk of institutional care if not for the provision of HCBS. The services are intended to prevent or delay ICF-DD (Intermediate Care Facility for the Developmentally Disabled) placements, Nursing Facility placements, and neurobehavioral rehabilitative hospitalizations. HCBS also include Housing Stabilization Services (HSS).
Local Agency	A county or multi-county agency that is authorized under Minnesota Statutes, §§ 393.01, Subd. 7, and 393.07, Subd. 2, as the agency responsible for determining a Member's eligibility for the Medical Assistance program. Local Agency also means a federally recognized American Indian tribe's social service, human service, and/or health services agency that is responsible for DD (Developmental Disabilities), CADI (Community Alternatives for Disabled Individuals) or BI (Brain Injury) waiver services.

Long Term Care Consultation ("LTCC"):	The assessment of Members, pursuant to Minnesota Statutes, § 256B.0911, for the purposes of preventing or delaying Nursing Facility placements or for admission to or transitioning out of Nursing Facilities and to offer cost-effective alternatives appropriate for the Member's needs, and to assure appropriate admissions to a Nursing Facility. In accordance with the Medica & DHS SNBC Agreement, all Long Term Care Consultation functions under Minnesota Statutes, § 256B.0911 are the responsibility of the Local Agency.
Medica & DHS SNBC Agreement:	The Minnesota Department of Human Services contract with Medica Health Plans for Medica's administration of SNBC as amended or renewed from time to time.
Member:	An individual properly enrolled for coverage under a Benefit Contract.
Nursing Facility:	A facility that meets the requirements of the terms "skilled nursing facility" or "nursing facility," as defined in 42 U.S.C. Sections 1395i-3(a) and 1396r, respectively.
Nursing Facility Services:	Services provided by a Nursing Facility that are covered under the Benefit Contract.
Nursing Home Certifiable ("NHC"):	A designation based on the LTCC that a Member is in need of Nursing Facility level of care, as defined by the Minnesota Department of Health level of care criteria.
Preadmission Screening ("PAS"):	The assessment of Members for the purpose of avoiding unnecessary or inappropriate Nursing Facility placements and offering cost-effective alternatives appropriate for the Member's needs in accordance with the Medica & DHS SNBC Agreement.
Provider:	A health care provider, including a physician or other health care professional, facility, or agency, that is appropriately licensed and/or certified in the state or states where that provider renders Health Services. The health care provider also must have: (a) been accepted by Medica to provide Health Services to Members; (b) satisfied all of the requirements, including but not limited, to licensing, certification, and permits of the state or states where services are rendered to Members by Provider; and (c) status as a participating provider that has not been terminated by Medica.
SNBC Services:	Health Services, Enhanced Services, Nursing Facility Services and all other services and supplies covered under a Member's Benefit Contract and coordinated pursuant to this Agreement. Such SNBC Services include services provided to SNBC Members.

Special Needs Basic Care ("SNBC"):	A Minnesota managed care program pursuant to Minnesota Statutes § 256B.69, Subd. 28, that provides health care and support services delivery system for people with disabilities ages 18 to 64 and who are eligible for Medicaid.
Special Needs BasicCare Medicare Advantage Dual Eligible Special Needs Plan ("SNBC D-SNP"):	An SNBC plan that is also a special type of Medicare Advantage plan and that provides health benefits for people who qualify for both Medicare and Medicaid.

Article 2
Eligibility for Health Services

Section 2.1 Identification Cards. Medica will give Members an identification card that contains the name of the Member and his or her Member number and identifies the specific Benefit Contract under which the Member has obtained coverage. In addition, for Members covered under a Benefit Contract that requires the Member to choose a primary care clinic, the identification card will indicate the Member's primary care clinic.

Section 2.2 Verification of Eligibility. Agency may verify the current status of the Member's eligibility for SNBC by requesting presentation by the Member of his or her identification card or by contacting Medica during normal office hours. However, if Medica subsequently determines that the individual was not eligible for coverage for the services rendered, those services are not eligible for payment.

Article 3
Provision of Health Services and Administrative Requirements

Section 3.1 Provision of Case Management Services and Quality of Care. Agency will provide Case Management Services through its Case Managers who are Agency employees and/or Case Management Subcontractors in accordance with this Agreement. Agency will cause each Case Manager to provide such Case Management Services to Members in accordance with the standards of practice in the community, including protocols established by Medica and as specified in the Medica & DHS SNBC Agreement, and any sub-regulatory guidance, where such Case Manager renders Case Management Services and in a manner so as to ensure quality of care and treatment.

Section 3.2 Case Management Participation and Authority to Contractually Bind Case Managers. Agency will and will cause each Case Manager to be subject to and comply with the terms and conditions of this Agreement.

Section 3.3 Case Management Subcontractors. All Case Management Subcontractors must be eligible for participation with Medica. Agency must provide to Medica, upon request, a list of Agency's Case Management Subcontractors. Medica may, at any time and in its sole discretion, direct Agency to terminate any subcontract with respect to the provision of Case Management Services to Members.

Each subcontract between Agency and a Case Management Subcontractor must:

(a) be in writing;

(b) comply with all applicable laws, regulations (including HIPAA), sub-regulatory guidance and accreditation standards regarding subcontract arrangements;

(c) acknowledge the Case Management Subcontractor's responsibility to comply with Agency's duties under this Agreement and the duties of health maintenance organization operation required by applicable statutes and regulations;

(d) acknowledge Medica's right, during reasonable business hours and upon reasonable notice, to obtain access to all information and records of the Case Management Subcontractor relative to the provision of Case Management Services to Members for the purpose of auditing the Case Management Subcontractor's compliance with the terms of this Agreement; and

(e) be enforced by Agency as necessary to ensure the Case Management Subcontractor's compliance therewith.

Agency will be responsible for any additional financial liability that Medica incurs as a result of either Agency's noncompliance with this Section 3.3 or the Case Management Subcontractor's noncompliance with its subcontract with Agency.

Section 3.4 No Relationship with Excluded Providers. Agency has not been and will not employ or contract with any individual or entity that has been excluded, suspended or debarred from participation in the Medicare, Medicaid or other government programs.

Section 3.5 Access and Standards of Case Management Service.

3.5.1 Access to Case Management Services. Agency will cause each Case Manager to:

(a) provide Case Management Services, as established in this Agreement as well as in Medica's Administrative Requirements and as specified in the Medica & DHS SNBC Agreement and sub-regulatory guidance, to Members as such Case Manager's client load and appointment calendar permit; and

(b) subject to such Case Manager's client load and appointment calendar, accept Members as new clients.

In performing the duties described in this Agreement, Agency will, and will cause each Case Manager to, provide Case Management Services (as specified in 3.5.1 (a) above) to Members and accept new clients on the same basis as Agency and each Case Manager provides such services to and accepts new clients who receive coverage under another, non-Medica benefit plan or health insurance policy. Agency will not, and will cause each Case Manager not to, discriminate against any person based on his or her race, color, religion, national origin, gender, marital status, status with regard to public assistance, disability, sexual orientation, age, physical or mental health status, or any other classification protected by law.

3.5.2 Standards of Case Management Services. On the Effective Date and for the term of this Agreement, Agency will demonstrate the ability and utilize all reasonable efforts to provide Case Management Services in Medica's service areas and maintain the following standards (except where otherwise mutually determined by Medica and Agency):

(a) employ health care professionals and/or technicians available in Medica's service area(s) who are licensed and/or certified in their applicable area of practice by an agency acceptable to Medica, or who have a level of certification, licensure, education, and/or experience

acceptable to Medica or who are under the supervision of a health care professional who is able to satisfy requirements of certification, licensure, education, and/or experience acceptable to Medica;

(b) per DHS notification of Certified Assessor requirements, employ a sufficient number of Certified Assessors to meet enrollment requirements; and

(c) provide education and support to Medica Members, and as may be requested by Medica, including, but not limited to the following;

(i) cooperate with Medica in its efforts to educate physicians and Medica staff regarding current and latest practices in Case Management Services,

(ii) participate in interdisciplinary team meeting (i.e. meetings with Medica case manager and physician, or other appropriate third party) as deemed necessary by Medica case manager,

(iii) participate in case management meetings on a quarterly basis, at a minimum, or as otherwise determined by Medica,

(iv) comply with and be familiar with Medica provided resources, member letters, training manuals, policies and other resources available on the Care Coordination website, and

(v) be responsible for the oversight of Agency staff to include training of new Agency staff working with Medica Members.

3.5.3 Administrative Requirements. Agency will, and will cause each Case Manager to, be subject to and fully comply with all administrative requirements and protocols of Medica as set forth in Medica's Administrative Requirements, Care Coordination Manual, policies, protocols, training manuals or other manuals and guidance, including without limitation those found on Medica's designated website for Care Coordinators ("Administrative Requirements") as well as any and all administrative requirements or protocols specified in the Medica & DHS SNBC Agreement, and any sub-regulatory guidance.

Medica will provide Agency with access to Medica's Administrative Requirements on or prior to the Effective Date and will provide Agency advance notice of any material change or addition to Medica's Administrative Requirements, including the nature of any such changes or additions, unless such change is required of Medica by law, regulation or sub-regulatory guidance in which case Medica will notify Agency of the change when the requirement is made known to Medica. Such notices and materials will be provided or made available to Agency either through access to electronic transmission of such materials or by distribution of paper copies.

3.5.4 Cooperation With and Participation in Review, Service and Performance Improvement Programs. To the extent allowed by law, Agency will, and will cause each Case Manager to, participate in and cooperate fully with such programs as are established by Medica to assess, evaluate and improve the ongoing performance of Agency and Case Managers related to the:

(a) operation of Agency;

(b) provision of Case Management Services; and

(c) provision of SNBC Services designed to improve the health of Members, Member satisfaction or administrative efficiency, including without limitation, quality assurance, health improvement and utilization programs.

During the term of this Agreement, Medica and Agency will confer periodically to review the performance of Agency and Medica under this Agreement.

Section 3.6 Practice Guideline Compliance. Agency will, and will cause each Case Manager to:

(a) cooperate with the implementation of practice guidelines developed by Medica; and

(b) report to Medica, Agency's level of compliance with such guidelines, in the format and within the time frames specified by Medica.

Section 3.7 Member Complaints. Agency will, and will cause each Case Manager to:

(a) report to Medica, in accordance with the requirements set forth in Medica's Administrative Requirements, complaints received from Members regarding Case Management Services provided under this Agreement; and

(b) cooperate with Medica to resolve such complaints from Members, and be bound by the results of such complaint resolution process as it relates to Medica.

Section 3.8 Failure to Comply. Failure to comply with an Administrative Requirement or any requirement under this Agreement may result in loss of reimbursement to Agency or imposition by Medica of a sanction or fine, and/or termination of this Agreement, as may be set forth in this Agreement or the Administrative Requirements. Agency will cooperate with all reasonable utilization management, quality assurance, peer review, Member grievance or other similar programs established by Medica. In the event Medica modifies these programs following the Effective Date of this Agreement, Medica will communicate such changes to Agency prior to their adoption and permit Agency 45 days to comply with such additional or revised programs, unless a longer period of time is agreed upon by both parties. If Medica requests from Agency records related to a Member assessment and care plan for the purpose of regulatory review or for any other reason, Agency will submit such information to Medica promptly and no later than 48 hours after Medica's request or upon the timeline provided by Medica.

Section 3.9 Consumer Data. Agency will comply with all reasonable requests by Medica for information or review of information that Medica intends to release to purchasers of health care coverage, Members, and other consumers, in order to promote high-quality, cost-effective care. Agency may have an opportunity to review consumer data prior to Medica's publication for Medica initiated transparency programs and Agency consents to Medica's release of Agency-related data, including, without limitation, Agency quality, outcomes, and patient satisfaction data, and will not attempt to prohibit or restrict Medica's release of such information in accordance with the Administrative Requirements. Notwithstanding the foregoing, any state or federal statutory or regulatory transparency requirements for Medica or Agency will not be subject to prior review and not subject to the Confidentiality provisions of this Agreement.

Section 3.10 Accessibility for Handicapped Members. Agency will comply with applicable provisions in the Americans with Disabilities Act of 1990, 42 U.S.C. 12101, *et seq*., regarding accessibility of Agency facilities and services to handicapped Members.

Section 3.11 Provision of SNBC Services.

3.11.1 General Requirements. Agency will arrange for the provision of all "medically necessary" SNBC Services for Members in accordance with the standard of practice in the

community in which Agency renders Case Management Services and in a manner so as to ensure quality of care and treatment. Such Case Management Services must include services appropriately tailored to minority and special needs Members as described in detail in the Medica & DHS SNBC Agreement. The medical necessity of mental health services will be determined in accordance with Minnesota Statutes, § 62Q.53. Home and Community Based Services and SNBC Services mandated by state or federal law are not subject to a medical necessity determination, unless otherwise permitted by law and the Medica & DHS SNBC Agreement. The medical necessity of all other SNBC Services will be determined in accordance with the Medica & DHS SNBC Agreement. Agency will ensure Member receives the transition services described in the Medica & DHS SNBC Agreement.

Agency will allow, and will cause each of its Case Managers to allow, qualified Members to directly access any Indian Health Services facility operated by a tribe or tribunal organized under funding authorized by 25 U.S.C. Sections 5321 through 5324 or Title I of the Indian Self-Determination Act, Public Law Number 93-638, for SNBC Services that would otherwise be covered by the Member's Benefit Contract. No prior approval or prior authorization may be placed on such services.

When providing SNBC Services to Members, Agency and Case Managers will consider the Members' rights described in the Medica & DHS SNBC Agreement.

In the event Agency determines it does not have capacity to accept additional Members as clients, Agency will advise Medica of the reasons for Agency's determination. In such instances, Medica may, in its sole discretion, cease offering Agency as a Case Management option to new Members, until Agency has capacity to accept additional Members as clients. Agency's refusal to accept additional Members after expiration of this period of time will constitute material breach of this agreement for which Medica may pursue termination pursuant to Section 9.2.1. Notwithstanding the foregoing, Medica may cease offering Agency as a Case Management option to new Members in its sole discretion at any time.

3.11.2 Preadmission Screening ("PAS") for SNBC. Agency will provide or arrange for each Member an initial evaluation of his/her required level of care to determine eligibility for Nursing Facility placement. The Agency must determine the Member's risk of Nursing Facility admission or current need for Nursing Facility care to ensure that each Member eligible to receive Nursing Facility benefits is screened accordingly. The Agency will perform the PAS on each Member entering Nursing Facilities who have been identified by the Agency, MCO or by a referral from the Senior LinkAge Line. Agency shall conduct the PAS process as described in the Medica & DHS SNBC Agreement.

When a Member is determined to be Nursing Home Certifiable ("NHC"), Agency will ensure that the Member or his or her legal representative is:

(a) informed of feasible alternatives to nursing home care;

(b) offered a plan of care consistent with the screening assessment that is designed to meet the needs of the Member and protect his or her health and safety; and

(c) informed of the right to appeal the level of care decision as required under the Medica & DHS SNBC Agreement and pursuant to Minnesota Statutes, § 256.045.

3.11.3 Health Risk Assessment. Agency shall conduct an HRA of each Member's health needs using the appropriate DHS or Medica form as set forth in the Administrative Requirements. The HRA shall be completed within the first sixty (60) calendar days of the Member's enrollment effective date in Medica, and at least annually thereafter or earlier as necessary due to a change in the Member's health status and/or needs. Agency and/or its Case Managers must not be in a position to directly influence Members' housing or employment to help avoid possible conflicts of interest. Agency may conduct the HRA via telephone or an in-person visit; however, Agency must offer an in-person assessment at least annually to Members who are not on a waiver program and to Members who permanently reside in a nursing facility unless otherwise directed by DHS or Medica. If Agency does not conduct all initial HRAs in-person, Agency shall establish written criteria, policies and procedures, identification processes, schedules and timelines for follow up in-person visits for all Members, based on each Member's needs and health conditions and service status as indicated and as set forth in the Administrative Requirements. The HRA shall include questions designed to identify health risks and chronic conditions, including but not limited to: (a) activities of daily living; (b) risk of hospitalizations; (c) need for primary and preventive care; (d) mental health needs; (e) rehabilitative services; (f) protocols for follow up to assure that physician visits, additional assessments or Case Management interventions are provided when indicated, and (g) social determinants of health. Use of the HRA component of DHS's MnCHOICES tool by Agency will meet the requirements of this section and will become mandatory when MnCHOICES is implemented. Agency shall enter the activities of daily living and other required information collected through the HRA, or Member refusal of having an HRA performed, into MMIS according to the Medica & DHS SNBC Agreement until such time MnCHOICES is implemented and this information is processed automatically.

If a Member refuses to participate in a HRA or Agency is unable to reach the Member after a minimum of three telephone attempts and a letter, Agency shall follow the protocol for unable to reach and refuser Members as set forth in the Administrative Requirements.

Agency shall develop and implement an appropriate plan of care based on information identified in the HRA and in accordance with the timeframes set forth in the Administrative Requirements. Agency will maintain the HRA and the plan of care in the Member's care coordination file.

3.11.4 Nursing Facility SNBC Services. For any Member who was not residing in a Nursing Facility at the time of enrollment under a Benefit Contract governed by this Agreement, Agency will arrange for 100 calendar days of Nursing Facility care to any Member who becomes eligible for such services.

3.11.5 Agency's Rights to Refuse Care. Notwithstanding anything to the contrary in this Agreement, Agency may refuse to provide SNBC Services to any Member when the Member's behavior threatens the safety or well-being of others, or is otherwise disruptive. Agency must receive prior written approval from Medica to refuse to provide SNBC Services to a Member.

Medica may terminate a Member when the Member's behavior threatens the safety or well-being of others, or has otherwise engaged in disruptive behavior as determined by the CMS process described in 42 CFR 422.74 in accordance with the Medica & DHS SNBC Agreement. Medica shall comply with applicable CMS and DHS regulations regarding termination of a Member.

All such decisions will comply with applicable federal and state laws, regulations, and any applicable sub-regulatory guidance. Further, Medica, Agency and Case Managers will cooperate to ensure continuity of care through any necessary care transitions including, but not limited to, providing care until transitional care is located.

3.11.6 Spousal Impoverishment Referral. In the event a Member is married and is admitted to a Nursing Facility, Agency will refer the Member's spouse to the appropriate Agency medical assistance eligibility office for financial evaluation.

3.11.7 Time Frame to Evaluate Requests for SNBC Services.

3.11.7.1 General Request for SNBC Services. Agency and its Case Managers will evaluate all requests for SNBC Services for Members in accordance with the standard of practice in the community in which Agency renders Case Management Services and in a manner so as to ensure quality of care and treatment for Members. Agency and its Case Managers will evaluate all requests for SNBC Services by a Member within the lesser of 10 working days or the time frame required by applicable law. Agency will promptly communicate its decision by telephone in accordance with the Administrative Requirements. If Agency's decision is to deny the request, Agency will follow Medica's process related to denials, including review of and communication about denials. Medica will provide written notification of the decision to the Member or his or her authorized representative and the provider. Each party must notify the other party of any information it has regarding applicable laws, regulations, sub-regulatory guidance and/or the National Committee for Quality Assurance accreditation requirements. The Member may appeal the decision in accordance with the Complaints and Appeals process described in the Benefit Contract and in the Medica & DHS SNBC Agreement.

3.11.7.2 Request for Urgent Services. If the need for SNBC Services is urgent or required to prevent institutionalization, Agency must evaluate the request for SNBC Services and communicate its decision to the Member or authorized representative and the appropriate provider within an expedited time frame that is appropriate to the type and necessity of SNBC Services requested by the Member or on the Member's behalf and in accordance with applicable law, but not later than 72 hours after receipt of the request, or a lesser time period if required by law. Additionally, all such services must be provided within the time frames as required by law.

3.11.7.3 Request for Mental Health/Substance Abuse Services. Agency will arrange mental health/substance abuse services as follows:

- Members requiring mental health/substance abuse crisis services will be treated immediately.
- Members requiring any other mental health/substance abuse services will be given an appropriate assessment of needs within 2 weeks from the Member's request. Members will be treated with any "medically necessary" SNBC Services indicated by the assessment of needs.
- Agency will refer to and follow all of Medica's mental health/substance abuse protocols, including its use of certain participating providers.

3.11.8 Modifications to Benefit Contract. The parties understand and agree that Medica may, on an annual basis, be required to modify or change the Benefit Contract as required by federal or state laws, regulations or sub-regulatory guidance. Any modification or change to this Agreement as a result of a change or modification to the Benefit Contract will be subject to the amendment procedure described in Section 11.1.1 or 11.1.2 of this Agreement.

3.11.9 Medica's Addition of Medica Providers. Medica may at any time add Medica Providers to Medica's participating provider network.

3.11.10 Restrictions in Use and Modification of Agency by Medica. Medica may not include Agency in a network for any additional Medica products without prior approval by Agency.

3.11.11 Case Management, Care Delivery and Care Coordination. Agency shall comply with Medica's Administrative Requirements and the requirements in the Medica & DHS SNBC Agreement related to Case Management Services for Members requiring assistance in accessing Case Management Services, including Members who require intensive Case Management due to serious health conditions. Agency and its Case Managers shall provide a range of Case Management Services from telephone consultation to in-person visits or intensive ongoing intervention based on defined criteria in accordance with the Medica & DHS SNBC Agreement. At least annually, Agency will offer to all Members not on a waiver a in-person visit to assess their needs. Case Managers of Agency will have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services. Case Managers are required to meet Medica's training requirements in the use and referral parameters for home care and mental health services covered by Medica and relevant linkages to fee for service Medicaid. Case Management will be provided and/or supervised by a qualified professional such as a registered nurse, social worker, nurse practitioner, physician assistant, or physician.

If there is a request or need for intensive case management by a county, health care provider, family member or Member, Agency must respond to that request within one (1) business day. Agency must contact Medica to access clinical consultation services as needed to identity the health care needs of the Member and develop a care plan that appropriately addresses the Member's health care needs.

Agency understands and agrees that in furtherance of the goals and purposes of the SNBC and/or SNBC D-SNP program, a substantial objective of Medica is developing the plan of health care coverage identified in the Benefit Contract that coordinates care pursuant to the Medica & DHS SNBC Agreement. Medica is entering into this Agreement to: (a) foster the creation of Care Systems in which all involved Case Managers are encouraged to fully coordinate care of Members among themselves and with Medica in ways that will ensure that all needed care is provided in an optimal manner; and (b) cause SNBC Services to be provided to Members through such means. Pursuant to the foregoing, Medica, in conjunction with Agency, is responsible for ensuring the delivery of the full continuum of SNBC Services available to Members under the Benefit Contract. In fulfilling this responsibility, Medica, in conjunction with Agency, will develop and utilize a disability-oriented case management program for Members. At a minimum, the disability-oriented Case Management program will:

a) ensure that the Case Management Services have the capacity to coordinate the provision of all Medicaid acute and basic care services, including services under a Care System;

b) facilitate annual Provider visits for Members for primary and preventive care;

c) provide an individual needs assessment and plan of care, monitor outcomes, and revise as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs and disability conditions of the Members;

d) develop a care plan within thirty (30) days from the completion of the HRA based on available information including but not limited to issues or needs identified by risk and comprehensive assessments, medical records and/or previous utilization, and Member and/or family input;

e) provide Case Management Services which include procedures for promoting rehabilitation of Members following acute events, and for ensuring smooth transitions and coordination of information among acute, sub-acute, rehabilitation, home care and other settings;

f) use strategies that ensure that all Members and/or authorized family members, representatives, or guardians are involved in care planning, and consent to the medical treatment;

g) make referrals to specialists and sub-specialists as appropriate;

h) coordinate care for American Indian Members;

i) coordinate with Individual Education Plan ("IEP"), an Individual Family Service Plan ("IFSP") or assessment summary including services and supports;

j) coordinate for SNBC Services with children's mental health collaboratives and family services collaboratives, and adult county mental health initiatives;

k) coordinate with county social services and case management systems; and

l) provide transitional care for children between the ages of eighteen (18) and twenty-one (21) who require ongoing services as they transition to adult programs covered under this Agreement.

At any time during the term of this Agreement, upon 30 calendar days prior written notice, either party may require the other party to meet to discuss in good faith the nature of the relationship between the parties and the extent to which the party or parties have been successful or unsuccessful in accomplishing the objectives described in this Section 3.11.11.

Section 3.12 Enhanced Services. Medica has determined that providing Enhanced Services favorably affects Members' total health. "Enhanced Services" are services that Medica believes may enhance the health or well-being of Members through prevention, promotion, assessment or other special interventions or services. Agency will coordinate Enhanced Services for Members as appropriate to achieve maximum health of Members.

Section 3.13 Mental Health/Substance Abuse, Pharmaceutical Providers and Chiropractic. Agency understands and agrees that Medica may, in its sole discretion, designate certain providers as Medica's sole mental health/substance abuse, pharmaceutical, and chiropractic Medica Providers under this

Agreement. If Medica makes any such designations, Agency will refer only to those entities for mental health/substance abuse, pharmaceutical, and chiropractic Health Services for Members.

Section 3.14 Transfers of Members. A Member may change his or her designation of Care System or primary care clinic according to the terms of the Member's Benefit Contract. It is Medica's standard practice that voluntary changes of Care Systems will be effective the first day of the month following notification to Medica. Medica may permit Care System changes at other times of the month in the event of exigent circumstances, such as a Member's allegation of malpractice by his/her Care System.

When Medica receives notice of a change in Care System, Medica will provide notice of such change to the Member's existing Care System and to the Care System into which the Member is changing. If the Member is experiencing an acute or sub-acute inpatient hospital or Nursing Facility episode as of the date at which the change in Care Systems is to occur for such Member, the Member's existing Care System will continue to provide SNBC Services to such Member until such acute or sub-acute episode ceases.

Agency will, and will cause Case Managers to, ensure that, if a Member transfers to another Care System at any time other than month end due to change of circumstances, including but not limited to transferring to a nursing home that is not a Nursing Facility or moving to an agency in which there are no Case Managers, the Case Manager who was the Member's most recent Case Manager will provide or arrange for the provision of Health Services to such Member through the end of the month of the transfer.

Section 3.15 Actions by Medica and Agency. Medica and Agency will use all reasonable efforts to timely and accurately provide all services required to be provided under this Agreement to accomplish the objectives of this Agreement.

Section 3.16 Waiver of Inpatient Hospital Admission. At the discretion of Agency, the three day hospital admission required before skilled nursing care coverage is available for care in a Nursing Facility, as outlined under the Benefit Contract, may be waived and Agency may authorize coverage for skilled nursing care in a Nursing Facility without a previous three day hospital admission under the following conditions: (a) all other applicable legal and regulatory criteria for the provision and coverage of skilled nursing care are met; and (b) the Nursing Facility has the capability of providing all appropriate Health Services pursuant to this Agreement.

Section 3.17 Compliance with Medica Contract with State for SNBC Program. Agency will, and will cause each Case Manager to, comply with all terms and provisions of any contract entered into between Medica and the State regarding the SNBC program. Medica will promptly notify Agency of any material amendments to any such agreement, including the Medica & DHS SNBC Agreement.

Article 4
Reimbursement for Case Management Services

Section 4.1 Reimbursement for Case Management Services. Medica will pay Agency the Case Management Fee and any additional payments in accordance with Appendix A to the extent Agency renders Services to SNBC Members. The total Case Management Fee will be calculated using the information available to Medica at the time of the calculation for the number of Members receiving Case Management Services from Agency for the month, including any adjustments from prior months. Medica will make payments under this Agreement to Agency unless Agency has assigned the right to payment to a third party. Medica will honor the assignment starting not more than 60 days after Agency has provided written notice of such assignment to Medica.

Agency is solely responsible for compensating Case Managers for Case Management Services rendered to Members, regardless of whether payments made to Agency by Medica for such Case Management Services are sufficient to reimburse Agency for payments made to Case Managers.

Section 4.2 Data and documentation related to Case Management Services. Upon request by Medica, Agency will submit data and documentation related to Case Management Services to Medica in a manner and format prescribed by Medica.

Section 4.3 Payment in Full. Agency will, and will cause each Case Manager performing Case Management Services to, accept as payment in full for such services the reimbursement paid by Medica in accordance with this Agreement. Agency will not, and will cause each Case Manager not to, hold financially responsible, collect or attempt to collect additional reimbursement for Case Management Services from:

(a) any Member, except for:

(i) Copayments or Coinsurance;

(ii) Deductibles; and

(iii) any service rendered by Agency or a Case Manager that is ineligible for coverage under the Member's Benefit Contract; provided, however, that if Agency or Case Manager has knowledge that such service is or will be ineligible for coverage under the Member's Benefit Contract, Agency or Case Manager must have informed the Member, in writing, of the ineligibility of any such service prior to its delivery. Agency or Case Manager must also receive Member's signed acknowledgment of such ineligibility and resultant responsibility to pay for such service prior to its delivery; or

(b) any third party, including without limitation:

(i) any insurer or other payor on behalf of a Member;

(ii) any alleged tortfeasor; and

(iii) such alleged tortfeasor's insurer or other payor.

Section 4.4 Member Protection Provisions.

(a) The following provisions are incorporated into this Agreement:

(i) as required by the Minnesota Health Maintenance Act of 1973, Minnesota Statutes, Chapter 62D, Agency agrees not to bill, charge, collect a deposit from, seek remuneration from, or have any recourse against any Member or persons acting on his or her behalf for services provided under this Agreement. This provision applies to, but is not limited to, the following events:

A. nonpayment by Medica; or

B. breach of this Agreement.

This provision does not prohibit Agency from collecting Copayments, Coinsurance, Deductibles, or charges for any services rendered by Agency that are ineligible for coverage.

This provision survives the termination of this Agreement for authorized services provided before this Agreement terminates, regardless of the reason for termination. This provision is for the benefit of Members. This provision does not apply to services provided after this Agreement terminates.

This provision supersedes any contrary oral or written agreement existing now or entered into in the future between Agency and Member or persons acting on his or her behalf regarding liability for payment for services provided under this Agreement.

For purposes of this provision, nonpayment by Medica includes nonpayment by Medica in the event of its insolvency.

(b) The following provision is incorporated into this Agreement as required by the federal regulations promulgated by the Secretary of Health and Human Services pursuant to authority granted to the Secretary under the Health Insurance for the Aged Act, 42 U.S.C. Section 1395hh, which regulations are codified at 42 C.F.R. 417.122(b).

Agency agrees that in the event of Medica's insolvency, Agency will continue to provide any Member with Case Management Services from the date of Medica's insolvency for the duration of the contract period for which premium payment has been made by such Member. Furthermore, Agency will continue to provide Case Management Services to those Members who are confined in an inpatient facility until such Members are discharged.

Section 4.5 Right of Offset. Medica may make adjustments to payments for any overpayments or underpayments, and Medica may exercise a right of offset with respect to any payments made pursuant to this Agreement.

Article 5
Relationship Between Parties

Section 5.1 Relationship Between Medica, Agency and Case Managers. The relationship between Medica and Agency is solely that of independent contractors. Nothing in this Agreement or otherwise will be construed, implied, or deemed to create any other relationship between the parties, including one of employment, agency, joint venture, association, partnership, or any other form of separate legal entity or organization. Neither party to this Agreement will have an express or implied right of authority to assume or create any obligation or responsibility on behalf of or in the name of the other party. The rendering of all Case Management Services and the operation and maintenance of all offices, facilities, and equipment of Agency, solely and exclusively is under the control and supervision of Agency. Medica will not control or be responsible for the Case Management Services rendered by Agency or any Case Manager.

Section 5.2 Relationship Between Agency, Case Manager and Members. The relationship between Agency, Case Managers and any Member is that of Case Manager and client.

Section 5.3 Communications with Members.

(a) Each Case Manager has the right and is encouraged within the Case Manager's scope of practice to discuss with each Member pertinent details regarding the diagnosis of such Member's condition, the nature and purpose of any recommended procedure or service, the

potential risks and benefits of any recommended treatment or service, and any reasonable alternatives to such recommended treatment or service.

(b) The obligations of Agency and each Case Manager to maintain the confidentiality of certain information, as described in this Agreement, do not apply to any disclosures to a Member determined by a Case Manager to be necessary or appropriate for the provision of Case Management Services or the diagnosis and care of a Member except to the extent such disclosure would otherwise violate the Case Manager's legal or ethical obligations.

Section 5.4 Designation as Being Part of Medica's Provider Network. Medica has the right to designate and make public reference to Agency and each Case Manager by name, symbol and/or service mark as being part of Medica's Provider Network. Agency and Case Managers have the right to designate and make public reference to their status as being part of Medica's Provider Network.

Article 6
Liability Insurance, Hold Harmless and Indemnification

Section 6.1 Liability Insurance.

Agency will ensure that Agency and each Care Coordinator/Case Manager under contract with Agency procures and maintains general and professional liability insurance with coverage limits as set forth in Minnesota Statutes, Chapter 466.

Upon request by Medica, Agency will give evidence of any insurance coverage procured pursuant to this Section 6.1. Agency will notify Medica within 30 days of any of the following events related to such insurance coverage:

(a) changes in carriers;

(b) changes in remaining coverage.]

Section 6.2 Agency Hold Harmless and Indemnification. Agency will indemnify and hold Medica harmless against any and all claims, liabilities, costs, damages, losses or judgments, including reasonable attorneys' fees and expenses, asserted against, imposed upon or incurred by Medica that arise out of or relate to acts or omissions, including malpractice, negligence or breach of this Agreement, by Agency or any Agency Case Manager or any of Agency's other employees, agents or representatives. Nothing herein is intended to waive any applicable liability limits set forth in Minnesota Statutes, Chapter 466.

Section 6.3 Medica Hold Harmless and Indemnification. Medica will indemnify and hold Agency harmless against any and all claims, liabilities, costs, damages, losses, or judgments, including reasonable attorneys' fees and expenses, asserted against, imposed upon or incurred by Agency that arise out of the acts or omissions, including the negligence or breach of this Agreement, by Medica or Medica's employees, agents or representatives; provided, however, that no person is an employee, agent or representative of Medica because of his or her relationship to Agency.

Article 7
Compliance and Licensure Requirements

Section 7.1 Compliance and Licensure Requirements. Agency will ensure that all Case Management Services provided under this Agreement will be provided by Case Managers acting within the scope of their authority. Agency will and will cause each Case Manager employed by or under contract with

Agency or any Case Manager to maintain, without material restriction, accreditation as may be required by Medica including all federal, state, and local licenses and permits required to provide Case Management Services under this Agreement and to fully comply with all applicable federal, state, and local laws, regulations, and any sub-regulatory guidance issued in the provision of such Case Management Services.

Agency and Medica are individually responsible for ensuring that their activities are in compliance with all applicable federal, state, and local laws, regulations, and any sub-regulatory guidance issued in the provision of such Case Management Services. Each party will cooperate with the other party in its efforts to achieve and/or maintain regulatory compliance. Agency shall comply with oversight activities imposed by Medica in accordance with the Medica & DHS SNBC Agreement, and Medica's policies.

Section 7.2 Fraud and Abuse Requirements.

(a) Agency understands that this Agreement involves the receipt by Agency of state and federal funds, and that Agency is, therefore, subject to criminal prosecution and/or civil or administrative actions for any intentional false statements or other fraudulent conduct related to its obligations under this Agreement.

(b) Agency will, upon the request of CMS, the Comptroller General, or their designees, and the applicable state fraud control unit or Attorney General's office make available to such requesting agency, unit or office all administrative, financial, medical and any other records that relate to the delivery of items or services under this Agreement. Agency will allow the investigating agency, fraud control unit or office access to these records during normal business hours. To the extent legally permitted and not prohibited by the requesting agency, state fraud control unit or office, Agency will notify Medica in the event of a request by an agency, state fraud control unit or Attorney General's Office to review any Agency records.

(c) Agency will report to Medica any suspected insurance fraud relating to Medica.

(d) In accordance with Section 1902(a)(68) of the Social Security Act, if Agency receives or makes annual payments under Medicaid of at least $5,000,000, Agency must:

(i) establish written policies for all employees, managers, officers, contractors, subcontractors and agents of Agency that provide detailed information about the federal False Claims Act, administrative remedies for false claims and statements, any applicable state laws pertaining to civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A);

(ii) include as part of such written policies detailed provisions regarding Agency's policies and procedures for detecting and preventing fraud, waste and abuse; and

(iii) include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and Agency's policies and procedures for detecting and preventing fraud, waste and abuse.

Section 7.3 Notice of Change in Licensure. Agency will notify Medica in writing within 10 days of any termination, suspension, revocation, restriction, stipulation, limitation, qualification, or other disciplinary action, corrective action plan or investigation regarding any Agency or Case Manager's status.

Section 7.4 Disclosure of Transactions and Ownership Information. Agency will and will ensure that its Case Managers comply with DHS and CMS requirements for disclosure of business transactions and ownership information in accordance with the Administrative Requirements.

Section 7.5 Business Continuity Disaster Recovery Plan. Agency will develop and implement a Business Continuity Disaster Recovery Plan ("BC/DR Plan") that is consistent with industry best practices and conforms to the terms of this Agreement and applicable law. Agency will maintain, review and annually test its BC/DR Plan throughout the term of this Agreement. Agency will provide Medica with a copy of its BC/DR Plan no later than ten (10) days after Medica's request.

Article 8
Books and Records

Section 8.1 Access to and Release of Books and Records. To the extent allowed by law, during the term of this Agreement and for 10 years following termination or expiration of this Agreement, or final audit, whichever is later, or longer in certain instances, as required by law, Agency will provide Medica and its authorized agents, during regular business hours and upon reasonable notice and demand, with access to all information and records, or copies of records, of Agency and each Case Manager related to Case Management Services under this Agreement, to the extent permitted by applicable law and without further authorization by any Member. Agency will and will cause each Case Manager to provide records or copies of records requested by Medica within the time frame provided under applicable law including, but not limited to, laws related to the resolution of Member complaints. If Agency or Case Manager fails to comply with this Section 8.1, Medica will have the right to withhold Agency reimbursement to Agency for Case Management Services furnished by Case Manager until Agency corrects such failure by fully complying with this Section 8.1 and Medica and/or its authorized agents have reviewed the requested information and records or copies of records. Nothing herein modifies or limits Medica's rights under the Dispute Resolution and Termination Articles of this Agreement, nor is it to be construed to bar other legal or equitable remedies that may be available to Medica. This Section 8.1 will not be construed to provide Medica with access to information related solely to the overall financial operations of Agency. Agency will allow Members to access their protected health information and amend incorrect protected health information contained within a designated record set and to receive an accounting of certain disclosures of protected health information as required by HIPAA privacy regulations and applicable state law.

Section 8.2 Access to Records by State and Federal Government. The state and federal government and any of their authorized representatives have access, in accordance with state and federal statutes and regulations, to all information and records, or copies of such, within the possession of Medica, Agency and/or Case Managers that are pertinent to and involve transactions related to this Agreement. Furthermore, Medica is authorized to release any such information and records, or copies of records as is necessary to comply with federal and state laws, regulations, and sub-regulatory guidance as well as requirements of CMS and DHS, applicable to Medica.

Article 9
Term and Termination

Section 9.1 Term. The term of this Agreement commences on the Effective Date, and continues through December 31, 2023 (the "Termination Date"). Unless otherwise terminated pursuant to this Article, this Agreement will automatically renew on the Termination Date and on each one-year anniversary of such date for additional terms of one year.

Section 9.2 Termination. This Agreement may be terminated as follows:

9.2.1 Termination upon Event of Default.

(a) This Agreement may be terminated by Medica immediately upon written notice to Agency upon the occurrence of an Event of Default by Agency hereunder. Each of the following constitutes an Event of Default by Agency:

(i) Agency's ability to perform under this Agreement is materially impaired;

(ii) Medica determines that the health, safety or welfare of Members is in immediate jeopardy if this Agreement is continued;

(iii) Agency files a voluntary petition in bankruptcy, admits in writing its inability to pay its debts, makes a general assignment for the benefit of creditors, is adjudicated as bankrupt or insolvent, or has an involuntary petition in bankruptcy or similar proceeding commenced against it, that continues undismissed for a period exceeding 60 days;

(iv) Agency fails to maintain an insurance program as described in Section 6.1;

(v) Medica reasonably believes that Agency is engaged in fraud or abuse with regard to the provision of Case Management Services under this Agreement. This reasonable belief may be, but is not required to be, based upon the finding of a state or federal government agency, a state fraud control unit, a court of law, or other legal entity that Agency is or has been engaged in fraud or abuse with regard to Case Management Services provided under this Agreement or similar services;

(vi) Agency fails to comply with Medica's privacy practices;

(vii) Agency fails to satisfy any other material term, covenant or condition of this Agreement, and fails to cure such breach within 30 days following its receipt of written notice from Medica describing with specificity the nature of the breach; or

(viii) Agency fails to respond to Medica's inquiries for information within the timeline specified in the communication and, if not specified, within 14 business days.

(b) Subject to the Member protection provisions of Section 4.3 hereof, this Agreement may be terminated by Agency immediately, upon written notice given by Agency to Medica upon the occurrence of an Event of Default by Medica hereunder. Each of the following constitutes an Event of Default by Medica:

(i) Medica continuously fails to make undisputed payments due to Agency pursuant to this Agreement within 45 days after payment is due in accordance with Appendix A for Medica Health Plans business conducted in Minnesota;

(ii) Revocation of any certification or license of Medica necessary for performance of this Agreement; or

(iii) Medica fails to satisfy any other material term, covenant or condition of this Agreement, and fails to cure such breach within 30 days following its receipt of written notice from Agency describing with specificity the nature of the breach.

9.2.2 Without Cause Termination. This Agreement may be terminated by Medica or Agency, without cause, by providing the other party with notice of its intent to terminate at least one hundred twenty-five (125) days in advance of the termination date and such termination will be effective on the date specified in the notice of termination.

9.2.3 Termination for Amendment. This Agreement may be terminated by Agency in the event of an amendment to this Agreement under Section 11.1.1 by providing one hundred twenty-five (125) days advance written notice to Medica, such notice to be provided not more than forty-five (45) days after the date notice of the amendment is received by Agency and such amendment will not take effect during the one hundred twenty-five (125)-day termination notice period if such amendment alters the reimbursement terms or materially alters the Administrative Requirements. All other amendments will take effect on the respective effective date of such amendment.

Section 9.3 Termination of Agency or Case Manager Participation. The participation status of Agency, or each Case Manager terminates upon the earliest of:

(a) the date termination of this Agreement is effective;

(b) the date such Agency, or Case Manager fails to continuously satisfy the standards and procedures of Medica;

(c) the date such Agency's, or Case Manager's state or federally required certification, licensing or other such requirement is suspended or terminated by any state or federal authority;

(d) the date a Case Manager's employment or other association with Agency terminates; and

(e) the date of such Case Manager's death or disability.

If Medica terminates the participation status of a Case Manager pursuant to this Section 9.3, Agency will establish a procedure to ensure that such Case Manager does not deliver Case Management Services to Members, other than in cases of emergency.

Section 9.4 Consequences of Termination. The following apply in the event this Agreement terminates pursuant to Section 9.2, or in the event the participation status of Agency or any Case Manager terminates pursuant to Section 9.3.

9.4.1 Continued Provision of Case Management Services from Date of Notice of Termination to Date of Termination. If termination of this Agreement or of the status of any

Case Manager is not immediate upon provision of notice of such termination, during the period after notice of termination and before the effective date of such termination, the status of Agency or such Case Manager as a provider of Case Management Services remains in full force and effect, except to the extent Medica, in its sole discretion, determines that such status will be restricted by, or otherwise controlled by, Medica:

(a) to ensure that Case Management Services are available and provided to Members in a manner consistent with:

(i) the obligations of Medica under its Benefit Contracts or under any state or federal laws, regulations or sub-regulatory guidance; and

(ii) other standards for provision and availability of Case Management Services established by Medica; or

(b) as a result of actions by Agency or such Case Manager that Medica determines negatively affect Medica's relationship with its Members.

Medica will notify Agency in writing upon imposition of any such restriction.

9.4.2 Review of Communications. Medica and Agency have the right to review any written communication proposed to be delivered by the other party to Members, Case Managers, or Providers regarding termination or suspension prior to distribution of such communication.

Article 10
Dispute Resolution

Section 10.1 Dispute Resolution. In the event a claim, controversy or dispute (collectively "Dispute") between Medica and Agency arises out of this Agreement, any party seeking to pursue the Dispute must proceed with the remedies and procedures as outlined in Medica's Administrative Requirements. If Medica's Administrative Requirements do not address the type of Dispute, timely written notice outlining the Dispute must be supplied by the party seeking to pursue the Dispute. The parties shall attempt in good faith to resolve the Dispute promptly through discussions and negotiations with each other. If the Dispute remains unresolved, either party may initiate litigation of such Dispute.

Nothing in this Agreement will preclude a party from seeking any action necessary to preclude imminent and irreparable harm, including, but not limited to, a temporary restraining order, temporary injunction or other equitable relief for any breach of any duty, obligation, covenant, representation, or warrant set forth in this Agreement.

During the period of time in which the Dispute is under consideration, the parties will proceed diligently with the performance of their duties under this Agreement in a businesslike and efficient manner.

Any and all disputes, controversies or claims involving fraud shall not be deemed to be a Dispute under this Section and; therefore, are exempt from this Section and either party may utilize litigation to resolve such disputes.

In addition, in the event a third party initiates litigation involving one of the parties to this Agreement, and the party hereto who is involved in such third party litigation desires to bring a claim against the other party hereto for indemnity or contribution, the indemnity or contribution claim may be brought in the same venue as the third party litigation.

Article 11
Miscellaneous

Section 11.1 Amendment. This Agreement may be amended as follows:

11.1.1 Amendment by Medica. Any amendment to this Agreement, including a change by Medica to the reimbursement terms or any material change or addition to Medica's Administrative Requirements, issued by Medica at least 45 days prior to the effective date of such amendment will be incorporated into this Agreement on the effective date of the amendment; provided, however, that an amendment that alters the reimbursement terms or materially alters Medica's Administrative Requirements will not take effect if Agency elects to terminate this Agreement as provided in Section 9.2.3.

11.1.2 Regulatory Amendment. Medica may amend this Agreement to comply with applicable laws, regulations, and/or sub-regulatory guidance. Such amendment will be effective on the date the applicable law, regulation, or sub-regulatory guidance becomes effective.

11.1.3 Mutual Amendment. Notwithstanding Section 11.1.1, this Agreement may be amended without satisfaction of the forty-five (45) days' notice requirement in the event the parties mutually agree to amend this Agreement effective on another date.

Section 11.2 Confidentiality. Medica and Agency (including Case Managers and other Agency personnel) will maintain the confidentiality of all information regarding Members in accordance with all applicable state and federal laws and regulations, including without limitation HIPAA privacy and security requirements. To the extent Agency is acting as a Business Associate of Medica as defined by HIPAA, it will comply with the HIPAA Business Associate Requirements set forth in Medica's Administrative Requirements. Agency will and will ensure that Case Managers and other Agency personnel safeguard Member privacy and confidentiality and assure the accuracy of Member health records. For purposes of complying with HIPAA security standards, Agency will maintain the appropriate administrative, technical and physical safeguards for individually identifiable health information that is electronically transmitted or maintained. In addition, except as otherwise required by law or regulation and except as otherwise permitted by Section 5.3 of this Agreement, Agency will, and will cause each Case Manager and other Agency personnel to, maintain, during the term of this Agreement and thereafter, the confidentiality of:

(a) all Member information;

(b) all quality assessment and utilization review information; and

(c) the terms of this Agreement, including without limitation, the amounts paid by Medica to Agency under this Agreement, and will not disclose any such information to:

(i) any third party, or

(ii) any division, business unit or affiliate of Agency that offers or intends to offer services similar to those offered by Medica.

Agency will, and will cause each Case Manager and other Agency personnel to, use its best efforts to protect such information from unauthorized disclosure by any person and will not use or allow any person to use any such information in any way that is detrimental to Medica or that may cause competitive disadvantage to Medica.

Section 11.3 Assignment; Notice of Mergers or Acquisitions. Agency's assignment of its rights or obligations under this Agreement is prohibited without Medica's written consent, whether the assignment

is voluntary or involuntary, by merger, consolidation, dissolution, operation of law, or otherwise. Any purported assignment of Agency's rights or obligations in violation of this Section 11.3 is null and void. Medica may, without the prior consent of Agency, assign its rights and obligations under this Agreement to any entity which controls Medica, is controlled by Medica, or is under common control with Medica. In the event of an assignment, this Agreement is binding upon and will inure to the benefit of each party's successors and assigns.

Agency will notify Medica of any transactions whereby Agency will acquire, be acquired by, be merged with another entity, or incur any other material change in ownership or control. Such notice will be provided at least one hundred twenty-five (125) days in advance of the effective date of such acquisition or merger, or as soon as reasonably practical. The acquired entities will remain under their existing Medica contract including the reimbursement provisions until their Medica contract's next renewal date.

Section 11.4 No Waiver of Rights. The failure of any party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy does not impair or waive any such right or remedy.

Section 11.5 Notice. All notices required under this Agreement will be in writing, signed by the party giving notice, and will be delivered by hand, email, or first class mail and sent to the address set forth at the end of this Agreement for Medica, unless otherwise indicated by Medica, and to the address on file with Medica for Agency, unless otherwise indicated by Agency. Notices to Medica will be addressed to the Director of Medicaid, SNP Product and Strategy. Notices sent by mail are deemed received 2 business days after the postmark date, notices delivered by hand are deemed received on the date of delivery, and email notices will be sent with a return receipt requested, if the return receipt is not received the sender will follow-up by first class mail.

Section 11.6 Administrative Duties. Agency acknowledges and agrees that certain administrative duties required to be performed by Medica under this Agreement may be performed by an entity that is under contract to provide management services to Medica.

Section 11.7 Entire Agreement. This Agreement, as it may be hereafter amended pursuant to Section 11.1, and any Addenda, Appendices, Exhibits and Attachments and Medica's Administrative Requirements as may be modified from time to time by Medica, and the application for participation of Agency and each Case Manager, constitute the entire agreement between the parties regarding the subject matter contained herein. This Agreement supersedes and replaces any agreement previously entered into between Medica and Agency or Medica and any Case Manager relating to the same subject matter and no prior representations or agreements between the parties relating to the same subject matter, oral or written, have any force or effect.

Section 11.8 Governing Law. This Agreement will be construed in accordance with the applicable laws of the State of Minnesota.

Section 11.9 Survival. The provisions of Section 4.4 (Member Protection Provisions), Article 6 (Liability Insurance, Hold Harmless and Indemnification), Section 7.2 (Fraud and Abuse Requirements), Article 8 (Books and Records), Article 10 (Dispute Resolution) and Section 11.2 (Confidentiality) survive termination of this Agreement.

Section 11.10 Severability. Each provision of this Agreement is intended to be severable. If any provision hereof is waived, deemed illegal or invalid for any reason, such waiver, illegality or invalidity does not affect the validity and enforceability of the remainder of this Agreement. The parties agree to

negotiate to achieve a comparable Agreement on a provision in the event such provision is deemed illegal or invalid.

IN WITNESS WHEREOF, duly authorized representatives of both parties have caused this Agreement to be executed.

Kanabec County
Street Address: _____
City, State and Zip Code: _____
_____

By: _____
Name: _____
Title: _____

Date_____

Medica Health Plans
P.O. Box 9310
Minneapolis, MN 55440-9310

Or

401 Carlson Parkway
Minnetonka, MN 55305

By: _____
Kristy Wilfahrt
Title: VP and GM Medicaid,
Markets Growth and Retention

Date_____

EXHIBIT 1

APPENDIX A

PAYMENT APPENDIX

TO

AMENDED AND RESTATED

SNBC CASE MANAGEMENT PARTICIPATION AGREEMENT

(the "AGREEMENT")

FOR

MINNESOTA SPECIAL NEEDS BASICCARE PROGRAM ("SNBC") and

MEDICA ACCESSABILITY SOLUTION ENHANCED ("SNBC D-SNP")

BETWEEN

MEDICA AND KANABEC COUNTY ("AGENCY")

Section 1. Case Management Services Payment.

a. Medica will pay Agency a monthly Case Management Fee of $115.00 per SNBC Member per month ("PMPM"), for Case Management Services rendered by Agency to each SNBC Member in accordance with the Agreement. The Case Management Fee will be paid to Agency on a monthly basis no later than the end of the month following the previous month for which payment is being made based on the enrollment information Medica receives from DHS.

b. The number of SNBC Members factored into the Case Management Fee calculation to determine total monthly payments will include those SNBC Members receiving Case Management Services from Agency at the beginning of the month for which reimbursement is being made. Monthly membership will be restated in order to accommodate changes in enrollment (such as additions or terminations of SNBC Members) that affect the previous months.

Section 2. Provider Taxes. To the extent any payment of taxes are required by law, amounts paid by Medica to Agency as reimbursement for Case Management Services will be inclusive of all taxes imposed on Agency's receipt of such reimbursement amounts, including taxes for which Agency has authority to transfer the additional tax-related expense to a third party. In the event legislative or regulatory action determines that any such tax does not apply to such reimbursement, reimbursements to Agency will exclude any payment for the tax, and Medica may recover from Agency all amounts paid to Agency attributable to such tax. In the event legislative or regulatory action increases or decreases the amount of such tax, reimbursement to Agency will be increased according to applicable law or may be decreased to reflect such change.

PROVIDER PARTICIPATION AGREEMENT

by and between

UCARE MINNESOTA

and

KANABEC COUNTY, dba KANABEC COUNTY COMMUNITY HEALTH

THIS PROVIDER PARTICIPATION AGREEMENT ("Agreement") is made and entered into by and between UCare Minnesota, together with its affiliate UCare Health, Inc. ("UCare"), and **Kanabec County** ("Participant"), (each a "Party" and collectively, the "Parties") and shall be effective as of the January 1, 2023 **OR** the first day of the second month following the month in which UCare signs this Agreement (the "Effective Date").

WHEREAS, UCare Minnesota, a health maintenance organization licensed by the State of Minnesota and its affiliate health plan companies, are engaged in the business of making quality health care available on a prepaid basis; and

WHEREAS, UCare strives to fulfill its mission to improve the health of its members through innovative services and partnerships across communities; and

WHEREAS, Participant desires to participate as a provider of certain covered services for UCare Enrollees in support of the UCare mission; and

WHEREAS, UCare desires that Participant participate as a provider of certain covered services for UCare Enrollees in support of the UCare mission;

NOW, THEREFORE, it is agreed as follows:

ARTICLE 1: DEFINITIONS

1.1 Definitions. The following terms as used in this Agreement shall have the meanings ascribed to them below unless the context clearly requires a different meaning:

"Abuse" means the definition set out in Minnesota Rules, Part 9505.2165, subpart 2, and in the Medicare Managed Care Manual Chapter 21, section 20. Abuse shall also include substantial failure to provide Medically Necessary items and services that are required to be provided to an Enrollee under this Agreement if the failure has adversely affected or has substantial likelihood of adversely affecting the health of the Enrollee.

"Advance Directives" means those requirements as specified under 42 C.F.R. § 422.128.

"Agent" means an entity which is under contract with UCare to perform certain functions related to this Agreement on behalf of UCare.

"Agreement" means this Provider Participation Agreement including any exhibits, schedules, appendices, addenda, or other attachments hereto, as well as the Provider Manual and Provider Communications, all as presently in effect or as hereafter modified and amended.

"Benefit Contract" means a plan of health care coverage issued by UCare to an Enrollee who is eligible for benefits under any of the products listed in Exhibit A, and which contains the terms and conditions of such coverage. Benefit Contract includes plans of health care coverage generally referred to as "evidence of coverage" for Enrollees enrolled in a Medicare product, as well as qualified health plans, as defined in 42 U.S.C. §18021(a), as may be amended from time to time, which are issued or offered by UCare.

"Billed Charges" means the charges for Covered Services included on a claim submitted by Participant.

"Clean Claim" means a claim that is submitted without defect or impropriety, includes any required substantiating documentation (which includes but is not limited to information regarding coordination of benefits and (1) in the case of interpreter services, Interpreter work order and Interpreter MDH roster number and (2) in the case of transportation services, Transportation Assignment number), and has no particular circumstance requiring special treatment that prevents timely payment from being made on a claim.

"Co-payment" or "Coinsurance" means the amount an Enrollee is required to pay for certain Covered Services in accordance with the Enrollee's Benefit Contract.

"Covered Services" means those medical, surgical, hospital, prescription drug, and other health care services designated as covered by the terms of the Benefit Contract, as well as interpreter and transportation services, to the extent designated as covered in the Benefit Contract.

"Deductible" means the annual dollar amount of allowed charges for Covered Services, as specified in the Enrollee's Benefit Contract, that the Enrollee is required to pay as a precondition to payment by UCare.

"Enrollee" means any person who is enrolled in a UCare plan and who is therefore eligible for benefits under a Benefit Contract.

"Event of Default" means a breach which provides an immediate right of termination as specified under this Agreement.

"Medicaid" means the Medical Assistance Program under Title XIX of the Social Security Act established pursuant to 42 U.S.C. § 1396 *et seq*.

"Medical Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the physical or mental health of the Enrollee (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) continuation of severe pain; (3) serious impairment to bodily functions; (4) serious dysfunction of any bodily organ or part; or (5) death.

"Medically Necessary" or "Medical Necessity" means a health service that is consistent with the Enrollee's diagnosis or condition and: (1) is recognized as the prevailing standard or current practice by the provider's peer group; (2) is rendered in response to a life threatening condition or pain; or to treat an injury, illness or infection; to care for a mother and child through the

maternity period; or to treat a condition that could result in physical or mental function consistent with prevailing community standards for diagnosis or condition; or (3) is a preventive health service defined under Minnesota Rules, Part 9505.0355.

"Medicare" means the federal insurance program for aged and disabled people operated under 42 U.S.C. § 1395 *et seq*.

"Medicare Advantage Plan(s)" means a coordinated care plan offered pursuant to 42 U.S.C. § 1395w-21(a)(2)(A), including specialized Medicare Advantage Plans for special needs individuals ("Special Needs Plans").

"Network" means the network of Participating Providers available to Enrollees.

"Never Events" means Medicare non-reimbursable hospital acquired conditions that are reportable as adverse events, pursuant to Minnesota Statutes §144.7065 and applicable Medicare regulations.

"Participating Provider" means a provider of Covered Services, or other services as may be agreed upon in writing, that has a valid, signed contract with UCare and is eligible to provide in-network services to Enrollees.

"Primary Care" means a type of medical care delivery which emphasizes first contact care and assumes ongoing care and/or coordination for the Enrollee in both health maintenance and preventive care as well as management of chronic and acute illness. It is comprehensive in scope and includes appropriate referrals to specialty providers, community resources, all health care services and laboratory services customarily furnished by or through a general practitioner, family practice physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, or other licensed practitioner as authorized by the State in which Covered Services are to be provided, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

"Primary Care Clinic" means any clinic which is a Participating Provider, and which employs or contracts with Primary Care Providers.

"Primary Care Provider" means any provider who is employed by or under contract with Participating Provider who practices Primary Care, and who is professionally qualified in specialty organizations in one or more of the following disciplines: family medicine, general practitioner, pediatrics, internal medicine, geriatrics, obstetrics and gynecology.

"Professional" means any healthcare provider licensed or otherwise authorized by the state in which Covered Services are to be provided, transportation services provider, and qualified interpreter.

"Provider Communications" includes newsletters, alerts, and such other materials as may be made available to Providers on UCare's website.

"Provider Manual" includes any administrative manual made available to Participating Providers by UCare, specifying various administrative policies and procedures, including the Provider Manual at www.ucare.org, which may be amended by UCare from time to time.

"Service Authorization" means an approval by UCare or UCare's Agent that a particular service or treatment is Medically Necessary and that all appropriate, cost effective alternatives have been considered. Service Authorizations are required for specified services or treatment for claims to be processed for payment.

"Urgent Care" means acute, episodic medical services available on a 24-hour basis that are required in order to prevent a serious deterioration of the health of an Enrollee.

ARTICLE 2: APPLICABILITY

2.1 Products Covered Under this Agreement. This Agreement sets forth the rights, obligations, and duties of the Parties in connection with the furnishing of Covered Services to Enrollees enrolled in the products described in Exhibit A, and the conditions under which Covered Services shall be provided by Participant to such Enrollees.

ARTICLE 3: ELIGIBILITY FOR COVERED SERVICES

3.1 Identification Cards. UCare shall give Enrollees an identification card that shall contain the name of the Enrollee, his or her Enrollee number, and the specific product under which the Enrollee has obtained coverage.

3.2 Verification of Eligibility. Participant may verify the current status of the Enrollee's eligibility for Covered Services by requesting presentation by the Enrollee of his or her identification card, through the State of Minnesota's Electronic Verification System, or by contacting UCare. However, if UCare subsequently determines that the individual was not eligible for coverage for the services rendered, those services shall be ineligible for payment and could be subject to payment recovery by UCare. Obtaining a Service Authorization shall not mean that Participant is entitled to payment under this Agreement if the service is not a Covered Service or does not meet UCare's payment requirements.

3.3 Individuals Ineligible for Coverage. If UCare determines that the individual was not eligible for coverage for the services rendered and those services are ineligible for payment as described above, Participant may then directly bill the Enrollee for such services, if permitted by applicable state and federal rules and regulations. UCare shall reimburse Participant for Covered Services when Participant affirmatively verifies the Enrollee's eligibility by using the UCare-approved process for electronic eligibility in accordance with Minnesota Statutes § 62J.536, even if UCare subsequently determines that the individual was not eligible for coverage under a UCare product at the time such services were rendered.

ARTICLE 4: PARTICIPANT OBLIGATIONS

4.1 Scope of Covered Services. Participant shall provide to Enrollees the Covered Services of the type specified in Exhibit B and appropriate ancillary Covered Services related thereto, in accordance with professionally recognized standards of practice, in a manner so as to assure quality of care and treatment, and the terms and conditions of this Agreement and the Provider Manual. In the event Participant provides services which are not Covered Services or are not provided in accordance with this Agreement, UCare will not compensate Participant for such services without prior written approval by UCare. However, if prior written approval was gained by Participant based upon false, misleading, or misrepresented information, or if Participant

otherwise knew or should have known that the provided services are not Covered Services or are not provided in accordance with this Agreement, UCare is not responsible for payment and claims may be denied or recouped, despite prior written approval.

4.2 Provision of Services. Participant agrees that, to the extent feasible, the Covered Services provided by it shall be made available and accessible to Enrollees promptly and in a manner which assures continuity of care. In addition, Participant shall:

a) Not differentiate or discriminate in the treatment of its patients by reason of the fact that a certain portion of its patients are government programs Enrollees;
b) Provide services to Enrollees and accept all referrals of Enrollees in the same manner and within the same time availability as offered its other patients;
c) Not differentiate or discriminate in the treatment of Enrollees because of race, sex, color, creed, religion, health status, age, physical disability, national origin, public assistance status, ancestry, marital status or sexual orientation;
d) Provide Covered Services in a culturally competent manner to all Enrollees including those Enrollees with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds and physical and mental disabilities;
e) Admit all Enrollees to Participant's facilities in a manner similar to those provided to any other Participant patient;
f) Comply with all applicable statutes and regulations regarding accessibility and availability of health care services, including without limitation:
    i) Medical Emergency services shall be made available to Enrollees immediately, 24 hours per day, 7 days per week, either by treating the Enrollee at Participant's site or by directing the Enrollee to an appropriate care site, without requiring Service Authorization;
    ii) Urgent Care services shall be made available to Enrollees within 24 hours of the time services are requested either by treating the Enrollee at Participant's site or by directing the Enrollee to an appropriate care site;
g) Ensure that Covered Services are provided to Enrollees by trained Professionals acting within the scope of an appropriate license, certification, or registration;
h) Not withhold or delay Medically Necessary care that is otherwise covered by this Agreement if withholding or delaying such care adversely affects, or has a substantial likelihood of adversely affecting, Enrollee's health;
i) If Participant provides Primary Care services, not encourage Enrollees under its care to select a different Primary Care Provider due to Enrollee's health status, unless Participant is unable to adequately care for Enrollee;
j) Where applicable, inform Enrollees of follow-up care and provide training in self-care;
k) If available through Participant, provide direct access for Enrollees to mammography screening and influenza vaccinations;
l) If available through Participant, provide direct access for Enrollees to in-network women's health specialists for routine and preventive services; and
m) Not engage in fraud, waste, or abuse.

4.3 Referral and Authorization Requirements. Participant shall provide Enrollees with Covered Services in accordance with any referral or Service Authorization requirements described in the Provider Manual and on UCare's website. In the event Participant provides and/or coordinates Covered Services which require a referral or Service Authorization pursuant to the Provider Manual, but which have not been authorized by UCare or UCare's Agent, UCare will not

compensate Participant for such services. Pursuant to Minnesota Statutes § 62D.l2, subd. 19, UCare will not deny or limit coverage of the service which the Enrollee has received solely on the basis of lack of Service Authorization, to the extent that the service would otherwise have been covered by UCare had Service Authorization been obtained. Participant will not bill Enrollee for lack of compensation from UCare due to Participant's failure to obtain a required referral or Service Authorization. Written referrals or Service Authorizations are not required for obstetrical and gynecological services mandated through Minnesota Statutes § 62Q.52.

4.4 Medical Emergency. In cases of a Medical Emergency, Participant shall notify Enrollee's Primary Care Provider or the on-call physician prior to admission, if feasible. Participant shall make all reasonable efforts to ensure that Enrollees experiencing a Medical Emergency utilize a hospital's emergency department, and to divert or coordinate Enrollees who are not experiencing a Medical Emergency to utilize their Primary Care Provider or an Urgent Care provider.

4.5 Obligations and Duties. Participant shall be and remain subject to all of the same duties, liabilities, and responsibilities towards Enrollees as exist generally between a healthcare professional and a patient. Nothing in this Agreement shall limit or relieve Participant's duties to its patients.

4.6 Communications with Enrollees. Participant shall have the right and is encouraged to discuss with each Enrollee pertinent details regarding the diagnosis of such Enrollee's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment, regardless of benefit coverage limitations. Participant may discuss UCare's provider reimbursement method with an Enrollee, subject to Participant's general contractual and ethical obligations not to make false or misleading statements, to Participant's obligation under this Agreement to maintain the confidentiality of specific reimbursement rates paid by UCare to Participant and to Participant's agreement as a Participating Provider not to disparage UCare or to encourage Enrollees to disenroll in UCare.

4.7 Participant's Internal Operations. The operation and maintenance of the offices, facilities and equipment of Participant shall be solely under the control and supervision of Participant. Participant shall have sole control over the selection and supervision of its staff. UCare shall not control or be responsible for the medical opinions or treatment rendered by Participant.

4.8 Location of Facilities. On or prior to the Effective Date, Participant shall identify to UCare all locations where Covered Services of Participant are made available (or, in the case of transportation services, from which they are dispatched, and in the case of interpreter services, from which interpreter services are arranged and where records of services are maintained), as shown in **Exhibit C**. Information provided shall include the Participant's national provider identifier number (or Unique Minnesota Provider Identification Number, if applicable).

4.8.1 Notice of Changes to Facilities. Participant shall provide notice to UCare, not less than sixty (60) days prior to any site opening, closing, change of location or material reduction in services. UCare shall have the right to refuse to include any proposed location as a result of any transaction (including, without limitation, the foregoing transactions) under this Agreement by giving written notice to Participant within sixty (60) days of receiving such notice. Failure to notify UCare in a timely manner is a material breach of the terms

of this Agreement. In the event that Participant fails to provide appropriate notice pursuant to this section, UCare shall have the right to terminate this Agreement retroactive to the effective date of the change.

4.8.2 Payment Obligations. Participant shall not be entitled to payment hereunder for Covered Services provided at any location not approved of by UCare in accordance with this Section 4.8. Further, in the event that UCare approves of the addition of a location hereunder, UCare shall have the option of paying for services rendered at the new location under UCare's existing agreement with the provider(s) rendering services at that location (if any such agreement exists) or under this Agreement.

4.9 Service Exhibits. To the extent Participant provides Transportation Services, Participant shall comply with **Exhibit E**. To the extent Participant provides Interpreter Services, Participant shall comply with **Exhibit F**.

4.10 Notice of Changes of Ownership and Other Changes of Information. Participant shall provide sixty (60) days' prior written notice to UCare of any change in Participant's name, tax identification number, merger, acquisition, affiliation, or change in fifty percent (50%) or more of the ownership interests in Participant. Failure to notify UCare in a timely manner is a material breach of the terms of this Agreement. In the event that Participant fails to provide appropriate notice of a transaction pursuant to this section, UCare shall have the right to terminate this Agreement retroactive to the effective date of the transaction. In the event any such transaction results in a new legal entity, UCare has no obligation to assign this Agreement to such entity. In the event such a transaction leaves Participant or another UCare in-network provider as the surviving entity, UCare shall have the right to determine, in its sole discretion, whether Participant's or the other UCare in-network provider's agreement applies to the surviving entity.

ARTICLE 5: CONFIDENTIALITY AND RECORDS

5.1 Confidentiality. UCare and Participant shall safeguard an Enrollee's privacy and confidentiality of all information regarding Enrollees in accordance with all applicable Federal and State statutes and regulations, including the requirements established by UCare and each applicable product. In addition, Participant agrees to assure the accuracy of an Enrollee's medical, health and enrollment information and records, as applicable.

5.2 HIPAA Compliance. UCare and Participant agree that each shall be in compliance with the privacy and security standards of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d), including all applicable provisions of the federal privacy standards at 45 C.F.R. §§ 160-164. UCare and Participant also agree that they shall enter into a business associate agreement, as described in those regulations at 45 C.F.R. §164.504(e), if such an agreement is required, as reasonably determined by either Party.

5.3 Agreement Terms. Participant shall, and shall cause its agents and employees to, keep confidential the terms of this Agreement, including the reimbursement rates, during and after the term of this Agreement, except as required by law.

5.4 Collection and Retention of Information. Participant agrees to maintain records, as described in

those regulations at 42 C.F.R. § 422.504(d) and the contracts between UCare and the State of Minnesota governing products under this Agreement, pertaining to Covered Services provided under this Agreement for a period of at least ten (10) years following provision of services.

5.5 Right to Inspect: Release of Information to UCare. Participant agrees to provide to UCare, during the term of this Agreement and for a period of ten (10) years following the provision of services, access to all information and records, or copies of records, related to this Agreement or to Covered Services provided under this Agreement. Participant shall promptly provide, without charge to UCare, records or copies of records relating to this Agreement or to Enrollees as requested by UCare and shall cooperate in any UCare investigation or inquiry into Covered Services provided under this Agreement. Participant has no obligation to release records to the extent such release is unlawful.

5.6 Right to Inspect: Release of Information to Federal and State Agencies. Participant agrees to cooperate, assist, and provide information (in a manner consistent with State and Federal law, including those regulations at 42 C.F.R. § 422.504(i)(2), as requested by the U.S. Department of Health and Human Services, the Comptroller General, CMS, the Medicaid Fraud Control Unit of the Minnesota Attorney General's Office, the Minnesota Department of Health ("MDH"), the Minnesota Department of Human Services ("DHS"), the Minnesota Department of Commerce and/or their designees in any audit or inspection during this Agreement and for a period of ten (10) years following its termination or from the date of completion of any audit, whichever is later, without charge to UCare. With respect to UCare's Medicare Advantage Plans, Participant agrees to ensure that a contract with a "downstream entity" as defined by 42 C.F.R. § 422.2 requires the downstream entity to allow the U.S. Department of Health and Human Services, the Comptroller General, CMS or their designees the right to audit, evaluate, and inspect any books, contracts, and records, including medical records, of the downstream entity involving any transactions related to CMS contract(s) with UCare for Medicare Advantage Plans including special needs plans. Participant has no obligation to release records to the extent such release is unlawful.

5.7 Advance Directives. As set forth in 42 C.F.R. § 422.128(b)(1)(ii)(E), Participant shall prominently document in each Medicare Enrollee's medical record whether or not the Enrollee has executed an Advance Directive.

5.8 Data Practices. To the extent the Minnesota Data Practices Act is deemed to apply to data collected, created, received, maintained or disseminated by UCare or its subcontractors for any purpose in the course of performance of this Agreement, such data shall be governed by the terms of that Act, Minnesota Statutes, Chapter 13, and the rules adopted to implement the Act, as well as any other state and federal laws on data privacy. Participant agrees to comply with these statutes and rules currently in effect and as they may be amended.

5.9 Confidentiality of Substance Use Disorder Records. Participant represents, warrants and covenants that it has obtained (and, prior to disclosure, shall obtain) the required consent to disclose records of substance use disorder treatment protected under 42 C.F.R., Part 2 ("SUD Records"), to the extent SUD Records are provided or required to be provided to UCare under this Agreement, and that such consent does, or shall, permit UCare to use SUD Records for its payment and health care operations purposes. UCare acknowledges and agrees that, to the extent 42 C.F.R., Part 2 applies to its use or disclosure of any patient identifying information contained in SUD Records received hereunder, it is fully bound by the provisions of part 2 upon receipt of the patient

identifying information. UCare further acknowledges receipt of the following notice, in connection with SUD Records, and Participant agrees to provide the following notice, or any other notice required by law in connection with each such disclosure: "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65." UCare shall be permitted to re-disclose SUD Records to its agents, helping UCare provide services described in the Agreement, as long as the agent only further discloses the information contained in the SUD Records back to UCare.

ARTICLE 6: BILLING AND COMPENSATION

6.1 Payment. Participant shall accept as payment in full for Covered Services the reimbursement paid by UCare in accordance with Exhibit D of this Agreement. Other than in coordinating benefits with other payers, Participant shall not:

a) Hold Enrollees financially responsible;
b) Collect or attempt to collect from Enrollee's reimbursement for Covered Services except for Co-payments, Coinsurance, and Deductibles;
c) Collect or attempt to collect from Enrollees additional reimbursement for any service rendered by Participant that is ineligible for coverage under the Enrollee's Benefit Contract unless Participant informed the Enrollee, in writing, of the ineligibility of such service and obtained Enrollee's signed acknowledgement of such ineligibility and resultant responsibility to pay for such service prior to its delivery; or
d) Collect or attempt to collect from Enrollee's reimbursement for influenza, pneumococcal, hepatitis B, and any other vaccinations for which UCare is responsible for payment.

Participant shall hold UCare ultimately responsible for payment for authorized Medically Necessary Covered Services rendered to Enrollees, except for Co-payments, Coinsurance, and Deductibles related to Covered Services.

6.2 Enrollee Protection Provisions.

6.2.1 State of Minnesota Enrollee Protection Provision. The following provision is incorporated into this Agreement as required by Minnesota Statutes § 62D.123 as amended from time to time, understanding that "Provider" refers and applies to Participant:

PROVIDER AGREES NOT TO BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK REMUNERATION FROM, OR HAVE ANY RECOURSE AGAINST AN ENROLLEE OR PERSONS ACTING ON THEIR BEHALF FOR SERVICES PROVIDED UNDER THIS AGREEMENT. THIS PROVISION APPLIES TO BUT IS NOT LIMITED TO THE FOLLOWING EVENTS: (1) NONPAYMENT BY THE HEALTH MAINTENANCE ORGANIZATION OR (2)

BREACH OF THIS AGREEMENT. THIS PROVISION DOES NOT PROHIBIT THE PROVIDER FROM COLLECTING CO-PAYMENTS OR FEES FOR UNCOVERED SERVICES.

THIS PROVISION SURVIVES THE TERMINATION OF THIS AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THIS AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF THE HEALTH MAINTENANCE ORGANIZATION ENROLLEES. THIS PROVISION DOES NOT APPLY TO SERVICES PROVIDED AFTER THIS AGREEMENT TERMINATES.

THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN THE PROVIDER AND THE ENROLLEE OR PERSONS ACTING ON THEIR BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THIS AGREEMENT."

6.2.2 Medicare Enrollee Protection Provision. The following provisions are incorporated into this Agreement as required by 42 C.F.R. § 422.504(g)(1) and 42 C.F.R. § 422.504(i)(3)(i) as amended from time to time:

Participant is prohibited from holding an Enrollee liable for payment of any fees that are the legal obligation of UCare. Participant agrees that in no event, including but not limited to nonpayment by UCare, insolvency of UCare, or breach of this Agreement, shall Participant bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Enrollee or persons (other than UCare) acting on his/her behalf for services provided pursuant to this Agreement. This provision does not prohibit Participant from collecting Co-payments, Coinsurance, Deductibles, or charges for any services rendered by Participant that are ineligible for coverage. In addition, provided this Agreement has not been terminated, Participant shall continue to provide Enrollees with Covered Services through the duration of the contract period for which CMS premium payment has been made to UCare.

For Enrollees eligible to receive benefits under both Medicare and Medicaid, Participant shall not hold Enrollees liable for Medicare Parts A and B cost sharing when the State is responsible for paying such amounts. Participant shall accept UCare's payment as payment in full.

6.3 Billing Procedure. Participant shall submit to UCare all statements for Covered Services rendered by Participant to Enrollees under this Agreement, using complete statistical and descriptive medical and patient data for services provided. Unless otherwise directed by UCare in writing, Participant shall submit claims in accordance with the Provider Manual and Minnesota Statutes § 62J.536, including related regulatory guidance as amended from time to time, using current HCPCS, ICD, and CPT codes. Claims shall comply with all requirements of applicable law, this Agreement, and the Provider Manual. Participant shall certify that such statements accurately and completely reflect the services provided. Participant shall not bill the Enrollee for Covered Services in the event Participant fails to submit claims in accordance with the provisions of this Agreement.

6.4 Claims Submission Timeline. Participant shall submit to UCare, in a format approved by UCare and in compliance with state and federal law, claims for Covered Services no more than twelve (12) months from the date the Covered Services were rendered, or from the date Participant had knowledge of Enrollee's coverage under a UCare Benefit Contract, whichever is later. Claims submitted after such period shall be denied.

6.5 Payment of Claims. UCare shall pay Participant for timely filed claims for Covered Services in an amount determined in accordance with Exhibit D**,** less any applicable Co-payments, Coinsurance, and Deductibles. UCare shall make prompt payment of Clean Claims (unless pended for coordination of benefits or to investigate fraud or abuse) within thirty (30) days after receipt and shall comply with all applicable State and Federal statutes, rules, and regulations relating to reimbursement of claims. UCare has no obligation to reimburse claims for services which are not consistent with the terms for this Agreement or the Provider Manual. Specifically, and without limitation, UCare has no obligation to pay claims submitted by Participant and its practitioners for services until the Participant and its practitioners have successfully completed the credentialing process or for services during periods in which Participant and its practitioners were not appropriately licensed or enrolled in federal and state health care programs.

6.6 Payment Provisions Intent. The Parties acknowledge and agree that the intent of Exhibit D is to reflect increases and decreases in managed care premium rates to UCare from CMS and the DHS, regardless of the specific mechanism used by DHS or CMS to implement the change. Accordingly, unless UCare otherwise notifies Participant in writing, UCare will not apply a change in the reimbursement to Participant if: (a) DHS or CMS does not reflect the value of the fee-for-service change in managed care premium rates to UCare, or (b) the legislation otherwise specifically exempts health plans from applying the change to their payments to providers.

6.7 Corrective Adjustments. UCare shall have the right to make, and Participant shall have the right to request, corrective adjustments to any previous payment for, or denial of, a claim for Covered Services; provided, however, that any corrections by UCare or requests for corrective adjustments by Participant shall be made within twelve (12) months from the date the claim was paid or denied by UCare. For purposes of this section, such time limit shall not apply to adjustments initiated by UCare to address duplicate claims payments, payments for claims determined to be related to fraud or abuse, payment for medical errors, or payment for claims submitted in a manner contrary to this Agreement or applicable law and regulation. UCare may use random sample extrapolation, as described in Minnesota Rules 9505.2220, and other generally accepted statistical methods in calculating the amount of any correction or corrective adjustment.

6.8 Verification and Collection of Co-payments or Deductible. Participant shall not deny Covered Services to an Enrollee receiving Medical Assistance or MinnesotaCare because of the Enrollee's inability to pay the Co-payment or Deductible pursuant to 42 C.F.R. § 447.56, except as otherwise provided by applicable law or regulatory guidance. Notwithstanding the foregoing, and where not prohibited by applicable law, in the event that an Enrollee enrolled in any product other than Medical Assistance continuously fails to make payment of Co-payments or Deductibles after being provided reasonable opportunity to make such payment, Participant may choose not to provide Covered Services to such Enrollee. In all instances, Participant must not deny services to the Enrollee upon his or her first visit to the provider, must provide Enrollee advance notice of Participant's debt policy, and must allow the Enrollee a reasonable opportunity to make payment on any outstanding debt. Participant is prohibited from routinely waiving Enrollee liability amounts.

6.9 Insurance Coordination and Subrogation. Participant shall make a good faith effort to secure information on the sources of third-party coverage available to an Enrollee for whom Participant provides Covered Services and shall forward such information to UCare. Participant agrees to coordinate benefits with other payers in accordance with industry and Medicare standards and procedures, and to submit copies of all bills coordinated with other payers to UCare upon UCare's request. Participant shall cooperate with UCare in connection with UCare's subrogation and coordination of benefits activities.

If UCare has primary financial responsibility for Covered Services, UCare shall pay Participant an amount determined in accordance with the payment terms of this Agreement without regard to payments to be made to Participant by such other payer. If UCare has secondary financial responsibility for Covered Services, UCare shall pay Participant, after receipt by Participant of payment from the primary payer, an amount equal to the payment that UCare would have paid to Participant under the payment terms of this Agreement had UCare been the primary payer, less any amounts paid to Participant by the primary payer.

Without limiting the foregoing, with respect to Enrollees in state public health care programs, Participant must return any third party payments for Covered Services to UCare if Participant received such third party payment more than eight (8) months after the date the claim was adjudicated, or such other period as set forth in Minnesota law or regulation or the contracts between UCare and the State of Minnesota governing products under this Agreement, in order to enable UCare to return the payment to the State of Minnesota.

6.10 Risk Adjustment Data. With respect to UCare's Medicare Advantage plans and to the extent applicable to Covered Services provided by Participant, Participant shall cooperate with UCare to ensure compliance with 42 C.F.R. § 422.310 as amended from time to time, and, as a condition of payment by UCare for Covered Services, Participant shall submit complete and accurate risk adjustment data as required by CMS, including complete and accurate diagnosis codes on claims for payment. Such data shall be supported by Participant's medical records in accordance with CMS documentation standards. Participant shall timely submit medical records or other information requested by UCare, CMS or their subcontractors for the validation of risk adjustment data in accordance with 42 C.F.R. § 422.310(e). If UCare coordinates, provides or identifies training or education addressing the submission of risk adjustment data and related medical record support, Participant shall ensure that its practitioners and staff involved in recording diagnoses in medical records and submitting diagnoses codes in claims participate in such training or education as reasonably requested by UCare. If CMS seeks recovery of overpayments from UCare resulting from Participant's submission of diagnosis data which did not meet applicable CMS requirements or if a UCare audit identifies such data as non-compliant, the Parties agree that Participant shall pay UCare the penalty and that they shall work together to identify any additional amounts due to UCare from Participant based on the amount or proportion of Participant's data and medical records that CMS or UCare determined were non-compliant. Evidence of CMS' findings or UCare audit findings will be shared with Participant, identifying the diagnosis codes submitted but not substantiated by Participant's medical records that created the overpayment.

6.11 No Payment for Medical Errors. Participant shall not bill UCare for medical errors, or "never events," in accordance with CMS' Medicare coverage guidelines or Medicaid standards as they may be amended from time to time. Participant shall notify UCare if a medical error has occurred

related to a claim that has been paid so that UCare can make the appropriate adjustment. UCare shall not reimburse Participant for medical errors and shall follow CMS coverage guidelines in determining whether denial or recovery of payment is warranted.

6.12 Suspension of Payments. Except when UCare has good cause, as described below, UCare must suspend all state public health care program payments to Participant after the following:

a) DHS has notified UCare that it has suspended all Medical Assistance, or Medicaid, payments to Participant based on a determination there is a credible allegation of fraud against Participant for which an investigation of payments made under the Medicaid program is pending; or
b) UCare determines there is a credible allegation of fraud against Participant for which an investigation is pending under a state public health care program.

The suspension of payments under this paragraph will be temporary and will not continue after either of the following:

a) DHS or UCare or the prosecuting authorities determine there is insufficient evidence of fraud by Participant and DHS or UCare has notified Participant of the lack of evidence; or
b) Legal proceedings related to Participant's alleged fraud are completed.

UCare may find good cause exists not to suspend payments, not to continue a payment suspension previously imposed, or to suspend payment only in part if any of the provisions of 42 C.F.R. § 455.23(e) or (f) are applicable. For purposes of implementing a good cause exception under the provisions of 42 C.F.R. § 455.23(e) and (f), "UCare" determinations shall be substituted for "State" determinations.

For purposes of a payment suspension, "credible allegation of fraud" means an allegation which has been verified by DHS or another state or federal agency, or by UCare, from any source, and which has indicia of reliability. To effectuate the payment suspension, UCare may suspend participation of Participant in UCare's Network and restrict Enrollees' access to Participant's services. Suspension under this section is not subject to Section 10.4 Dispute Resolution.

ARTICLE 7: QUALITY ASSURANCE AND UTILIZATION MANAGEMENT AND EVALUATION

7.1 Services Review and Evaluation. Participant agrees to cooperate fully with, participate in, and abide by UCare's decisions concerning any reasonable programs, such as quality assurance review, utilization management, and peer review, that may be established from time to time by, at the direction of, or in cooperation with UCare to promote the provision of high-quality Covered Services to Enrollees and to monitor and control the quality, utilization and cost of Covered Services rendered to Enrollees by Participant. Participant further agrees to cooperate, as may be reasonably requested by UCare, with any independent organization or entity contracted by UCare to provide quality review, utilization review, or quality improvement activities related to Covered Services provided under this Agreement. Participant shall make available to UCare all information pertaining to Enrollees reasonably requested by UCare in connection with each such review or program.

7.2 Reports and Data. Participant agrees to furnish UCare with any reports or data concerning the services provided by Participant to Enrollees as UCare may reasonably require and in such form

as UCare shall reasonably designate. Such data and reports shall be accurate, provided at Participant's expense and by a date determined by UCare after consultation with Participant. Participant shall report to UCare credible information about fraud, waste and abuse related to services provided to Enrollees, as required by CMS and DHS. Participant acknowledges that Enrollees consent to such disclosures upon enrollment and shall not require UCare to obtain additional consents and releases from Enrollees prior to providing such data and reports to UCare. The chief executive officer of Participant, the chief financial officer, or an individual delegated the authority to sign on behalf of one of these officers, shall certify from time to time, as requested by UCare, in accordance with 42 C.F.R. § 422.504(l)(3) that the encounter data and other data supplied by Participant (based on their best knowledge, information and belief) are accurate, complete and truthful.

7.3 Complaints, Appeals and Grievances. Participant shall cooperate with UCare's Enrollee complaint system and procedures as described in the Enrollee's Benefit Contract. Participant shall designate a person with appropriate authority to be responsible for cooperating with UCare in the handling and resolution of all complaints, appeals, and grievances. Participant shall cooperate in providing information and access to documents and Participant's personnel in conjunction with any UCare investigation or inquiry. If requested by UCare, Participant shall conduct a thorough internal investigation and take appropriate remedial action to address complaints, appeals and grievances that involve any Participant Professionals or other staff. Such an investigation must be conducted as soon as practicable, but, in any event no longer than five (5) business days after UCare notifies Participant of an issue. In the event of serious allegations, such as sexual harassment, unsafe behavior or significant member safety concerns, the involved Professionals may not provide Covered Services under this Agreement during the period in which the allegation is being investigated. Participant shall adhere to the applicable state and federal appeals and expedited appeals procedures, including gathering and forwarding to UCare information regarding such appeals in accordance with the procedure described in the Provider Manual. Participant shall inform UCare of all material complaints, appeals, and grievances filed with Participant that are related to Participant's delivery of Covered Services. Participant shall cooperate with and participate in UCare's dispute resolution process, shall comply with UCare's requirements (as described in the Provider Manual) related to resolution of service denials or reductions, and shall assist UCare in resolving complaints, appeals, and grievances, as reasonably requested by UCare.

7.4 Medical Error Detection and Reduction. Participant shall develop and implement patient safety policies to systemically reduce medical errors. Such policies shall include systems for identifying and reporting errors and processes to discover and implement error-reducing technologies.

7.5 Review, Performance, and Service Improvement Programs. Participant shall be subject to and comply fully with all reasonable protocols established or modified from time to time by UCare with respect to the provision of Covered Services to Enrollees, including, without limitation:

a) Protocols related to coverage policies, quality assurance, and utilization management;
b) Protocols and procedures as set forth in the Provider Manual or other protocols and procedures disseminated to Participant;
c) Protocols and procedures related to UCare's surveys of Participant's sites;
d) Protocols and procedures to identify assess and establish treatment plans for Enrollees who have complex or serious medical conditions; and
e) Protocols and procedures to use patient-centered decision-making tools designed to engage Enrollees early in the decision-making process.

In the event UCare modifies these programs following the Effective Date of this Agreement, UCare shall communicate such changes to Participant prior to their adoption and permit Participant thirty (30) days to comply with such additional or revised programs, unless a longer period of time is agreed upon by the Parties. UCare may modify these programs through the Provider Manual, Provider Communications, or by communicating directly with Participant in writing. Participant is responsible to sign up to receive changes to the Provider Manual, Provider Communications, and other UCare communications, and to review and understand such changes. Continued failure to comply with any protocol, procedure, term of the Provider Manual, or term of this Agreement may result in loss of reimbursement to Participant and/or termination of the Agreement.

7.6 Performance Data. Participant agrees to allow UCare to use data regarding performance by Participant, including its practitioners, for purposes as permitted by law, including but not limited to quality improvement activities, public reporting to consumers, and designation as a preferred or tiered network.

7.7 Off-Shore Services. If Participant or any subcontractor of Participant performs or intends to perform any activities pursuant to this Agreement outside the territory of the United States of America or to send information regarding UCare members outside of such territory ("Off-Shore Services"), Participant must obtain the prior written consent of UCare's Chief Legal Officer or his or her designee. If UCare gives consent to Participant, or any subcontractor of Participant, to provide Off-Shore Services, UCare reserves the right to revoke such consent in its reasonable discretion, or if UCare is required to do so due to any regulatory or other legal requirements.

ARTICLE 8: LICENSURE STATUS, CREDENTIALING, AND COMPLIANCE

8.1 Licensure Status. Participant agrees to ensure that its employed and contracted physicians, other Professionals, and facilities will maintain, without material restriction, all federal, state, and local licenses and permits required to provide Covered Services under this Agreement. Participant also agrees to notify UCare in writing within ten (10) days of any of the following:

a) Anticipated or actual material change in the capability of its physicians, its Professionals, or facilities to provide Covered Services under this Agreement;
b) Restriction, termination, stipulation, suspension, qualification, surrender, loss or limitation of licensure (including, in the case of transportation providers, loss of a driver's license or insurance), registration, certification, medical staff privileges at any health care facility, interpreter privileges at any health care facility or health plan or other disciplinary actions regarding the license;
c) Disciplinary action, corrective action plan or investigation regarding Participant's or any Professional's license, certification, medical staff privileges at any health care facility, or interpreter privileges at any health care facility or health plan;
d) Change in participation status with Medicare, Medicaid or any Minnesota state health care program of any Professional(s) providing services under this Agreement or employed by Participant;
e) The filing of any legal action, excluding medical malpractice actions, against Participant or any of its employed or contracted physicians, other Professionals, or facilities;
f) Participant's, employed or contracted physicians, or other Professionals' conviction of a crime, excluding misdemeanors;
g) Any judicial or regulatory finding that Participant or any of its employed or contracted

physicians, other Professionals, or facilities, is liable for the death of a patient, passenger, or resident or has engaged in the maltreatment of a child or vulnerable adult;

h) The revocation, conditioning, restriction, denial, suspension, voluntary surrender, or other adverse action involving any of Participant's facilities' licenses, accreditations, certifications, or provider enrollments;

i) The assessment of any penalty or fine against, or the institution of any investigation involving, Participant by a governmental entity, including, without limitation, the Medicare program (or any of its private contractors), or any Medicaid program (or any of their private contractors);

j) Any third-party payer's revocation, reduction, denial, suspension, or other adverse action taken against Participant's network participating due to inappropriate utilization management or quality of care issues; and

k) Any other failure of Participant or any of its Professionals to meet the requirements of section 8.2 or other competency requirements set forth in this Agreement or an Exhibit hereto.

Failure to notify UCare in a timely manner is a material breach of the terms of this Agreement.

8.2 Credentialing. Participant and its Professionals shall be subject to and comply with UCare's applicable credentialing requirements as specified in the Provider Manual. UCare shall furnish to Participant notice of any change or addition to the credentialing requirements, including the nature of any such changes or additions, prior to the effective date of such changes or additions.

8.2.1 As specified in UCare's credentialing requirements, Participant shall demonstrate to UCare upon UCare's request, at minimum, that:

a) Each of its physicians has a current and unencumbered license to practice medicine in each state in which he or she practices;

b) Each of its non-physician Professionals who must be credentialed (as described in the Provider Manual) is appropriately licensed, registered, or certified, without restrictions, in each state in which he or she furnishes services;

c) Its physicians have current and unencumbered Drug Enforcement Agency (DEA) numbers;

d) It is not and will not during the term of this Agreement become a party to any exclusive agreement which, by its terms, precludes Participant or any Professional from rendering Covered Services hereunder; and

e) It and its Professionals have never been convicted of fraud in regard to the United States Internal Revenue Service or any state tax agency.

8.2.2 If appropriate, Participant shall further demonstrate to the satisfaction of UCare that its physicians are certified to practice in their respective medical specialty by the appropriate medical specialty board or other nationally recognized organization or are otherwise qualified to provide Covered Services pursuant to this Agreement.

8.2.3 A physician or other Professional employed by or under contract with Participant who is not yet credentialed by UCare, but who must be credentialed (as described in the Provider Manual), shall not provide services to Enrollees; however, this Agreement shall continue to be in effect for all physicians and other Professionals employed by or under contract with Participant who are and remain so credentialed.

8.3 Certification. Participant warrants that its contracted and employed providers are currently certified as providers under Title XVIII and Part A of Title XI of the Social Security Act (Medicare), and certified in accordance with the regulations governing participation of providers in the Medical Assistance Program under Title XIX of the Social Security Act (Medicaid) and that it will endeavor to maintain said certifications during the term of this Agreement. In the event any action is taken against a provider to revoke or suspend such certification, Participant shall, immediately upon learning of such action or the possibility of such action, give notice to UCare. Pursuant to 42 C.F.R. § 422.204, Participating Providers that are "providers of services" under Section 1861(u) of the Social Security Act must have a provider agreement with CMS permitting them to provide services under original Medicare.

8.4 Compliance with State and Federal Laws. Participant agrees to comply fully with all applicable state and federal statutes, rules, and regulations pertaining to the delivery of Covered Services, including but not limited to:

a) Medicare laws, regulations, and CMS instructions, as well as UCare's contractual obligations with CMS as applicable;
b) At minimum, quarterly updates to demographic data, as required by the Medicare Managed Care Manual;
c) DHS, MDH, Minnesota Department of Commerce and other Minnesota state laws, rules, regulations and instructions;
d) All state and federal laws applicable to entities which receive federal funds, including but not limited to the Stark Law set forth under 42 U.S.C. § 1395nn, and 42 C.F.R. § 411.350 through § 411.389, the federal Anti-Kickback Law set forth under 42 U.S.C. § 1320a-7b and related regulations, and the federal False Claims Act set forth under 42 U.S.C. § 3729 and related regulations;
e) Applicable provisions of contracts between UCare and the State of Minnesota governing products under this Agreement which have been communicated to Participant; and
f) All applicable laws and regulations promulgated under Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Americans with Disabilities Act.

8.5 Oversight. Participant acknowledges that UCare oversees and is accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations and shall cooperate with UCare's oversight efforts. To the extent UCare delegates any functions, it shall comply with the Medicare Advantage delegation regulatory requirements, as amended from time to time. UCare shall only delegate activities or functions to Participant pursuant to a written delegation agreement in compliance with 42 C.F.R. § 422.504(i)(3) and (4).

8.6 Fraud, Waste and Abuse. Participant shall cooperate with UCare as part of its investigative process and prevention efforts pertaining to fraud, waste and abuse, including participating, and requiring Participant's staff to participate, in such training coordinated or designated by UCare. Participant hereby attests and acknowledges that it has a compliance program which addresses fraud, waste and abuse (including but not limited to the federal laws described in Section 8.4(d) above) and includes training of employees and of contractors on a regular basis, but in no event less than annually. The chief executive officer of Participant, the chief financial officer, or an individual delegated the authority to sign on behalf of one of these officers, shall certify, when requested by UCare, that Participant is in compliance with all fraud, waste and abuse requirements and that all Participant staff have completed training on fraud, waste and abuse in accordance with this section. Participant shall document that training on fraud, waste and abuse has occurred in

accordance with this section, and promptly provide UCare evidence of such training upon UCare's request. For purposes of this section, the term "fraud" includes, without limitation, the definition set forth in Minnesota Rules, Part 9505.2165, subpart 4 and in the Medicare Managed Care Manual Chapter 21, section 20.

8.7 Physician Incentive Arrangements. Participant agrees that for Covered Services provided under this Agreement it does not, and will not without the prior written consent of UCare, enter into contracted relationships with any physician or "physician group," as that term is defined in 42 C.F.R. § 422.208, or any intermediate entity that contracts with any physician or physician group, which places physicians at "substantial financial risk," as that term is defined in 42 C.F.R. § 422.208, for services Participant does not furnish. In addition, Participant shall disclose to UCare, on an annual basis, the following information regarding any "physician incentive plans" (as that term is defined in 42 C.F.R. § 422.208 and used in 42 C.F.R. §§ 438.3(i) and 422.210) to which Participant or its approved subcontractors is a party, and shall comply with the following requirements: (1) The physician/physician group for which risk has been transferred for services not furnished by the physician/physician group, such as referral services; (2) The type of incentive arrangement such as withhold, bonus or capitation associated with the transfer of risk for the physician/physician group; (3) The percent of the potential payment to the physician/physician group that is at risk for referrals; (4) The panel size, and if patients are pooled, the pooling method used to determine if substantial financial risk (SFR) exists for the physician/physician group; (5) If SFR exists, Participant must provide an assurance that the physician or physician group at SFR has adequate stop-loss protection, including the threshold amounts for individual/professional, institutional, or combination for all services, and the type of coverage (for example, per member per year or aggregate); and (6) If the Participant has Physician Incentive Plans that place physicians or physician groups at SFR for the cost of referral services it must cooperate with UCare in conducting Enrollee surveys and provide a summary of the survey results, consistent with 42 CFR §§438.3(i), 422.208, and 417.479(h) and 417.479(g)(1).

8.8 Exclusion from Federal Health Care Programs. Participant agrees that it shall monitor the list of individuals and entities excluded from participating in the Medicare and Medicaid programs which is maintained by the HHS-OIG, as well as the Preclusion List maintained by CMS, and ensure that it does not employ or contract with individuals or entities which Participant knows or should know are or become excluded from participation in federal health care programs under § 1128 or § 1128A of the Social Security Act or that appear on the Preclusion List. If any contracted provider, subcontractor, employee or owner becomes excluded or appears on the Preclusion List, Participant shall take corrective action and make a report to UCare within 24 hours of learning of the exclusion or appearance on the Preclusion List. Participant agrees to not employ or contract with any entity or individual who is excluded or appears on the Preclusion List, subsequently becomes excluded or appears on the Preclusion List, or, to the best of Participant's knowledge, is in the process of becoming excluded, from participation in any federal health care benefit or government procurement program, including but not limited to federal health care programs under § 1128 or § 1128A of the Social Security Act or that appear on the Preclusion List. Participant agrees not to employ or contract with any individual who has been convicted of a criminal offense related to their involvement in Medicaid, Medicare, or social service programs under Title XX of the Social Security Act or who is listed on the Office of Foreign Assets Control Specially Designated Nationals List.

Participant agrees to search monthly the OIG List of Excluded Individuals Entities (LEIE), the Excluded Parties List System (EPLS, within the HHS System for Awards Management) database, the Office of Foreign Assets Control Specially Designated Nationals List, the Minnesota Department of Human Services Excluded Providers List, as well as the Preclusion List maintained by CMS and the UCare list of prohibited individuals, to determine the status of any person with an ownership or control interest and all officers, directors, employees, contractors and Subcontractors of Participant. If the foregoing databases indicate an individual or entity described above is excluded or appears on the Preclusion List, Participant shall immediately inform UCare and ensure that such individual or entity is not providing Services under this Agreement. Participant shall report to UCare immediately any information that Participant knows or should know regarding individuals or entities specified above or who have been convicted of a criminal offense related to their involvement with any federal program or who have been excluded or precluded from participation in Medicare or Medicaid under § 1128 or § 1128A of the Social Security Act or from participation in Minnesota state health care programs or who otherwise appear on the above-referenced lists. Participant shall immediately inform UCare in the event that Participant is sanctioned by a state or federal agency in connection with participation in any such program or in the event of a change in its participation status. Participant represents and warrants that neither Participant nor any of its Interpreters have ever been convicted of fraud in regard to the United States Internal Revenue Service or any state tax agency.

8.9 Lobbying Disclosure. Participant certifies that federally appropriated funds are not and have not been expended by or on behalf of Participant to pay for any person for influencing or attempting to influence an officer or employee of any federal agency or any member or employee of the U.S. Congress in connection with the awarding of a federal contract, grant, loan, or cooperative agreement, or the renewal or modification thereof. If funds other than federally appropriated funds have been or will be paid for any activity described by the preceding sentence, Participant shall complete and submit the Standard Form LLL "Disclosure of Lobbying Activities" in accordance with its instructions.

8.10 Attestation of Compliance with CMS Requirements for "Downstream" Contracts. If Participant subcontracts with providers and entities ("Subcontractors") to provide services to Medicare Advantage Plan Enrollees, such subcontracts must contain provisions that are consistent with the below CMS requirements. Participant shall provide UCare with copies of the subcontracts upon UCare's request, to confirm compliance, as follows:

a) Subcontractor agrees to safeguard an Enrollee's privacy and confidentiality, consistent with all State and Federal laws (including requirements from UCare necessary for compliance), and to assure the accuracy of an Enrollee's medical, health and enrollment information; and records, as applicable;
b) Subcontractor shall hold Enrollees harmless for payment of fees that are the legal obligation of UCare. In addition, provided this Agreement has not been terminated, Subcontractor shall continue to provide any Medicare Advantage Enrollee with Covered Services through the duration of the contract period for which CMS premium payment has been made to UCare. Furthermore, in the event an Enrollee is hospitalized on the date of termination of UCare's contract with CMS or in the event of UCare's insolvency, Subcontractor shall continue to provide the Enrollee Covered Services until the Enrollee is discharged;
c) Subcontractor agrees to maintain records pertaining to Covered Services provided under the

agreement for a period of at least ten (10) years following provision of services, and agrees to allow the U.S. Department of Health and Human Services, the Comptroller General, or their designees the right to audit, evaluate, and inspect any books, contracts, and records, including medical records, of the Subcontractor involving any transactions related to CMS' contract(s) with UCare for Medicare Advantage plans including special needs plans, during the Agreement and for a period of ten (10) years following its termination or from the date of completion of any audit, whichever is later;

d) Subcontractor acknowledges that UCare oversees and is accountable to CMS for any functions and responsibilities described in Medicare Advantage regulations, and Subcontractor agrees to comply with Medicare laws, regulations, and CMS instructions, as well as provide services consistent with and comply with UCare's contractual obligations with CMS;

e) Subcontractor shall comply with all protocols and procedures established or modified from time to time by UCare with respect to Covered Services provided to Enrollees, including but not limited to the UCare Provider Manual;

f) Any function delegated by UCare to Participant under this Agreement that is further delegated by Subcontractor to another person or entity must be pursuant to a written agreement that complies with 42 C.F.R. § 422.504(i)(4); and

g) Subcontractor acknowledges that UCare or its Agent agrees to make reimbursement within thirty (30) days after receipt of a Clean Claim, using any forms approved by UCare.

8.11 Ownership Disclosures. Participant shall disclose to UCare ownership information in accordance with 42 C.F.R. § 455.104 and as required by DHS, and in a manner and frequency as required by UCare.

ARTICLE 9: INSURANCE AND INDEMNIFICATION

9.1 Participant Insurance. Participant shall procure and maintain throughout the term of this Agreement, at Participant's sole cost and expense, liability insurance as described herein. The coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Service is provided. Liability insurance shall be, at minimum, of the types and in the amounts set forth in the table below. Medical malpractice insurance shall be either occurrence or claims made with an extended period reporting option. Participant shall provide to UCare within ten (10) days of UCare's request evidence of initial and continued compliance with the provisions of this section.

To the extent Participant's insurance policies are issued on a claims-made basis, Participant agrees to maintain the insurance policies described in this section for six (6) years following termination of this Agreement.

Type of Insurance	**Minimum Limits**
Medical malpractice and/ or professional liability insurance	One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate
Commercial general and/or umbrella liability insurance	One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate

9.2 Participant Hold Harmless. Participant shall indemnify, defend and hold UCare harmless from any third-party claims, liabilities, losses, demands and costs and expenses of any kind, including reasonable attorney's fees, regulatory penalties, and payment recoveries by government agencies, which UCare may hereafter incur, sustain or be required to pay by reason of any negligent act or omission, breach of this Agreement, violation of third-party intellectual property rights, violation of any applicable law or regulation, or any intentional misconduct of Participant or of any servant, agent, physician, employee, contractor or staff member of Participant.

ARTICLE 10: TERM AND TERMINATION

10.1 Term. The term of this Agreement shall commence on the Effective Date of this Agreement and shall continue until terminated in accordance with the terms of this Agreement.

10.2 Termination. This Agreement may be terminated by the mutual agreement of the Parties or as follows:

10.2.1 Termination by UCare Upon Event of Default. This Agreement may be terminated by UCare upon written notice to Participant, with such termination effective as described in this section, upon the occurrence of an Event of Default by Participant hereunder. Each of the following shall constitute an Event of Default by Participant and termination may occur as follows:

a) Effective immediately, upon Participant's suspension or exclusion from participation in federal or state health care programs (including appearance on the CMS Preclusion List);
b) Effective immediately, upon a determination by UCare that the health, safety, or welfare of one or more Enrollees is in immediate jeopardy if the Agreement is continued;
c) Effective immediately, upon any material impairment of Participant's ability to perform under this Agreement;
d) Effective immediately, if Participant fails to comply with any term of Article 8 (Licensure Status, Credentialing, and Compliance), fails to maintain an insurance program as described in Section 9.1 (Participant Insurance) or fails to make required ownership disclosures as described in Section 8.11 (Ownership Disclosures);
e) Effective immediately, if Participant fails to comply with any federal or state law;
f) Effective immediately, if Participant becomes insolvent, is adjudicated as bankrupt or has a receiver appointed or makes a general assignment for the benefit of creditors;
g) Effective immediately, upon a determination by UCare based on reliable evidence that Participant has made any untrue statements of material fact or any intentional misrepresentation of any fact, whether or not material, in any claim for payment, or any application form, survey, questionnaire or statement provided to UCare;
h) Effective immediately, upon a reasonable belief by UCare that Participant is engaged in fraud or abuse with regard to the provision of Covered Services under

this Agreement. This reasonable belief may be, but is not required to be, based upon the finding of a state or federal government agency, the Medicaid Fraud Control Unit, a court of law, or other legal entity that Participant is or has been engaged in fraud or abuse with regard to Covered Services provided under this Agreement or similar services;

i) Effective no less than thirty (30) days following notice, if a change occurs in Participant's affiliations, staff privileges, or specialty status in such a way as to substantially limit Participant's range of services or access to participating hospitals;

j) Effective no less than thirty (30) days following notice, if one or more of Participant's Professionals or other personnel is (i) suspended or excluded from the federal or state health care programs (including appearance on the Preclusion List), (ii) indicted or convicted for a felony or any criminal charge relating to the practice of medicine or to providing health care services or other services covered by government programs, or (iii) the subject of disciplinary action by an applicable board, another health plan, insurance company, government entity, or a hospital (including any limitations on the Professional's registration, license, participation status or staff privileges), provided that UCare may, in addition to or in lieu of terminating this Agreement, terminate such Professional's authority to provide Covered Services under this Agreement, effective immediately upon notice thereof; or

k) Effective on the timelines set forth above, if UCare's participation or services agreement with any entity related to Participant (defined as an entity sharing a managing employee, owner, officer or director with Participant) is subject to contract termination by UCare on any of the above bases or for breach in accordance with Section 10.2.3 below.

10.2.2 Termination by Participant upon Event of Default. This Agreement may be terminated by Participant immediately upon written notice to UCare upon the occurrence of an Event of Default by UCare hereunder. Each of the following shall constitute an Event of Default by UCare:

a) Revocation of any certification or license of UCare necessary for performance of this Agreement; or

b) UCare becomes insolvent, is adjudicated as bankrupt or has a receiver appointed or makes a general assignment for the benefit of creditors.

10.2.3 Breach. Except as otherwise permitted upon an Event of Default as defined above, either Party shall have the right to terminate this Agreement in the event of the other Party's material breach of a provision of this Agreement or the terms of the Provider Manual, which are incorporated herein by reference, in accordance with this section. The Party alleging the breach shall provide the other Party with detailed notice of the alleged breach and of its intent to terminate the Agreement in the event the breach is not cured within a specified reasonable time period, which shall not be less than thirty (30) days. In the event that the breach is not cured within such time frame, then this Agreement shall terminate as provided in the notice provided by the terminating Party. The non-breaching Party may terminate this Agreement immediately upon written notice, without providing the breaching Party an opportunity to cure the material breach, if the material breach is of the same type as described in a prior written notice sent, pursuant to this section and within the twelve (12) months prior to the current breach, by the non-breaching Party to

the breaching Party regarding a breach that was previously cured.

10.2.4 Termination Without Cause. This Agreement may be terminated by UCare or Participant, without cause in accordance with this paragraph, by providing the other Party with written notice of its intent to terminate. Such notice must specify the termination date. The termination date must be the last day of a month and must be a date that is at least one hundred twenty-five (125) days after written notice is given. Unless otherwise terminated pursuant to this Section 10.2, such termination shall be effective only on the termination date.

10.2.5 Termination of Subcontracts. In the event Participant has subcontracted with other providers or entities to provide Covered Services under this Agreement, any termination of this Agreement shall also apply to those providers or entities for Covered Services provided under this Agreement.

10.3 Rights and Obligations. The rights and obligations of each Party to this Agreement shall continue through the termination date hereof. Each Party will remain liable for any obligations or liabilities arising from activities undertaken prior to the effective date of termination.

10.3.1 Notice to Enrollees. Upon notice of termination of this Agreement, UCare and Participant each shall have the right to give notice of that termination to Enrollees to the extent and in the manner required by applicable law and the Provider Manual. UCare and Participant each shall cooperate with the other in providing such notification, and Participant shall cooperate with UCare in transferring to other Participating Providers all Enrollees then under Participant's care, effective no later than the termination of this Agreement.

10.3.2 Continuation of Covered Services. Upon termination of this Agreement, Participant shall, as required by 42 C.F.R. § 422.504(g)(2), continue to provide Covered Services for Enrollees for the duration of the contract period for which CMS had made payments to UCare. For Enrollees who are hospitalized on the date the CMS contract terminates, or in the event of UCare's insolvency, Participant shall provide Covered Services through the date of discharge of the Enrollee. In certain cases, Participant may be required to continue providing Covered Services to Enrollees for up to one hundred and twenty (120) days or for a longer period of time, in accordance with Minnesota Statutes § 62Q.56, subd. 1(a). For such continued care, UCare shall compensate Participant under the terms of this Agreement with respect to otherwise Covered Services rendered by Participant to the Enrollee.

10.3.3 Upon termination of this Agreement, Participant will immediately discontinue use of any and all signs, plaques, letterheads, forms, or other materials identifying Participant as a UCare Participating Provider.

10.4 Dispute Resolution. Any dispute arising out of or related to this Agreement shall be settled in accordance with this section or as otherwise required by law. Nothing in this section shall prohibit a Party from terminating this Agreement pursuant to its terms.

10.4.1 If any dispute develops that is subject to UCare's credentialing plan, policies and procedures, it will be handled in accordance with UCare's credentialing plan, policies and procedures. If any other dispute develops between the Parties relating to this Agreement, the Parties shall each appoint a key contact to meet and negotiate in good faith in an attempt to resolve it. If the dispute remains unresolved for thirty (30) days, either party may bring litigation against the other, or the parties may mutually agree to any form of binding or non-binding alternative dispute resolution.

10.4.2 Nothing in this section will limit a Party from bringing an action in any court of competent jurisdiction for injunctive or other equitable relief as a Party deems necessary or appropriate to stop the conduct or threatened conduct of the other Party. In addition, if a Party to this Agreement is named as a defendant in a third-party lawsuit, claims for contribution or indemnification against the other Party hereto may be brought in the third-party litigation.

ARTICLE 11: MISCELLANEOUS

11.1 Notice. All notices, communications, payments, and other documents required or permitted hereunder shall be in writing. Such notices shall be given: (i) by delivery in person; (ii) by courier service; (iii) by certified mail, postage prepaid, return receipt requested; (iv) by facsimile; or (v) by electronic mail addressed to the recipient at the address shown in the signature block to this Agreement, or to such other addresses as may be provided by either Party to the other.

Notices given shall be effective upon (i) receipt by the Party to which notice is given, or (ii) three (3) days following mailing, whichever occurs first.

11.2 Relationship of Parties. The relationship between the Parties hereto is that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither of the Parties hereto, nor any of their respective employees, shall be construed to be the agent, employee or representative of the other. Further, this Agreement shall not be construed to create a partnership, joint venture or like relationship between the Parties hereto.

11.3 Advertisement. Participant agrees that UCare may list Participant's name, address, telephone number, website, specialty or other area of concentration, and other publicly available information such as special services offered by Participant in such listings, directories, brochures and other writings as may be determined by UCare. Except as otherwise described herein or required by applicable law, Participant shall not use UCare's name, symbol or service mark without prior written approval.

11.4 Amendment. This Agreement may be amended by UCare by providing written notice to Participant specifying the effective date, in accordance with and subject to the limitations of this section, for purposes of bringing this Agreement into compliance with a federal or state law, rule, regulation, or agency mandate. Such amendment shall become effective on the effective date or the compliance date (if later) of the law, regulation, or agency mandate that gave rise to the need to amend this Agreement for purposes of conforming to such requirement. UCare shall also have the right to amend this Agreement upon forty-five (45) days' written notice to Participant; provided, however, that an amendment that is not required by law and that alters

the fee schedule hereunder or otherwise materially alters this Agreement will not take effect if Participant elects to terminate this Agreement without cause, as permitted hereunder. Except as otherwise provided herein, any other amendments or modifications to this Agreement must be mutually agreed to by the Parties, in writing, and signed by both Parties.

11.5 Governing Law. This Agreement is made and entered into in the State of Minnesota and shall be governed in all respects by the laws of the State of Minnesota. Any litigation related to this Agreement that is permitted to be brought in accordance with the dispute resolution provisions hereof shall be venued in Minnesota.

11.6 Conflict. In the event of a conflict between the Provider Manual and this Agreement, then (a) if the conflicting language in the Provider Manual was published by UCare on or before the Effective Date, the Agreement shall govern and (b) if the conflicting language in the Provider Manual was published by UCare after the Effective Date, the Provider Manual shall govern,

11.7 Benefit and Assignment; Change of Control. Participant's rights, duties, obligations and undertakings under this Agreement are binding upon Participant and are not assignable in whole or in part without the prior written approval of UCare, which consent shall not be unreasonably withheld. This Agreement, and all Exhibits, shall be binding upon, and shall inure to the benefit of the Parties hereto and their respective successors and assigns. Assignments subject to this limitation shall include assignment to an entity affiliated with Participant, and assignments by Participant to a successor in interest as a result of a merger, acquisition, or reorganization or sale of substantially all of Participant's assets. Any attempted assignment without UCare's consent shall be void. Upon receiving a written request to consent to an assignment or notification of a Change of Control (as that term is defined below), UCare may terminate this Agreement after at least thirty (30) days' prior written notice to Participant. In the event that UCare approves of an assignment of this Agreement, and the approved assignee is already a Participating Provider under an agreement with UCare, UCare shall have the option of paying the approved assignee under its existing agreement with UCare or under this Agreement. UCare shall have the absolute right, in its sole discretion, to assign all or any of its rights and obligations hereunder to an entity that controls or is controlled by UCare, or to add another affiliate of UCare as an additional party to this Agreement. Participant shall notify UCare in writing prior to any change in the identity of the person or persons holding fifty percent (50%) or more of the total financial or governance rights in Participant (a "Change of Control"). In the event of a Change of Control resulting in fifty percent (50%) of the financial or governance rights in Participant being held by a person that is already a Participating Provider under an agreement with UCare, UCare shall have the option of paying Participant under such person's existing agreement with UCare or under this Agreement.

11.8 Entire Agreement. Except as otherwise expressly provided herein, this Agreement as it may be amended pursuant to Section 11.4 embodies the entire agreement between UCare and Participant concerning the subject matter of this Agreement. This Agreement supersedes and replaces all other previous oral or written agreements concerning all or any part of the subject matter of this Agreement, and no such prior representations or agreements between the parties relating to the same subject matter shall have any force or effect.

11.9 Severability. If any part of this Agreement should be determined to be invalid, unenforceable, or contrary to law, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

11.10 Survival. Any section of this Agreement that by its terms contemplates or requires continuing effect following termination of this Agreement shall survive such termination. Specifically, and without limitation, Article 5 (Confidentiality and Records), Section 6.2 (Enrollee Protection Provisions), Article 9 (Insurance and Indemnification), Section 10.3 (Rights and Obligations), Section 10.4 (Dispute Resolution) and Section 11.5 (Governing Law) shall survive termination of this Agreement.

11.11 Approvals of this Agreement. The effectiveness of this Agreement is subject to the approval of this Agreement by the Minnesota Department of Health.

11.12 Waiver. The failure of any Party at any time to require performance of any provision or to resort to any remedy provided under this Agreement shall in no way affect the right of that Party to require performance or to resort to a remedy at any time thereafter, nor shall the waiver by any Party of a breach be deemed to be a waiver of any subsequent breach. A waiver shall not be effective unless it is in writing and signed by the Party against whom the waiver is being enforced. No course of dealing, nor any failure to exercise, nor any delay in exercising any right, power or privilege hereunder shall operate as a waiver thereof.

11.13 Compliance with Laws. Participant agrees to comply with (1) all applicable Medicare and Medicaid laws and regulations, and applicable CMS instructions, (2) all applicable Minnesota laws, regulations and guidance applicable to Minnesota state health care programs; (3) the applicable provisions of the contracts between UCare and DHS, CMS, and MNsure, which are hereby incorporated by reference; (4) all state and federal laws applicable to entities which receive federal funds; (5) provisions of Minnesota law applicable to the commercial products offered by UCare, including but not limited to Minnesota Statutes Chapter 62V; and (6) all applicable state and federal laws, regulations and Executive Orders regarding prohibited discrimination, including Title VI of the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

11.14 DHS-Required Language. In the event the Medicare contract between CMS and UCare is terminated or non-renewed, the contract between DHS and UCare shall be terminated unless CMS and DHS agree to the contrary. Such termination shall be carried out in accordance with the termination requirement stated in 42 C.F.R. § 422.506 and § 422.512.

11.15 Force Majeure. Neither UCare nor Participant shall be responsible for any resulting loss if the fulfillment of any of the terms or provisions of this Agreement is delayed, prevented, or rendered impossible by revolutions, insurrections, riots, wars, acts of enemies, floods, fires, or other acts of God.

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IN WITNESS WHEREOF, each Party has caused this Agreement to be signed on its behalf by its duly authorized representative as of the Effective Date.

UCare Minnesota PO Box 52 500 Stinson Blvd NE Minneapolis, MN 55440-8551	**Kanabec County Family Services** 905 Forest Ave. E. Suite 150 Mora, MN 55051
_____	_____
Ghita Worcester Executive Vice President of Public Affairs and Chief Growth Officer prccontractadmin@ucare.org	*Signature* Printed Name: _____ Title_____ Email: _____
_____	_____
Date	Date

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EXHIBIT A
to the
PROVIDER PARTICIPATION AGREEMENT

PRODUCTS COVERED UNDER THIS AGREEMENT

- Minnesota Health Care Programs products, including but not limited to:
  - Medical Assistance
  - MinnesotaCare (including any program funded by the Basic Health Program)
  - Minnesota Senior Care Plus (MSC+), non-dually eligible
  - Minnesota Special Needs Basic Care, non-dually eligible

- Dual Eligibles, including but not limited to:
  - Minnesota Senior Health Options (MSHO)
  - Minnesota Senior Care Plus (MSC+), dually eligible (MHCP portion only)
  - Minnesota Special Needs Basic Care, dually eligible, non-integrated (MHCP portion only)
  - Minnesota Special Needs Basic Care, dually eligible, integrated

- Medicare Products, including but not limited to:
  - Medicare Advantage products / UCare Medicare Plans
  - Medicare Advantage products / *EssentiaCare* (Medicare PPO) ONLY IF APPROVED
  - Medicare Advantage products / UCare Medicare with M Health Fairview & North Memorial ONLY IF APPROVED
  - Medicare Select / *UCare SeniorSelect*

- Qualified Health Plan Products, including but not limited to:
  - UCare Individual & Family Plans
  - UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

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EXHIBIT B
to the
PROVIDER PARTICIPATION AGREEMENT

SERVICES PROVIDED UNDER THIS AGREEMENT

Mental Health Services (including Targeted Case Management Services)
Care Coordination

Case Management

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EXHIBIT C
to the
PROVIDER PARTICIPATION AGREEMENT

SITE LISTING

Use this one for more than 3 sites.

The Site Listing for this Agreement shall be contained in a separate document to be agreed upon by the Parties and incorporated herein by reference

[The rest of this page intentionally left blank.]

Use this one for 3 sites or less.

Practice Name and Address	**Fed ID / NPI**	**Billing Name and Address**
Kanabec County Family Services 905 Forest Ave. E. Suite 150 «Mora, MN 55051 Phone: 320-679-6350	Tax ID #: 416005815 NPI #: 1396819108	Kanabec County Family Services 905 Forest Ave. E. Suite 150 Mora, MN 55051
Practice Name and Address	**Fed ID / Type II NPI**	**Billing Name and Address**
«ExhibitC_PvdrNameLoc2» «AddrLoc2» «AddrLoc2a» «CityStateZipLoc2» Phone: «PhoneLoc2» Practice County: «CountyLoc2»	Tax ID #: «TaxIDLoc2» NPI #: «NPILoc2»	«BillingNameLoc2» «BillingAddrLoc2» «BillingAddrLoc2a» «BillingCityStateZipLoc2»
Practice Name and Address	**Fed ID / Type II NPI**	**Billing Name and Address**
«ExhibitC_PvdrNameLoc3» «AddrLoc3» «AddrLoc3a» «BillingCityStateZipLoc3» Phone: «PhoneLoc3» Practice County: «CountyLoc2»	Tax ID #: «TaxIDLoc3» NPI #: «NPILoc3»	«BillingNameLoc3» «BillingAddrLoc3» «BillingAddrLoc3a» «BillingCityStateZipLoc3»

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EXHIBIT D
to the
PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

CAR SEAT EDUCATION

Products:

- Medical Assistance
- MinnesotaCare (including any program funded by the Basic Health Program)
- Minnesota Special Needs Basic Care, non-dually eligible
- Minnesota Special Needs Basic Care, dually eligible, non-integrated (MHCP portion only)
- Minnesota Special Needs Basic Care, dually eligible, integrated

Car Seat Education Individual Services

- Individual Car Seat Safety Education is reimbursed at $80 per household per same date of service:
    - One member of the household receiving a car seat - $80
    - More than one member of the household receiving seats on same date of service – divide $80 by the number of seats being given to members in the household (ill each member separately):
      Examples:
      2 members = $40 each
      3 members = $27*each (*round up to the nearest whole dollar)
      4 members = $20 each
- Reimbursement is for the education provided to members, each person receiving education must be a UCare member and is not based on the number of car seats being provided during the session (UCare pays for the car seats separately).
- Billing:
    - Diagnosis Code: Z71.89 (injury prevention)
    - Procedure Code: S9445 (Patient education – individual)
    - Place of Service: A valid place of service must be included on the claim
- Interpretation services related to car seat education are not a reimbursable service.
- Car seat storage and handling by Public Health or partnering agency is not reimbursable service.

Car Seat Education Group Classes

- Group (Class) Car Seat Safety Education is reimbursed at $57 per household per same date of service.
    - One member of the household receiving a car seat - $57
    - More than one member of the household receiving seats on same date of service– divide $57 by the number of seats being given to members in the household. Bill each member separately.
      Examples:

2 members = $29* each (*round up to nearest whole dollar)
3 members = $19 each
4 members = $15* each (*round up to nearest whole dollar)

- Reimbursement is based on a "per session" rate and is not based on the length of the session or the number of seats being given to members in the same household. Reimbursement is for the education provided to UCare members, each person receiving education must be a UCare member.
- Billing:
  - Diagnosis Code: Z71.89 (injury prevention)
  - Procedure Code: S9446 (Patient education - group)
  - Place of Service: A valid place of service must be included on the claim
- Interpretation services related to car seat education are not a reimbursable service.
- Car seat storage and handling by Public Health or partnering agency is not reimbursable service.

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EXHIBIT D1
to the
PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

ARTICLE I: HOSPICE

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge. If there is no rate in the Payment Methodology / Reimbursement fee schedule, then UCare will pay based on the rates in Default 1 and if there is no rate available in the Default 1 fee schedule, payment will revert to the payment rates in Default 2 and finally, if there is no rate available in Default 2, payment will revert to the payment rates in Default 3. Referenced fee schedules are those in effect at the time of the service. Claims are paid in accordance with UCare's payment policies and procedures.

Products:
- Medical Assistance
- MinnesotaCare (including any program funded by the Basic Health Program)
- Minnesota Senior Care Plus (MSC+), non-dually eligible
- Minnesota Special Needs Basic Care, non-dually eligible

Payment Methodology / Reimbursement	Default – 1	Default- 2	Default – 3
100% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Products:
Qualified Health Plan Products, including but not limited to:
- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

Revenue Code / Description	Hospice Reimbursement	Default – 1	Default- 2
Revenue Code 0651 Routine Home Care	100% of the Wage Adjusted CMS Routine Home Care Per Diem	100% of the UCare Standard fee schedule	50% of eligible billed charges
Revenue Code 0652 Continuous Home Care	100% of the Wage Adjusted CMS Continuous Home Care Per Diem	100% of the UCare Standard fee schedule	50% of eligible billed charges

Revenue Code 0655 Inpatient Respite Care	100% of the Wage Adjusted CMS Inpatient Respite Care Per Diem	100% of the UCare Standard fee schedule	50% of eligible billed charges
Revenue Code 0656 General Inpatient Care	100% of the Wage Adjusted CMS General Inpatient Care Per Diem	100% of the UCare Standard fee schedule	50% of eligible billed charges

UCare Minnesota Health Care Programs (MHCP) fee schedule. The UCare MHCP fee schedule is based on the State of Minnesota Health Care Programs fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Standard fee schedule. The UCare Standard fee schedule is a fee schedule developed by UCare. This fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare fee schedule. The UCare Medicare fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) professional fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

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EXHIBIT D2
to the
PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

ARTICLE I: MEDICARE CERTIFIED HOME HEALTH CARE SERVICES

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge. If there is no rate in the Payment Methodology / Reimbursement fee schedule, then UCare will pay based on the rates in Default 1 and if there is no rate available in the Default 1 fee schedule, payment will revert to the payment rates in Default 2, if there is no rate available in Default 2, payment will revert to the payment rates in Default 3. If there is no rate available in Default 3, payment will revert to the payment rates in Default 4. Referenced fee schedules are those in effect at the time of the service. Claims are paid in accordance with UCare's payment policies and procedures.

Products:
Non-Dually Eligible
- Medical Assistance
- MinnesotaCare
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care

Payment Methodology / Reimbursement	Default - 1	Default- 2	Default - 3
100% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Products:
Dually Eligible:
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care, dually eligible, non-integrated

Payment Methodology / Reimbursement	Default - 1	Default- 2	Default - 3
In accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 100% of the UCare MHCP fee schedule allowable rate where a Medicare coinsurance and/or deductible has been applied. UCare payment will be the difference between the Medicare payment and the UCare MHCP calculated allowable rate where the difference is greater than zero. If the difference is less than or equal to zero, the UCare payment will be zero. For services not in accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Participant for practitioner services at 100% of the UCare MHCP fee schedule.			

Product:

- Minnesota Senior Health Options (MSHO)

Payment Methodology / Reimbursement	Default - 1	Default - 2	Default - 3
100% of the UCare CMS Low Utilization payment Adjustment (LUPA) per visit rate	Not Applicable	Not Applicable	Not Applicable
All Other Services: 100% of the UCare MSHO fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Product:

- Minnesota Special Needs Basic Care, dually eligible, integrated

Payment Methodology / Reimbursement	Default - 1	Default - 2	Default - 3
100% of the UCare CMS Low Utilization payment Adjustment (LUPA) per visit rate	Not Applicable	Not Applicable	Not Applicable
All Other Services: 100% of the UCare SNBC fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Products:

Medicare Products, including but not limited to:

- Medicare Advantage products / UCare Medicare Plans
- Medicare Advantage products / *EssentiaCare* (Medicare PPO) ONLY IF APPROVED
- Medicare Advantage products / UCare Medicare with M Health Fairview & North Memorial ONLY IF APPROVED

Payment Methodology / Reimbursement	Default - 1	Default - 2	Default - 3
100% of the UCare CMS Low Utilization payment Adjustment (LUPA) per visit rate	Not Applicable	Not Applicable	Not Applicable
All Other Services: 100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Product:

- Medicare Select

Payment Methodology / Reimbursement	Default - 1	Default - 2	Default - 3	Default – 4
Subsequent to the Medicare Fiscal Intermediary's payment; 100% of the Enrollee's Copayments, Coinsurance, and Deductibles.	100% of the UCare CMS Low Utilization payment Adjustment (LUPA) per visit rate	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Products:

Qualified Health Plan Products, including but not limited to:

- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

UCare Minnesota Health Care Programs (MHCP) fee schedule. The UCare MHCP fee schedule is based on the State of Minnesota Health Care Programs fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Standard fee schedule. The UCare Standard fee schedule is a fee schedule developed by UCare. This fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Minnesota Senior Health Options (MSHO) fee schedule. The UCare MSHO fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare MSHO fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare MSHO fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Special Needs Basic Care (SNBC) fee schedule. The UCare SNBC fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare SNBC fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare SNBC fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare fee schedule. The UCare Medicare fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) professional fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare CMS Low Utilization Payment Adjustment (LUPA). For purpose of the above fee schedule relating to home health care, "CMS LUPA" rate is based upon the rate as determined by the Centers

for Medicare and Medicaid Services (CMS) LUPA national standardized per visit rates instead of the Home Health PPS case-mix system.

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EXHIBIT D3
to the

PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

ARTICLE I: PROFESSIONAL SERVICES (Includes all professional services, with the exception of RHC and FQHC. Includes Public Health Nursing Services)

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge. If there is no rate in the Payment Methodology fee schedule, then UCare will pay based on the rates in Default 1 and if there is no rate available in the Default 1 fee schedule, payment will revert to the payment rates in Default 2 and finally, if there is no rate available in Default 2, payment will revert to the payment rates in Default 3. Referenced fee schedules are those in effect at the time of the service. Claims are paid in accordance with UCare's payment policies and procedures.

Professional Services:

Products:
Non-Dually Eligible
- Medical Assistance
- MinnesotaCare
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care

Payment Methodology / Reimbursement	Default - 1	Default- 2	Default - 3
100% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Certified Health Care Home Program. If designated by Minnesota Department of Health (MDH) UCare shall reimburse Participant for Covered HCH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Health Care Home	100% of the Minnesota Health Care Home Fee Schedule

Products:
Dually Eligible
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care, dually eligible, non-integrated

Payment Methodology / Reimbursement	Default - 1	Default- 2	Default - 3

In accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for services up to 100% of the UCare MHCP fee schedule allowable rate where a Medicare coinsurance and/or deductible has been applied. UCare payment will be the difference between the Medicare payment and the UCare MHCP calculated allowable rate where the difference is greater than zero. If the difference is less than or equal to zero, the UCare payment will be zero. For services not in accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for services up to 100% of the UCare MHCP fee schedule.	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Health Care Home Program. If designated by Minnesota Department of Health (MDH) UCare shall reimburse Participant for Covered HCH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Health Care Home	100% of the Minnesota Health Care Home Fee Schedule

Product:

- Minnesota Senior Health Options (MSHO)

Payment Methodology / Reimbursement	Default - 1	Default- 2	Default - 3
100% of the UCare MSHO fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Health Care Home Program. If designated by Minnesota Department of Health (MDH) UCare shall reimburse Participant for Covered HCH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Health Care Home	100% of the Minnesota Health Care Home Fee Schedule

Product:

- Minnesota Special Needs Basic Care, dually eligible, integrated

Payment Methodology / Reimbursement	Default - 1	Default – 2	Default - 3
100% of the UCare SNBC fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Health Care Home Program. If designated by Minnesota Department of Health (MDH) UCare shall reimburse Participant for Covered HCH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Health Care Home	100% of the Minnesota Health Care Home Fee Schedule

Products:

Medicare Products, including but not limited to:

- Medicare Advantage products / UCare Medicare Plans
- Medicare Advantage products / *EssentiaCare* (Medicare PPO) ONLY IF APPROVED
- Medicare Advantage products / UCare Medicare with M Health Fairview & North Memorial ONLY IF APPROVED

Professional Services Payment Methodology / Reimbursement	**Default - 1**	**Default – 2**	**Default - 3**
100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable
DMEPOS Payment Methodology / Reimbursement	**Default - 1**	**Default – 2**	**Default - 3**
100% of the UCare Medicare DMEPOS fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

Clinical Laboratory Payment Methodology / Reimbursement	**Default - 1**	**Default – 2**	**Default - 3**
100% of the UCare Medicare Clinical Lab fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

Drugs and Biologicals Payment Methodology / Reimbursement	**Default - 1**	**Default – 2**	**Default - 3**
100% of the UCare Medicare ASP fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

Product:

- Medicare Select

Payment Methodology / Reimbursement	Default - 1	Default – 2	Default - 3
Subsequent to the Medicare Fiscal Intermediary's payment; 100% of the Enrollee's Copayments, Coinsurance, and Deductibles.	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Products:

Qualified Health Plan Products, including but not limited to:

- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
160% of the applicable UCare Medicare Fee Schedule rate	160% of the UCare Standard fee schedule	65% of eligible charges	Not Applicable

DMEPOS Payment Methodology / Reimbursement	Default - 1	Default – 2	Default - 3
100% of the UCare Medicare DMEPOS fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

Clinical Laboratory Payment Methodology / Reimbursement	Default – 1	Default – 2	Default - 3
155% of the UCare Medicare Clinical Lab fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

Drugs and Biologicals Payment Methodology / Reimbursement (non-Vaccine)	Default - 1	Default – 2	Default - 3
100% of the UCare ASP Pricing File rate	AWP minus 17%	Not Applicable	Not Applicable

Drugs and Biologicals Payment Methodology / Reimbursement (Vaccines)	Default - 1	Default – 2	Default - 3

100% of the UCare Vaccination fee schedule	Revert to Professional Services schedule above	Not Applicable	Not Applicable

UCare Minnesota Health Care Programs (MHCP) fee schedule. The UCare MHCP fee schedule is based on the State of Minnesota Health Care Programs fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Minnesota Senior Health Options (MSHO) fee schedule. The UCare MSHO fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare MSHO Fee Schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare MSHO fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Minnesota Special Needs Basic Care (SNBC) fee schedule. The UCare SNBC fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare SNBC Fee Schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare SNBC fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare fee schedule. The UCare Medicare fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) professional fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Standard fee schedule. The UCare Standard fee schedule is a fee schedule developed by UCare. The fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare Clinical Lab fee schedule: Fee schedule reimbursement rate as determined by the Centers for Medicare and Medicaid Services (CMS) Clinical Lab Fee Schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

CMS Average Sales Price (ASP). Reimbursement rates as determined by the Centers for Medicare and Medicaid Services (CMS) Average Sales Price (ASP) Drug Pricing Files; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare DMEPOS fee schedule. The UCare Medicare DMEPOS fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) DMEPOS fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Vaccination fee schedule. The UCare Vaccination fee schedule is based on the State of Minnesota Health Care Programs fee schedule specific to vaccination codes.

Average Wholesale Price (AWP). Reimbursement rates as determined by First Databank AWP pricing files.

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EXHIBIT D4
to the
PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

PUBLIC HEALTH NURSE HOME VISITS

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge.

• Medical Assistance • MinnesotaCare • Minnesota Senior Care Plus (MSC+) • Minnesota Special Needs Basic Care (*UCare Connect*) • Minnesota Senior Health Options (MSHO) • Minnesota Special Needs Basic Care, integrated (*UCare Connect + Medicare*)	S9123 - $180.00 S9123-U8- $180.00 *Provider will file claims to UCare with the U8 modifier, when applicable, in accordance with DHS guidelines.*

Public Health Nurse Home Visits billed with codes other than S9123 will be reimbursed in accordance with the Professional Services Reimbursement Schedule.

EXHIBIT D5
to the
PROVIDER PARTICIPATION AGREEMENT

REIMBURSEMENT SCHEDULE

ARTICLE 1: MENTAL HEALTH SERVICES

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge. If there is no rate in the Payment Methodology/ Reimbursement fee schedule, then UCare will pay based on the rates in Default 1 and if there is no rate available in the Default 1 fee schedule, payment will revert to the payment rates in Default 2 and finally, if there is no rate available in Default 2, payment will revert to the payment rates in Default 3. Referenced fee schedules are those in effect at the time of the service. Claims are paid in accordance with UCare's payment policies and procedures.

Products:
Non-Dually Eligible:

- Medical Assistance
- MinnesotaCare
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
ACT, CCBHC, CRT, IRMHS, IRTS, PRTF, RCS and TCM services rendered by state approved providers only: 100% of the MHCP provider-specific rate or contracted county host rate. Providers billing MH-TCM services should file claims to UCare with charge amounts listed at 100% of the then-current established rate.	Not Applicable	Not Applicable	Not Applicable
ARMHS and DBT services rendered by state approved providers only: 100% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges
All Other Services: 110% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Certified Behavioral Health Home Program. If designated by Minnesota Department of Human Services (DHS) UCare shall reimburse Participant for Covered BHH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Behavioral Health Home	100% of the UCare MHCP Behavioral Health Home fee schedule

As directed by DHS, UCare will not reimburse Participant for duplicative services associated with treatment similar to the Behavioral Health Home model. The services deemed as duplicative include Mental Health Targeted Case Management (TCM) and Assertive Community Treatment (ACT) or any additional services designated by DHS. UCare will only reimburse Participant for the first claim submitted of this service type and recover any duplicative services through post-payment claim review.

Products:

Dually Eligible:

- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care, dually eligible, non-integrated

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
ACT, CCBHC, CRT, IRMHS, IRTS, PRTF, RCS and TCM services rendered by state approved providers only: 100% of the MHCP provider-specific rate or contracted county host rate. Providers billing MH-TCM services should file claims to UCare with charge amounts listed at 100% of the then-current established rate.	Not Applicable	Not Applicable	Not Applicable
ARMHS and DBT services rendered by state approved providers only: In accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 100% of the UCare MHCP fee schedule allowable rate where a Medicare coinsurance and/or deductible has been applied. UCare payment will be the difference between the Medicare payment and the UCare MHCP calculated allowable rate where the difference is greater than zero. If the difference is less than or equal to zero, the UCare payment will be zero. For services not in accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 100% of the UCare MHCP fee schedule.	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

All Other Services: In accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 110% of the UCare MHCP fee schedule allowable rate where a Medicare coinsurance and/or deductible has been applied. UCare payment will be the difference between the Medicare payment and the UCare MHCP calculated allowable rate where the difference is greater than zero. If the difference is less than or equal to zero, the UCare payment will be zero. For services not in accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 110% of the UCare MHCP fee schedule.	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Behavioral Health Home Program. If designated by Minnesota Department of Human Services (DHS) UCare shall reimburse Participant for Covered BHH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Behavioral Health Home	100% of the UCare MHCP Behavioral Health Home fee schedule

As directed by DHS, UCare will not reimburse Participant for duplicative services associated with treatment similar to the Behavioral Health Home model. The services deemed as duplicative include Mental Health Targeted Case Management (TCM) and Assertive Community Treatment (ACT) or any additional services designated by DHS. UCare will only reimburse Participant for the first claim submitted of this service type and recover any duplicative services through post-payment claim review.

Product:

- Minnesota Senior Health Options (MSHO)

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
ACT, CCBHC, CRT, IRMHS, IRTS, PRTF, RCS and TCM services rendered by state approved providers only: 100% of the MHCP provider-specific rate or contracted county host rate. Providers billing MH-TCM services should file claims to UCare with charge amounts listed at 100% of the then-current established rate.	Not Applicable	Not Applicable	Not Applicable

ARMHS and DBT services rendered by state approved providers only: 100% of the UCare MSHO fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable
All Other Services: 105% of the UCare MSHO fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Behavioral Health Home Program. If designated by Minnesota Department of Human Services (DHS) UCare shall reimburse Participant for Covered BHH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Behavioral Health Home	100% of the UCare MHCP Behavioral Health Home fee schedule

As directed by DHS, UCare will not reimburse Participant for duplicative services associated with treatment similar to the Behavioral Health Home model. The services deemed as duplicative include Mental Health Targeted Case Management (TCM) and Assertive Community Treatment (ACT) or any additional services designated by DHS. UCare will only reimburse Participant for the first claim submitted of this service type and recover any duplicative services through post-payment claim review.

Product:

- Special Needs Basic Care, dually eligible, integrated

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
ACT, CCBHC, CRT, IRMHS, IRTS, PRTF, RCS and TCM services rendered by state approved providers only: 100% of the MHCP provider-specific rate or contracted county host rate. Providers billing MH-TCM services should file claims to UCare with charge amounts listed at 100% of the then-current established rate.	Not Applicable	Not Applicable	Not Applicable
ARMHS and DBT services rendered by state approved providers only: 100% of the UCare SNBC fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable
All Other Services: 105% of the UCare SNBC fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Certified Behavioral Health Home Program. If designated by Minnesota Department of Human

Services (DHS) UCare shall reimburse Participant for Covered BHH Services according to the State of Minnesota Medical Assistance fee in effect at the time of service.

Service	Rate
Certified Behavioral Health Home	100% of the UCare MHCP Behavioral Health Home fee schedule

As directed by DHS, UCare will not reimburse Participant for duplicative services associated with treatment similar to the Behavioral Health Home model. The services deemed as duplicative include Mental Health Targeted Case Management (TCM) and Assertive Community Treatment (ACT) or any additional services designated by DHS. UCare will only reimburse Participant for the first claim submitted of this service type and recover any duplicative services through post-payment claim review.

Product:

Medicare Products, including but not limited to:

- Medicare Advantage products / UCare Medicare Plans
- Medicare Advantage products / *EssentiaCare* (Medicare PPO) ONLY IF APPROVED
- Medicare Advantage products / UCare Medicare with M Health Fairview & North Memorial ONLY IF APPROVED

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
105% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Product:

- Medicare Select

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
Subsequent to the Medicare Fiscal Intermediary's payment; 100% of the Enrollee's Copayments, Coinsurance, and Deductibles.	UCare shall reimburse Participant for Covered Services listed in the Certificate of Coverage which are not eligible for coverage by fee-for-service Medicare at the UCare Standard fee schedule	Not Applicable	Not Applicable

Product(s):

Qualified Health Plan Products, including but not limited to:

- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3

CRT or IRTS services rendered by state approved providers only: 100% of the MHCP provider-specific rate or contracted county host rate.	Not Applicable	Not Applicable	Not Applicable
DBT services rendered by state approved providers only: 100% of the UCare MHCP fee schedule	160% of the UCare Medicare fee schedule	160% of the UCare Standard fee schedule	65% of eligible billed charges
All Other Services: 160% of the UCare Medicare fee schedule	160% of the UCare Standard fee schedule	65% of eligible billed charges	Not Applicable

UCare Minnesota Health Care Programs (MHCP) fee schedule. The UCare MHCP fee schedule is based on the State of Minnesota Health Care Programs fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Standard fee schedule. The UCare Standard fee schedule is a fee schedule developed by UCare. The UCare Standard fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Minnesota Senior Health Options (MSHO) fee schedule. The UCare MSHO fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare MSHO fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare MSHO fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Special Needs Basic Care (SNBC) fee schedule. The UCare SNBC fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare SNBC fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare SNBC fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare fee schedule. The UCare Medicare fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) professional fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

ARTICLE 2: SUBSTANCE USE DISORDER HEALTH SERVICES

Reimbursement for Covered Services provided to UCare Programs Enrollees. UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedules, less any applicable Copayments, Coinsurance, and Deductibles, unless the billed charge is less than the amount identified in the schedule, in which case UCare will pay the billed charge. If there is no rate in the Payment Methodology/ Reimbursement fee schedule, then UCare will pay based on the rates in Default 1 and if there is no rate available in the Default 1 fee schedule, payment will revert to the payment rates in Default 2 and finally, if there is no rate available in Default 2, payment will revert to the payment rates in Default 3. Referenced fee schedules are those in effect at the time of the service. Claims are paid in accordance with UCare's payment policies and procedures.

Products:

Non-Dually Eligible:

- Medical Assistance
- MinnesotaCare
- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
BHF Services: 100% of the BHF rates	Not Applicable	Not Applicable	Not Applicable
All Other Services: 110% of the UCare MHCP fee schedule	100% of the UCare Medicare fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges

Products:

Dually Eligible:

- Minnesota Senior Care Plus (MSC+)
- Minnesota Special Needs Basic Care, dually eligible, non-integrated

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
BHF Services: 100% of the BHF rates	Not Applicable	Not Applicable	Not Applicable
All Other Services: In accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 110% of the UCare MHCP fee schedule allowable rate where a Medicare coinsurance and/or deductible has been applied. UCare payment will be the difference between the Medicare payment and the UCare MHCP calculated allowable rate where the difference is greater than zero. If the difference is less than or equal to zero, the UCare payment will be zero. For services not in accordance with Minnesota Statutes, Section 256B.0625, Subdivision 57, UCare shall reimburse Participant for practitioner services up to 110% of the UCare MHCP fee schedule.	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Product:

- Minnesota Senior Health Options (MSHO)

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
BHF Services: 100% of the BHF rates	Not Applicable	Not Applicable	Not Applicable
All Other Services: 105% of the UCare MSHO fee schedule	100% of the UCare	50% of eligible billed	Not Applicable

	Standard fee schedule	charges	

Product:

- Minnesota Special Needs Basic Care, dually eligible, integrated

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
BHF Services: 100% of the BHF rates	Not Applicable	Not Applicable	Not Applicable
All Other Services: 105% of the UCare SNBC fee schedule	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Products:

Medicare Products, including but not limited to:

- Medicare Advantage products / UCare Medicare Plans
- Medicare Advantage products / *EssentiaCare* (Medicare PPO) ONLY IF APPROVED
- Medicare Advantage products / UCare Medicare with M Health Fairview & North Memorial ONLY IF APPROVED

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
105% of the UCare Medicare fee schedule	100 % of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

Product:

- Medicare Select

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3
Subsequent to the Medicare Fiscal Intermediary's payment; 100% of the Enrollee's Copayments, Coinsurance, and Deductibles.	UCare shall reimburse Participant for Covered Services listed in the Certificate of Coverage which are not eligible for coverage by fee-for-service Medicare at the UCare Standard fee schedule	Not Applicable	Not Applicable

Products:

Qualified Health Plan Products, including but not limited to:

- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview ONLY IF APPROVED

Payment Methodology / Reimbursement	Default – 1	Default – 2	Default – 3

BHF Services: 100% of the BHF rates	Not Applicable	Not Applicable	Not Applicable
All Other Services: 160% of the UCare MHCP fee schedule	160% of the UCare Standard Fee Schedule	65% of eligible billed charges	Not Applicable

BHF Rates. Fee schedule reimbursement rate as determined by the Minnesota Department of Human Services for Behavioral Health Fund (BHF).

UCare Minnesota Health Care Programs (MHCP) fee schedule. The UCare MHCP fee schedule is based on the State of Minnesota Health Care Programs fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Standard fee schedule. The UCare Standard fee schedule is a fee schedule developed by UCare. The UCare Standard fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Minnesota Senior Health Options (MSHO) fee schedule. The UCare MSHO fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare MSHO fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare MSHO fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Special Needs Basic Care (SNBC) fee schedule. The UCare SNBC fee schedule is based upon Minnesota Statutes, Section 256B.0625, Subdivision 57. The UCare SNBC fee schedule is established using 80% of the UCare Medicare fee schedule, or 100% of the UCare MHCP fee schedule, whichever is the greater of the two. The UCare SNBC fee schedule will be updated according to the schedule published in the UCare Provider Manual.

UCare Medicare fee schedule. The UCare Medicare fee schedule is based on the Centers for Medicare and Medicaid Services (CMS) professional fee schedule; however, the fee schedule will be updated according to the schedule published in the UCare Provider Manual.

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EXHIBIT D6
to the
PROVIDER PARTICIPATION AGREEMENT

DELEGATED CARE COORDINATION SERVICES

REIMBURSEMENT SCHEDULE

UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedule:

Product	Enrollee Status	Reimbursement
Minnesota Special Needs Basic Care, dually eligible, integrated Minnesota Special Needs Basic Care	Enrollees newly enrolled in UCare's Minnesota Special Needs Basic Care, dually eligible, integrated or Minnesota Special Needs Basic Care products	$XX Per Member Per Month (PMPM), up to two months
	Enrollee declined to complete a Health Risk Assessment and subsequent care coordination, or Enrollee requested to be closed to care coordination services after previously being opened to care coordination services	$XX Per Member Per Month (PMPM)
	Enrollee unable to be reached by Participant	$XX Per Member Per Month (PMPM)
	Enrollee open to care coordination and receiving the following services: • Initial Health Risk Assessment & required reassessment(s) • Comprehensive support plan • Coordination of medical and mental health services, social drivers of health, or any additional needs for which the Enrollee requests or requires assistance.	$XX Per Member Per Month (PMPM)

UCare will make payment only for eligible Enrollees based on status of Enrollee during the applicable month.

Participant does not need to bill UCare for care coordination services. UCare reserves the right to implement alternative billing requirements at a later date.

Enrollees are assigned to Participant via the monthly enrollment roster.

Enrollees assigned to Participant will reside in the following locations:

List county service area or other information here—

Scope of Services. Participant will perform services according to the Special Needs Basic Care, Care Coordination Requirements Grids.

Such standards may include:

- Appointment timeliness and access to care standards
- Demonstrating cultural and disability sensitivity in member interactions
- Timely communication of clinical information to member
- Communication of information among providers when referrals are made
- Member input to treatment plan
- Health record standards such as member identifiers, problem list, medications, advance directives, allergies, etc.
- Communication of information among providers when referrals are made
- Members are provided with continuity of care and appropriate community and social services
- Member information is protected and handled in a confidential manner Members are not discriminated against based on their gender, ability to pay, etc.
- Written policies and procedures specifying the elements identified above as existing care coordination standards. The policies and procedures will be on file, current, and available for audit by UCare
- Access to medical records and personal interviews to substantiate conformity to the policies and procedures
- Timely submission of prior authorization requests with necessary supporting information
- Response to regulatory changes on a timely basis

Additional details concerning the program specifications and definitions can be accessed in a Companion Guide, which UCare may edit as necessary.

EXHIBIT D7
to the
PROVIDER PARTICIPATION AGREEMENT

CASE MANAGEMENT SERVICES

REIMBURSEMENT SCHEDULE

UCare shall reimburse Participant for Covered Services provided to Enrollees according to the following schedule:

Product	**Reimbursement**
Minnesota Senior Health Options (MSHO) Case Management services including: • Initial Health Risk Assessment & required reassessment(s) • Comprehensive support plan • Coordination of medical and mental health services, social drivers of health, or any additional needs for which the Enrollee requests or requires assistance	Community Based, without EW Services $ Per Member Per Month (PMPM) Community Based, with EW Services $ Per Member Per Month (PMPM) Institutional $ Per Member Per Month (PMPM)
Initial Health Risk Assessment	$

Product	**Reimbursement**
Minnesota Senior Care Plus (MSC+) Case Management services including: • Initial Health Risk Assessment & required reassessment(s) • Comprehensive support plan	Community Based, without EW Services $ Per Member Per Month (PMPM) Community Based, with EW Services $ Per Member Per Month (PMPM) Institutional

• Coordination of medical and mental health services, social drivers of health, or any additional needs for which the Enrollee requests or requires assistance	$ Per Member Per Month (PMPM)
Initial Health Risk Assessment	$

UCare will make payment only for eligible Enrollees.

Participant does not need to bill UCare for case management services. UCare reserves the right to implement alternative billing requirements at a later date.

Enrollees are assigned to Participant via the monthly enrollment roster.

The Enrollees included under this agreement will be listed on the monthly roster and may include the following, as assigned by UCare.

List service area here—for example, list of primary care clinics, county assignments, etc.

Scope of Services. Participant will perform services according to community standards.

Such standards may include:

- Appointment timeliness and access to care standards
- Demonstrating cultural and disability sensitivity in member interactions
- Timely communication of clinical information to member
- Communication of information among providers when referrals are made
- Member input to treatment plan
- Health record standards such as member identifiers, problem list, medications, advance directives, allergies, etc.
- Communication of information among providers when referrals are made
- Members are provided with continuity of care and appropriate community and social services
- Member information is protected and handled in a confidential manner Members are not discriminated against based on their gender, ability to pay, etc.
- Written policies and procedures specifying the elements identified above as existing community standards. The policies and procedures will be on file, current, and available for audit by UCare.
- Access to medical records and personal interviews to substantiate conformity to the policies and procedures
- Timely submission of prior authorization requests with necessary supporting information
- Response to regulatory changes on a timely basis

Resolution # KCCH - 11/15/2022

Health Plans Care Coordination Agreement Resolution

WHEREAS, the Minnesota Department of Human Services has determined that it is in the best interest of counties and their residents to have a choice in the health plans available to them for public programs, and

WHEREAS, Kanabec County was notified that Blue Cross Blue Shield, Medica and U Care will be added along with South Country Health Alliance as the health plans providing service in the County, and

WHEREAS, the Community Health Director has met with the three new health plans and their request is that Kanabec County Community Health would provide the care coordination services/case management for Kanabec County residents to foster communication and coordinate care and services among members, providers, staff and other organizations, and

WHEREAS Kanabec County desires to provide the delegated services in accordance with the health plans' policies and procedures and in compliance with applicable federal and state laws and regulations and the National Committee for Quality Assurance accreditation standards.

WHEREAS, the Kanabec County Attorney has reviewed and approved the aforementioned contracts with liability language changes to be made by UCare

THEREFORE BE IT RESOLVED the Kanabec County Community Health Board approves the Community Health Director signing contracts with Blue Cross Blue Shield, Medica and U Care to provide public programs care coordination /case management for County residents for the contracted period and per the health plans' rate schedules.

Resolution # KCCH - 11/15/2022

TTPT - Health Plans Transportation Agreement Resolution

WHEREAS, the Minnesota Department of Human Services has determined that it is in the best interest of counties and their residents to have a choice in the health plans available to them for public programs, and

WHEREAS, Kanabec County was notified that Blue Cross Blue Shield, Medica and U Care will be added to South Country Health Alliance as the health plans providing service in the County, and

WHEREAS, Timber Trails Public Transit is the main transportation provider within Kanabec County and as such would like to contract with the health plans to provide medical rides for county residents, and

WHEREAS the Transit Director is recommending to contract with the health plans to provide medical transportation services to county residents.

WHEREAS, the Kanabec County Attorney has reviewed and approved the aforementioned contracts with liability language changes to be made by UCare

THEREFORE BE IT RESOLVED the Kanabec County Community Health Board approves the Transit Director to sign contracts with Blue Cross Blue Shield, Medica and U Care to provide medical transportation for County residents for the contracted period with negotiated rate schedules.

9:30am Appointment

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: University of Minnesota Extension Presentation	**b. Origination**: Request of the Board of Commissioners
c. Estimated time: 30 minutes	**d. Presenter**(s): Susanne Hinrichs, Regional Director Northeast Region, Jan Derdowski, Program Leader for the Northeast Region for the Center for Youth Development, & Jean Mattson, Chair of the Kanabec Extension Committee

e. Board action requested:

Information only.

f. Background:

During budget work sessions, the Board requested information from the University of Minnesota Extension program about programs, active participation, contract expenses, etc.

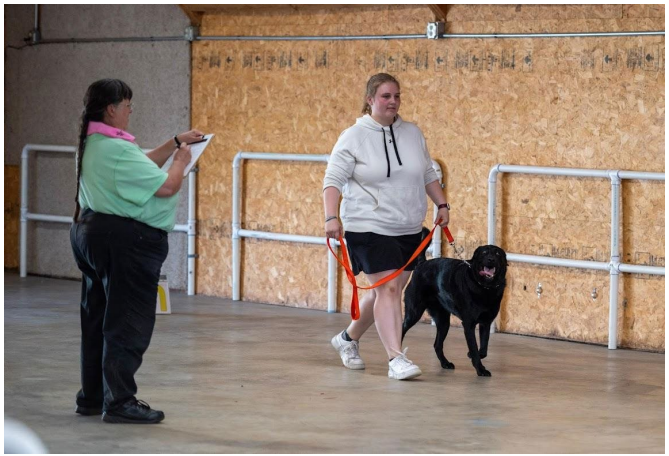
Supporting Documents: None **Attached: ☑**

Date received in County Coordinators Office:

Coordinators Comments:

Kanabec County Extension

What is 4-H and what does it mean to young people and the larger community



Our vision for Minnesota youth

Youth who thrive

in their **happiness**,

success and **connection**

to others and the

world around them

Center for Youth Development goals

1. Youth will **learn** by developing a passion in their areas of interest
2. Youth will **lead** by being innovators and positive change agents
3. Adults will create high quality, culturally responsive **learning environments**

Moving forward

- **2021 - 2022** was our building year
- **2022 - 2023** is our growth year with quality & DEIA at the center

Center for Youth Development Goals

Center goals that we identified in the midst of our building year.

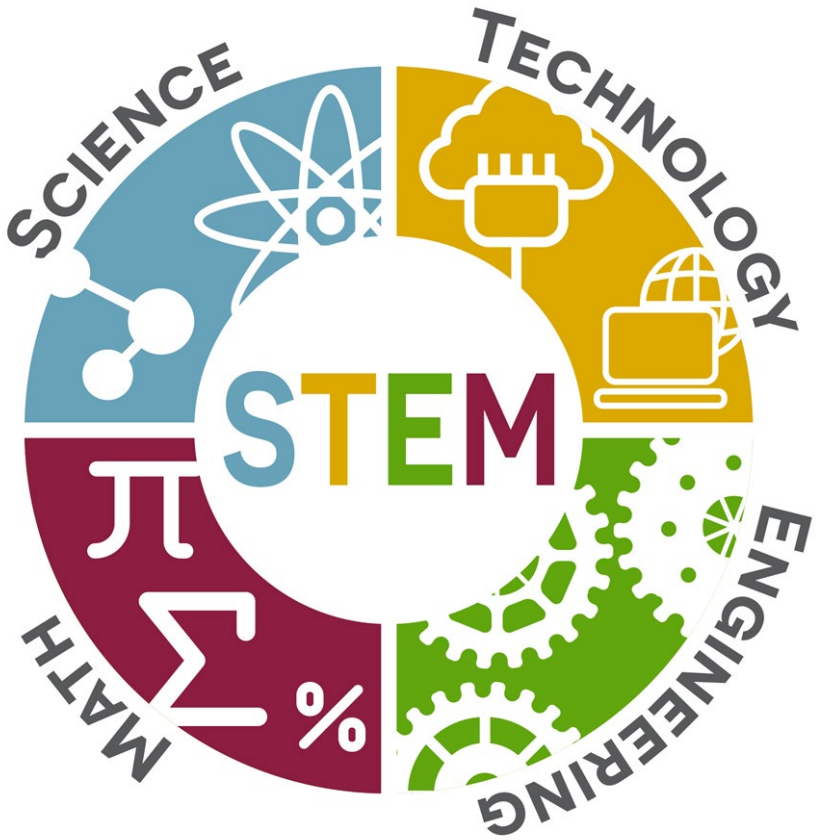
- all counties have well-developed and functioning enrollment systems
- first-year members have a fantastic experience and choose to re-enroll
- creating cloverbud programs that transition youth into upper grades
- programming available that appeals to older youth

State and Regional Function Teams that support local 4-H Programs

- STEM
- Civic engagement & leadership
- Volunteer systems
- Animal science

STEM

- Environmental Science
- Engineering
- Agronomy



4-H Shooting Sports & Wildlife -

CIVIC ENGAGEMENT & LEADERSHIP

Charge: reach middle and high school aged youth statewide, through innovative program models that engage more youth as change agents.

Exploring Leadership

Youth have opportunities to observe youth leadership in action

Emerging Leadership

Youth decide to lead and begin to identify and develop personal leadership skills

Developing Leadership

Youth engage in opportunities to grow and develop skills while collaborating with others

Advancing Leadership

Youth demonstrate leadership competence and use their skills to inspire & influence

Exemplary Leadership

Youth develop and implement a significant project to make positive changes for society

Youth as learners:
Focus on identifying & developing personal leadership skills and abilities while exploring topics of interest

Youth as leaders:
Focus on leading others and leading with others while continuing education and self-reflection to deepen their leadership skills

Youth as change agents:
Focus on using their skills and abilities to positively impact society

4-H County Ambassadors

Kanabec County 4-H Volunteers

VOLUNTEER SYSTEMS

- a volunteer community inspired and prepared to **create high-quality, inclusive, equitable, and culturally-responsive learning environments** for Minnesota youth.
- Create new and different volunteer roles that attract new and diverse volunteers
- Strengthen resources related to welcoming new Minnesota 4-H volunteers
- Develop and deliver volunteer learning opportunities

MN 4-H Animal Science Program
Guiding Principles

- Be **youth centered**, supported by **caring adults**, who are vested in ensuring a positive learning experience.
- Focus on **educational content and life skill development**. It is recognized that competition may be a component of the learning process.
- Embrace expanded use of **science and technology** in all parts of our work.
- Engage **trained MN 4-H volunteers** and partners in program development and delivery in ways that value their participation and reflects MN 4-H Policies.

Animal Science Team

Sharon Davis
Director

Things we all do:

- Project Development Committee support
- Curriculum development & review
- Build resources
- Refresh existing resources
- Camp, campus, speciality program support

Renee Kostick
Central Region

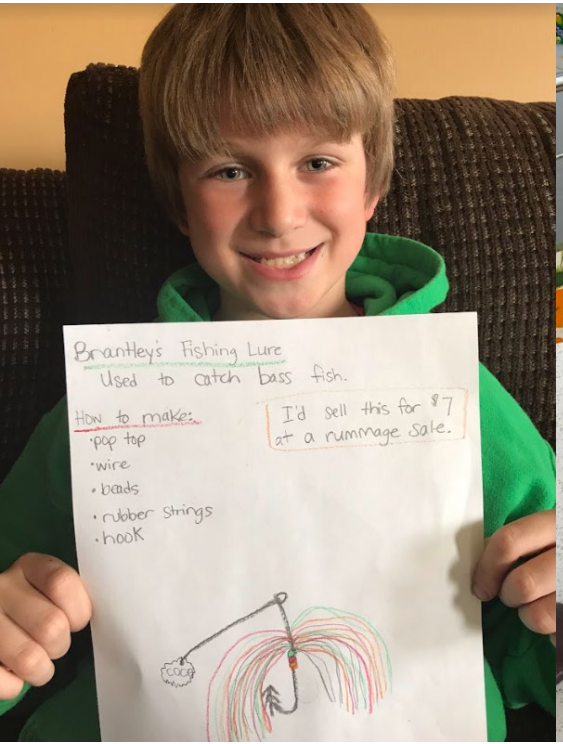
Samantha Lahman
Northwest Region

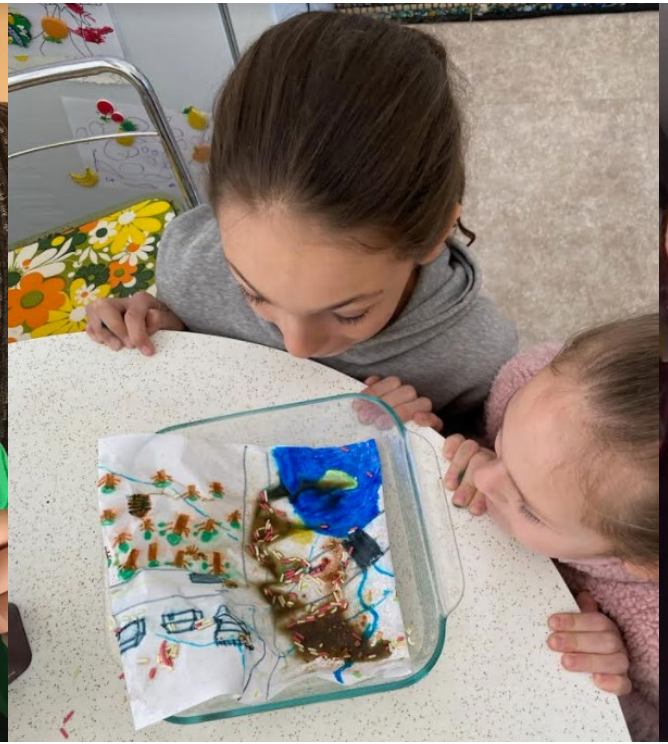
Katie Johnson
Southeast Region

Kirstin Koch
Southwest Region

4-H at the Kanabec County Fair

Virtual Programs





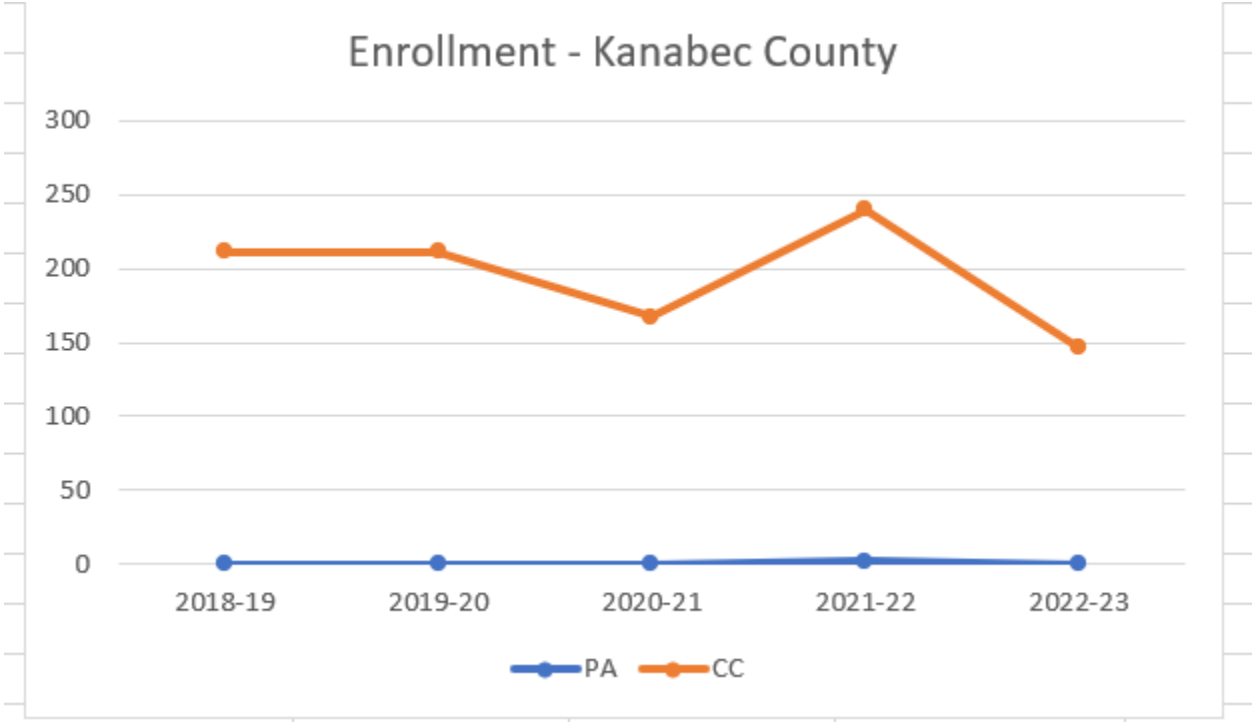
4-H Cloverbud Project Day

4-H is available and is important for the entire county

Total student enrollment in Kanabec County schools is 2,137

Total students eligible for free/reduced meals is 874 (41% of Kanabec County students)

Kanabec County 4-H Enrollment



County Extension budget and costs

County Extension budget and costs

- salary ranges for 4-H Extension educator from $45,400 - $60,000+)

Compare to County HR costs for a position posted

Current position posted: **Community Health Planner RPC**
wage posted at $26.97 - $33.05 per hour (average wage $30.01 per hour)

*doesn't include mileage, professional development or supervision costs

Compare to ~~contr~~act for 4-H educator at $76,680

Local Impact of Kanabec County's 4-H program

"**4-H is affordable** for families; programs are either free or nominal cost. **4-H is open to everybody,** no matter their income level…" - Faye Lilyerd, Ann Lake Township

I learned many valuable skills in 4-H, things that I use to this day…I became proficient in parliamentary procedure which I regularly use as an adult. I learned organization…of paperwork or for organizing a show. And time management, being able to plan and implement projects. I learned how to prioritize…and good study skills…" -Stacy (Soderstrom) Thoeny

Having a County Extension Office, brings more Extension programs to Kanabec County

Minnesota Master Naturalists

Youth Development Function Teams

Teams are important to accomplishing the work of the Extension Center for Youth Development. Members of a team work together to accomplish the ongoing responsibilities to ensure strong regional and local programs. The following regional functions support and guide local 4-H educators in the development of robust local 4-H programs.

Supervision and program planning

Educators will supervise local youth development staff by providing program leadership and work direction. This includes onboarding and training; conducting performance reviews and supervisory meetings; engaging staff in a professional plan of work process through goal setting; and setting expectations for program quality, budgeting, and risk management.

Through coaching, educators will build the capacity of employees to enhance performance and overcome challenges. Educators will work in partnership with local staff to build annual program plans that align with local and organizational priorities and carry out evaluation responsibilities. Educators will serve as the point-of-contact for youth code of conduct issues.

Volunteer systems

Educators will lead, manage and monitor aspects of volunteer systems to ensure the organization's ability to deliver county, tribal, regional, and state programs that align with organizational priorities. Educators will lead efforts to ensure that components central to a successful volunteer system (staff and organizational readiness, volunteer education and engagement, sustainability, and review and analysis of systems for improvement) are developed and effectively operationalized within each region.

Educators will work directly with local 4-H educators and volunteers to build and strengthen the county's or tribal community's volunteer system. Educators will design, develop, evaluate and improve upon resources and tools that support an effective volunteer system. Educators will ensure a plan for volunteer training (to include annual volunteer training, online volunteer training, and risk management training) is established and implemented within the region. Educators will review and recommend updates to volunteer-related policies and practices. Educators will make decisions on the acceptance of volunteer applicants and manage and facilitate problem-solving processes for responding and bringing resolution to volunteer performance issues within the region.

4-H program operations

Educators will be responsible for 4-H program operations across the state to ensure compliance with the requirements of federal and state government, the University of Minnesota, and the 4-H youth development program. Educators will lead, manage and monitor compliance with the requirements of the 4-H program as a public youth-serving organization. This includes group

exemption status, chartering, constitution and bylaws, financial management, tax management, equipment inventory, contracts, and risk management.

Educators will design, develop, evaluate, and improve upon resources and tools that streamline operational procedures. Educators will review and recommend updates to general program policies, rules, and practices. Educators will also build regional capacity with employees, volunteers, and youth by ensuring they have the training, resources, and guidance needed to lead and implement practices locally and regionally. Additionally, educators will manage and facilitate problem-solving processes for responding and bringing resolution to operational questions and concerns within the region.

Quality program development

Educators will lead, manage and monitor aspects of club and camp programming. Educators will be responsible for starting, sustaining, improving upon, and sunsetting current clubs and camps. Educators will design new and innovative programmatic approaches to enhance learning experiences for young people. Educators, in collaboration with local 4-H educators and other functions, will ensure that high-quality clubs and camps are designed and delivered within the region that focuses on organizational priorities and meets local needs. Educators will lead partnership, curriculum, and resource development efforts, manage logistics, and recommend updates to program policies and procedures.

Educators will develop and deliver training opportunities for staff, volunteers, and youth in order to carry out program quality assessments and planning processes. Educators will build regional capacity with staff, youth, and adult volunteers to ensure that the high-quality learning environments found in clubs and camps are grounded in youth development principles and have educational value.

Animal science

Educators will lead, manage and monitor aspects of animal science programming. Educators will be responsible for sustaining, improving upon, and sunsetting current programs. Educators will design new and innovative programmatic approaches to enhance learning experiences for young people. Educators will lead partnership, curriculum, and resource development efforts; implement educational programs, events, and activities; manage operations, and recommend updates to program policies and procedures.

Additionally, educators will lead the design and delivery of this content area within the region, aligning with state priorities and local needs. Educators will build regional capacity with staff, judges, youth, and adult volunteers to ensure high-quality learning environments around animal science topics are guided by project-based curricula and include opportunities for youth to showcase new knowledge and skills. Educators will work with county program staff to ensure the delivery of Livestock Quality Assurance training throughout their region.

Educators will lead the design and delivery of animal science day camps in their region and contribute to the delivery of regional project bowls as well as other programs specific to the

region. Educators will lead and support one or more statewide animal science projects, including the PDC and/or show committee. Educators will be the primary point of contact for one or more animal science efforts during the Minnesota State Fair, State Horse Show, and/or State Dog Show.

Civic engagement and leadership

Educators will lead, manage and monitor aspects of civic engagement and leadership programming. Educators will be responsible for sustaining, improving upon, and sunsetting current programs. Educators will design new and innovative programmatic approaches to enhance learning experiences for young people. Educators will lead partnership, curriculum, and resource development efforts; implement educational programs, events, and activities; manage logistics, and recommend updates to program policies and procedures.

Additionally, educators will lead the design and delivery of this content area within the region, aligning with state priorities and local needs. Educators will build regional capacity with staff, youth, and adult volunteers to ensure high-quality learning environments around civic engagement and leadership topics that are guided by project-based curricula and include opportunities for youth to showcase new knowledge and skills.

Educators will lead the design and delivery of BLU in their region and contribute to the delivery of YELLO. Educators will promote the regional, state, and national civic engagement and leadership events, activities and programs. This includes National 4-H Conference (N4HC), Citizenship Washington Focus (CWF), Youth in Government (YIG), and Extension Legislative Action Day (ELAD). Educators will lead the implementation of the local ambassador program and manage the region's state ambassador selection process.

STEM

Educators will lead, manage and monitor aspects of STEM programming. Educators will be responsible for sustaining, improving upon, and sunsetting current programs. Educators will design new and innovative programmatic approaches to enhance learning experiences for young people. Educators will lead partnership, curriculum, and resource development efforts; implement educational programs, events, and activities; manage logistics, and recommend updates to program policies and procedures.

Additionally, educators will lead the design and delivery of this content area within the region, aligning with state priorities and local needs. Educators will build regional capacity with staff, youth, and adult volunteers to ensure high-quality learning environments around STEM topics that are guided by project-based curricula and include opportunities for youth to showcase new knowledge and skills.

UNIVERSITY OF MINNESOTA
EXTENSION
Driven to Discover℠

Extension Educator- 4-H Youth Development
Extension Center for Youth Development

Working Title:	Extension Educator – 4-H Youth Development (multiple openings)
Appointment:	Assistant Extension Educator (9625ST), Academic Professional (P&A)
Reports To:	Extension Educator in Youth Development
Application Deadline:	**September 30, 2022**; positions open until filled

Locations and Percentage Times
Carver (Cologne) – 100%
Faribault (Blue Earth) – 100%
Grant (Wheaton) – 80%
Kanabec (Mora) – 100%
Otter Tail East (New York Mills) – 100%
Scott (Jordan) – 100%
South St. Louis (Duluth) – 100%
Todd (Long Prairie) – 100%
Traverse (Wheaton) – 80%
Washington (Stillwater) – 75%

About the Position
Extension Educators are community-based academic professionals of the University of Minnesota Extension. They are a link between the land grant University research and Minnesota residents by creating learning opportunities that address local needs.

This position leads, manages and stewards the full range of 4-H Youth Development programming in the county/tribal community. 4-H Educators work collaboratively with youth, volunteers, community partners, and University faculty/staff to reach two overarching program goals: *Youth will learn by developing a passion in their areas of interest; Youth will lead by being innovators and social change agents.* 4-H Educators ensure program quality, growth, retention, and impact. They also:

- Build relationships with youth, parents, volunteers, partners and stakeholders
- Recruit, train, supervise and support volunteers
- Plan, manage, deliver, and evaluate educational programs and events
- Develop outreach and educational materials
- Teach and provide information to youth, volunteers, and community youth workers
- Promote and market the 4-H Youth Development program
- Provide financial guidance
- Ensure policies and expected procedures are communicated and followed.
- Prioritize responsibilities based upon the 4-H Educator's percentage of time and additional staffing available for the local program.

The 4-H Educator position is supervised by a regional Extension Educator in Youth Development.

Responsibilities

1. **Program Development and Delivery – 40%**
    - Engage youth, volunteers, and partners to create a program plan that reflects the demographics of the county/tribal community, addresses local needs and opportunities, aligns with the strategic direction of the MN 4-H Youth Development program and leads to program growth and sustainability.

- Design and develop high quality, culturally-relevant, impactful programs that support youth in learning and leading.
- Convene and facilitate planning meetings with youth, volunteers, and partners.
- Develop/adapt lesson plans and teach/facilitate youth/adult learning using relevant content and pedagogy/andragogy.
- Plan and manage the delivery of 4-H clubs, camps, after school programs, showcase opportunities, and other events and activities.
- Plan and manage 4-H experiences during the county fair, providing opportunities for recruitment, education, judging, and public recognition.
- Coordinate youth and volunteer involvement in regional, state and national 4-H programs and showcase events.
- Identify and implement strategies to diversify program participation, ensuring programs and processes are welcoming, accessible, and inclusive of youth, volunteers, and staff with varying backgrounds and experience.
- Develop and support community partnerships that extend programmatic reach and expand programmatic impact; complete program agreements.
- Establish and maintain an effective staffing plan including partners, volunteers, interns, and seasonal employees.
- Determine fiscal resources needed for each program and identify potential funding sources.
- Utilize established evaluation tools and processes to inform future program design, improve effectiveness, demonstrate value, and market the program.

2. **Volunteer Systems – 35%**
   - Establish and support a volunteer development system that builds the capacity and long-term sustainability of the 4-H program.
   - Identify needs/opportunities for volunteers to serve in management and delivery roles, and recruit and place individuals in these roles.
   - Ensure the volunteer screening process is implemented and up to date.
   - Cultivate relationships with and build capacity of volunteers through a support system consisting of effective orientation, training, utilization, recognition, and evaluation.
   - Teach and/or facilitate training for volunteers and community youth workers.
   - Address problems that arise with volunteer roles.

3. **Program Operations – 15%**
   - Manage and monitor compliance with organizational policies and procedures.
   - Recruit, orientate, supervise and support interns and seasonal employees.
   - Guide and monitor operations of local governing boards (4-H federations/councils) and county/tribal committees, ensuring compliance with requirements for group exemption status.
   - Oversee and ensure completion of chartering process for 4-H Federation/Council and 4-H clubs/groups.
   - Manage established processes for youth enrollment, volunteer enrollment, event participation, and program agreements.
   - Ensure potential and current participants have full access to programs, services, and facilities.
   - Plan for and manage risk-utilizing resources and established procedures.
   - Guide budget development, secure and leverage resources, monitor spending, ensure financial accountability.

- Manage use of facilities and equipment, including completion of required inventories and agreements.
- Maintain organized records and provide reports.

4. **Communication and Reporting – 10%**
   - Develop and maintain respectful working relationships with youth, families, volunteers, colleagues, community partners, and other stakeholders.
   - Develop/adapt and implement a year-round promotion and marketing strategy that attracts youth, families, and volunteers from diverse backgrounds and leads to enrollment and retention.
   - Develop/adapt and implement a communication plan with program participants, families, volunteers and partners that utilizes effective and contemporary approaches, including current electronic technologies.
   - Distribute marketing materials created for regional, state, and national 4-H educational programs and events.
   - Write content for various media sources (e.g., newspapers, radio, newsletters, web, social media) to promote programs, report on programs, and educate the public.
   - Collect data and prepare reports and presentations to share the public value, impacts, and accomplishments of 4-H Youth Development with local stakeholders.

Qualifications

Required:

- Bachelor's degree in a subject/discipline relevant to the programmatic responsibilities of this position.
- Experience (paid or unpaid) leading, teaching, and/or managing programs for youth.
- Evidenced ability to effectively communicate in English using oral and written communication methods (e.g., publications, presentations, web, and social media).
- Experience effectively interacting with people from various cultural backgrounds, including race, ethnicity, national origin, religion, socioeconomic status, age, gender, disability, sexual orientation, and other aspects of human diversity.
- Ability to work evenings and weekends.
- Use personal vehicle and cell phone for work, to include applicable driver license and vehicle insurance.
- Access to a reliable internet connection and ability to work remotely when Extension offices are closed due to the COVID-19 pandemic.

Strongly Preferred:

- Two (2) or more years of post-Bachelor's degree experience relevant to youth development, program development, and/or volunteer systems development.
- Evidenced knowledge of youth development theory and practice (e.g., college coursework, volunteer training)
- Experience designing, developing, delivering, and/or evaluating educational programs.
- Experience recruiting, guiding, and/or supervising volunteers and/or staff.
- Strong interpersonal skills including demonstrated ability to resolve conflicts.
- Proficient use of technology for communicating, locating information, monitoring trends, designing, delivering, and evaluating programs, and reporting.

Preferred:

- Master's degree in a subject matter/academic discipline relevant to the programmatic responsibilities of this position.
- Evidenced ability to work cooperatively with community partners and local governments to address educational needs.

- Demonstrated success in creating and sustaining high quality, culturally-relevant, educational programs for youth.
- Experience teaching youth and/or adults in a non-formal setting.
- Experience organizing and managing events and activities.
- Experience with board leadership or development.
- Experience applying relevant organizational policies, procedures and regulations.
- Experience planning for youth safety and managing risk.
- Experience developing budgets and managing finances.
- Bilingual; fluent in a second language relevant to the location of the position.
- Strong skills in analytical thinking, decision-making, judgement.
- Demonstrated ability to manage multiple tasks, timelines, and schedules while maintaining high quality of work.
- Evidence of working productively with minimal supervision.

Additional requirements/Working Conditions:

- Work within an office (or hybrid setting during pandemic) as well as in various educational settings.
- Work days, evenings, and weekends, as needed, to meet responsibilities of the position.
- This position often works in the community. Must be able to travel several times per week and regionally/statewide multiple times per year. Must provide vehicle or make individual arrangements for transportation. Mileage reimbursement provided.
- Cell phone required to meet responsibilities of this position. Cell phone number will be published in the Extension directory.
- Must have the ability to lift, carry, pull, and push 20 pounds.
- Must be able to stand for 90 minutes at a time and sit for 90 minutes at a time. Some days will require hours of standing or sitting.
- Must be able to submit proof of being fully vaccinated against COVID-19 or submit a completed religious/medical exemption and agree to comply with the University's testing requirement.
- This position is not eligible for employment visa sponsorship.

Appointment/Salary/Benefits

1. The position has an annual University academic professional appointment as Assistant Extension Educator, Job code 9625ST.
2. The appointment is reviewed for renewal annually, with continuation dependent on performance, results, availability of county funds, and program needs.
3. Internal promotion is available. Meeting the promotion policy criteria to achieve promotion is expected.
4. Salary commensurate with education and experience, minimum starting salary is $45,400 for a 100% time position.
5. Reimbursement for travel and subsistence is available in accordance with University policy.
6. University of Minnesota offers a **comprehensive benefits package,** based on percentage of appointment:
    - Medical, dental, and pharmacy plans https://hr.umn.edu/Jobs/Applicant-Center/About-Working-U/Benefits-Summaries-Prospective-Employees.
    - University Paid Leaves, Flexible Spending Accounts, Retirement Plans, paid Life Insurance, Disability Insurance, Tuition Reimbursement, EAP, Wellbeing Programs, and more. To learn about these excellent benefits, go to https://hr.umn.edu/Benefits/U-M-Employment-Benefits.

About Extension and 4-H

University of Minnesota Extension is a major outreach arm of the University of Minnesota with a mission to serve the public through applied research and education. Our mission is to make a difference by connecting community needs and University resources to address critical issues in Minnesota. Extension

strives to attract and retain high-quality, passionate employees, and weave diversity, equity and inclusion into all aspects of Extension's programming and employee engagement https://extension.umn.edu/.

University of Minnesota Extension Center for Youth Development works in partnership with communities to build engaged young people who are ready to learn and lead in a global society. Using youth development methods and principles, that are based on experiential learning and proven to result in positive youth development; we foster sustainability and resilience by building community-wide knowledge, capacity, and networks that support the healthy development of youth. Our audiences include: youth grades K-13 living in urban, suburban, rural, tribal, and online communities; volunteers, youth workers, and partners who deliver positive youth development programming; and, agencies, organizations, and groups that affect the lives of youth. To learn more about our programs, please visit https://extension.umn.edu/4-H.

TO APPLY
Please apply at: https://extension.umn.edu/about-extension/careers **Job Opening ID: 351423**

Applications must be submitted online. To be considered for this position, please click on the Apply button and follow the instructions. You will be given the opportunity to complete an online application for the position. Please include the following attachments with your online application:

- **Cover letter** – include your location(s) preference.
- **Resume** – include all relevant experience (paid or unpaid)
- ***Diversity Statement:*** *In 500 words or less, highlight your unique strengths, experiences, perspectives and values as they relate to equity, diversity and inclusion. Your statement could include the following:*
    a. *Personalized views and experiences*
    b. *Topics through the lens of your own knowledge or experience*
    c. *If you do not have personal experience on a topic, reflect on why*
    d. *Demonstrated learning and growth*

Three (3) professional references and transcripts for all college work (unofficial transcripts are acceptable) will be required during the interview process.

Additional documents may be attached after the application by accessing your "My Job Applications" page and uploading documents in the "My Cover Letters and Attachments" section. See full instructions,
https://hr.umn.edu/Jobs/Applicant-Center/Help-Job-Applications/Using-Job-Application-System.
To request an accommodation during the application process, please email employ@umn.edu or call 612-624-UOHR (8647).

(Please note: this position is not eligible for H-1B or Green Card sponsorship.)

For questions about the position, please contact:
Nancy Hegland, Program Leader, Youth Development, nhegland@umn.edu.

For questions about applying online, contact:
Tiffany McMillan, Extension Human Resources, tiffmcm@umn.edu.

Employment Requirements
Any offer of employment is contingent upon the successful completion of a background check. Our presumption is that prospective employees are eligible to work here. Criminal convictions do not automatically disqualify finalists from employment.

Please note: All employees at the University of Minnesota are required to comply with the University's Administrative Policy: COVID-19 Vaccination and Safety Protocol by either providing proof of being fully vaccinated on their first day of employment, or complete a request for an exemption for medical exemption or religious reasons. To learn more please visit: https://safe-campus.umn.edu/return-campus/get-the-vax.

Diversity

The University of Minnesota and Extension recognize and value the importance of diversity and inclusion in enriching the employment experience of its employees and in supporting the academic mission. The University is committed to attracting and retaining employees with varying identities and backgrounds.

The University of Minnesota provides equal access to and opportunity in its programs, facilities, and employment without regard to race, color, creed, religion, national origin, gender, age, marital status, disability, public assistance status, veteran status, sexual orientation, gender identity, or gender expression. To learn more about diversity at the U: http://diversity.umn.edu.

Dear Kanabec County Board of Commissioners:

Growing up as a member of the Kanabec County 4-H Program was a tremendous experience for me as a youth. I enjoyed being able to learn important life skills and gain knowledge by working with 4-H peers, staff, as well as volunteer leaders that helped prepare me as an individual to be successful in my life today.

4-H is a wonderful organization to be a part of and continually challenges everyone to think better and do better for yourself, your family, your friends, your community and your world.

As a 4-H member, I feel I learned so much during my membership years. What I have learned in 4-H is hard to quantify, as I can directly attribute many, many life skills to my time in 4-H, in addition to many indirect skills.

Through 4-H I learned how to speak publicly and lead others through a meeting. I learned how to delegate and prioritize time and obligations. I learned how to properly address a room and I have been able to teach, share and consult through my several jobs in a way that I would not have been able to had I not been part of this youth development organization. Other skills that I find started with 4-H would be creative and logical thinking and always being prepared by having a "Plan B." Projects such as livestock judging, showing my livestock animals and even sewing, have helped me develop skills that have allowed me to connect and network with many other young professionals since graduating from 4-H in 2009.

As a 4-H Alumni, I reflect on what I gained from being part of the Kanabec County 4-H Program. I feel 4-H taught me the value of leadership, but also showed me the importance of volunteering and serving one's community for the greater good. 4H gave me a sense of pride in my county and community which I have carried into my adulthood.

Being part of the Kanabec County 4-H Program also helped to prepare me for college. It provided me the skills, knowledge and experience to be able to connect with new people I had to live with and helped me to forge relationships with a diverse group of people. It prepared me in regards to responsibility, time management, project management and the ability to form timelines and be prepared for presentations and other major projects that were required in college. These important skills learned in 4-H continue to help me every day in my current work and career.

4H gave me the self confidence and courage to move across the county after I graduated high school to pursue my passion in the equine industry. After graduating with an equine and animal science degree from Colorado State University, I returned to Minnesota and began working for the Minnesota State Fair managing an equine exhibit overseeing several hundred volunteers and educating thousands of people about horses. I worked as a large animal veterinarian assistant for several years growing my knowledge base and connections in the agriculture community. My husband (who is also a Kanabec County 4-H alum) and I have grown our small hobby farm into a 50 head cow/calf operation, and I also breed, raise, and sell performance foals across the country every year. I have worked as an equine specialist at an equine assisted therapy facility educating others and witnessing horses change the lives of many people in the community. Most recently my journey has led me to apply for the Extension Educator position in Kanabec County. As of writing this letter, I have my final presentation and interview next week.

This journey of my life started with 4H. The relationships I have made and the experiences I have been fortunate enough to be a part of, sparked the passion that led me down my path. The life skills that 4-H taught me as well as the experiences the program provided me all helped me to be prepared to work for a variety of equine and animal operations and succeed in these positions.

4-H also helped me to be a leader and productive citizen in my community. The 4-H program showed me that there are more ways than one to make a difference and even the smallest act of selflessness and volunteering can go a long way to improve the life of another. It definitely taught me that it only takes a spark and soon that fire will be glowing. 4-H showed me how to be an active and productive individual in my community and helps me every day to continue to look for ways to make a difference.

I feel strongly that the skills learned in 4-H will guide individuals down a path toward a career they want and definitely helps to provide skills to be prepared to work and be successful. However, the friendships and connections made along the way are by and far the best benefits of being a 4-H'er. Some of the members I met as a young child are still some of my best friends today.

In a time when positive opportunities for peer connections are continuously becoming harder to find, the ability to be a part of 4H is more important than ever. Kids today are drowning in overstimulation, screens, social media, and virtual reality; allowing kids to learn about gardening, canning, sewing, and raising livestock when they may otherwise never be able to gain these skill will only strengthen our community. Learning how to speak to a room and follow Robert's Rule of Order is something that most kids will never learn anymore. Preserving 4-H in our community is akin to preserving the youth in our community.

4-H is a wonderful organization to be a part of and continually challenges everyone to think better and do better for yourself, your family, your friends, your community and your world.

Thank you for your time and consideration,

Nikki Priebe

Hello, thank you for your request for support of the Kanabec County 4-H and Extension Office. As you know, I enjoyed many years as a 4-Her and working in the office in the summer (including the trips to vaccinate cows with the local vet and weighing hay for moisture content in farmers fields). I think the most memorable though is when I was alone in the office surveying farmers on the phone at night and a bat flew through the courthouse! I've sent the following letter to all the commissioners, including mailing the letter to the one who doesn't show an e-mail address. Good luck!

Hello, my name is Bonnie (Toenies) Hays and I participated and represented Kanabec County in local (Brunswick township), county, state and national activities during my twelve years in 4-H. Those formative years taught me many practical skills such as cooking, sewing and gardening that I continue to use today in addition to soft skills such as public speaking and leadership.

4-H provided an environment outside my academic public education that nurtured my competitive nature and my desire to grow and learn more in a broad spectrum of topics not found in a classroom. I learned skills in record keeping that rewarded me with a trip to Washington D.C. and a 4-H State Ambassadorship, and public speaking from multiple demonstrations at the Minnesota State Fair. I continue to use the skills in my current management job where strong writing and public speaking skills are required daily. A strong commitment to volunteerism that started with 4-H has continued to be important to me and I have shared it with my family.

As a current Hennepin County employee, I understand the challenge to stretch public dollars to address the needs of county residents and stay within the budget. I see 4-H and the Kanabec County Extension as an investment in the community. Youth gain skills that contribute to the community in the short term and learn life skills that long term make them productive members of the community and reduce the burden of other county services such as the corrections system. The investment is minimal and the results are great. Please continue to invest Kanabec County budget dollars in these important programs.

Sincerely,

Bonnie Toenies Hays

Bonnie Toenies Hays

October 19, 2022

To the Kanabec County Board of Commissioners,

My name is Faye Lilyerd, and I have been a Kanabec County 4-H volunteer for 19 years. I wish to express my concern for, and thoughts of, the conversation to lessen, or cut, the Extension/4-H program in our county.

In 2020 I was given the 4-H Volunteer Service Award in our county, which I mention only as a sign that 4-H has been important enough to me to put in strong effort to give our county youth positive experiences in project areas and with the people around them. Someone appreciated my involvement enough to nominate me for the award, which attests to how much they value the 4-H program and the volunteers involved in making it happen in our county.

My four now-grown children were involved in 4-H from Cloverbuds on up through one year past high school; that's 14 years each, with the exception of my oldest son who joined 4-H in 5th grade. It all began with him taking the Archery course. That led to club membership. That also led to taking the 4-H Airgun classes. That led to participating in the 4-H State Shoot in Jackson, MN that year. Long story short, my kids participated in the full range of Shooting Sports, which encompasses seven shooting disciplines as well as wildlife education; they showed a myriad of static projects, along with performing arts, at the county and state fair, and enjoyed showing poultry, goats, dogs, and horses. They attended the 4-H State Shoot, as well as being members of our state team going to the National SS/W Invitational in multiple disciplines. Two of my kids went on to become Shooting Sports instructors.

In addition to being a club co-leader for the Quamba Crusaders, I am also a certified Muzzleloading, and Wildlife, Instructor, for over 10 years each. I have led some sessions over the years with the 4-H Afterschool Program and 4-H Day Camp. I have been our Shooting Sports/Wildlife PDC (project development committee) secretary for over 13 years, and am on our state Shooting Sports/Wildlife PDC for my 9th year.

I continue on in 4-H as an adult volunteer, even though my kids are all grown, because I can see the positive impact this organization has on youth, their families, and the community. The world opens up to our youth through the many project areas they can explore. Whatever youth wish to learn about and discover, we help them with resources, knowledge, a helping hand, and a high five for their growth. They learn through successes and failures. They learn leadership, cooperation, community awareness and pride, teamwork, problem solving, and how to step out of their comfort zone. They learn that adults can be mentors and friends. Even though I have many years in 4-H, I am still learning, from the kids just as much as from my peers. 4-H has opened up the world to me in new ways, too!

My time in 4-H is a drop in the bucket compared to those I know who are still involved, even now that their grandchildren are part of it. Ginny Anderson has put in 25 years, Bob Hessenius has put in 36, Mickie Hessenius just clocked 40 years, Corey Stanchfield is above that yet, I believe. Jim Evenson, who passed away on Sept 3, 2022, served 4-H in many capacities for over 50 years!!! These recognized individuals, plus hundreds of those working alongside them, know the value of 4-H in our county, otherwise they would not VOLUNTEER so much of their time, resources, and often money, to it.

Here are points I wish to address concerning the cutting of 4-H, whether to part time or completely:

- Financing 4-H: I understand needing to be financially responsible. How can that be done county-wide without lessening or eliminating the program? There is so much going on in 4-H on a year round basis that cutting the Extension position to part-time will stress our extension educator, causing programs to suffer.
- My 22 year old son said this when he heard of the issue: "So what, you are against spending money on kids? They have a blast in 4-H!" 4-H is an investment in our future, a positive way to direct the paths of our youth.
- Should 4-H charge money for every program: I don't believe we should charge for everything. 4-H is AFFORDABLE for families; programs are either free, or of nominal cost. 4-H is open to everybody, no matter their income level, and allows more youth and families to be positively impacted in ways they may not be otherwise. Many school sports cost a lot, and that can exclude youth whose parents can't afford the fees. Charging families for everything in 4-H will again make people pick and choose what they can do, which yes is a part of life, but does everything have to be that way??
- There already aren't enough activities in our county for kids to do to keep them on the right track, so let's not take away the one thing that does have positive impact on youth and families, and offers them many areas to be involved in, at little to no cost to them.
- Consider the impact to the county fair if 4-H is eliminated. Sadly, our fair doesn't have a whole lot to offer already.

Needless to say, I am an advocate for keeping 4-H strong in our county. Let's be proactive in offering positive outlets for our youth, instead of reactive when we need to deal with bad behavior and poor decisions that stress our youth, their families, and our community.

Sincerely,
Faye Lilyerd
Ann Lake Township
Mora, MN
320-679-0877

Dear Kanabec County Board of Commissioners:

I am writing to you on behalf of my family that has been involved in the Kanabec County 4-H program for the past 35 years as 4-H participants and volunteer club leaders. Our family has participated in showing animals and exhibiting general exhibits at the county fair and representing Kanabec County at the Minnesota State Fair.

We are proud to say that Kanabec County 4-H has given us the confidence to lead an effective meeting, a creative outlet, and most importantly leadership and public speaking skills that are used on a daily basis.

It is important to our family that the county use public dollars to support Kanabec County 4-H so many more families will benefit from all 4-H has to offer.

Sincerely,

Pam (Heikes) Burmaster
Grasston Go-Getters 4-H Club Leader

Kanabec County Commissioners,

For those of you who don't know me, I am Brooke Dunsmore, a senior at UW-River Falls. Although I sought further education, the skills and morals I utilize daily can be credited to Kanabec County 4H. I was raised on the Dunsmore Farm outside of Mora where my parents raised my brother and I alongside grain crops and produce. At a young age, I decided my dream was to raise livestock. With the help of my family and friends, I found my way to our county's 4H program at age five. During just my first year in the program, I learned to care for my ewe lamb, present club projects, develop community relationships, and to be a part of something bigger than myself. In the years to come my passion for the organization would snowball into a heavy involvement in 4H on the county, state, and national level by participating in public speaking, performing arts, ambassador teams, club leader positions, camp facilitating, and countless other initiatives led by 4H. Throughout 15 years in the program, my experience developed into a show lamb and beef operation in which the goal is to raise show animals for kids like myself with an excitement about learning. My reasoning behind dedicating an insurmountable amount of time and effort to these animals is the irreplicable teaching behind one's involvement in 4H.

Recently, I was informed of the possibility that the Kanabec County 4H program would be discontinued. This caused me to reflect on the scenario of my life without 4H. My closest, most valued friends and heroes would have been strangers, the livestock I have loved would be animals in a pasture, the children I mentored would be kids without a cause, and I would not be Brooke Dunsmore. To you, members of the community, I don't have to tell you that without 4H our county would be lost. Youth in our area would be put at an immediate disadvantage, the county fair would cease to exist as we know it, community services would be left undone, and countless opportunities would go dark. I speak for each Kanabec County 4H alumni when I say that not only is Kanabec County 4H the program we built, it is the program that built us.

In conclusion, I am more than aware of the scarcity of funds for seemingly small and unimportant parts of our community. But, the benefits far outweigh the cost when you view the developmental differences in students involved in 4H versus those that aren't. I am taking the time out of my busy schedule to contact you because I feel strongly that this is something worth fighting for. So, I thank you for taking the time to hear my input on this difficult decision and I hope you'll consider keeping Kanabec County 4H alive. Thank you.

Brooke Dunsmore

Dear Kanabec County Commissioners,
I'm writing to you to urge you to support funding the Kanabec County Extension.

I am a Kanabec County 4-H Alumni. My primary project in 4-H was sheep, I also had projects in veterinary science, arts and crafts, youth leadership, and food and nutrition. I was a county 4-H ambassador, active in my club, active on the Livestock Project Development Committee, and the County Leaders Council. Over my 10 years as a 4-H member, I served in many different leadership rolls, such as president, vice president, and secretary. I was also on the county Livestock Judging Team, and Livestock Project Bowl Team.

I learned many valuable skills in 4-H, things that I use to this day. With all the meetings I attended in 4-H, I became proficient at parliamentary procedure. I regularly use parliamentary procedure as an adult, at our saddle club meetings, 4-H meetings (I now coach the youth during the meetings to pass it on), and when I served on the county Farm Bureau board. In 4-H I also learned organization, whether it was for paperwork, or organizing a show. That also went along with time management, being able to plan and implement projects. In judging, I learned how to prioritize and rank, and then to give my reasons for my decisions. In project bowl I learned study skills (which served me well in college). Also, at the county and state fairs, you learned to graciously win and humbly loose.

For youth, 4-H is one of the few organizations that you can get hands on training in an agricultural career. Because of my experience through 4-H, I went on to earn my bachelors degree in Animal Science from North Dakota State University. Since I had been on the 4-H Livestock Judging Team, I decided to apply to be on the collegiate judging team. That coach told me to get on the Meats Judging team first. So, I was on the Meats Judging team in college. That experience on the Meats Judging team is part of the reason I got my first job out of college as a Meat Inspector for the State of Minnesota. After college, I also worked in food safety for Goldn Plump Poultry, for our family dairy farm managing the calves and genetics program, and now home school my children and help with the crop farm. I attribute all of that to my start in 4-H.

Now, my kids are in 4-H. Their favorite projects are horse, sheep, and dog. We enjoy the family time both preparing for the shows, and at the shows. My kids are learning the same skills I benefitted from through 4-H.

This is my 15th year as a volunteer for Kanabec County 4-H. I serve as one of the adult volunteer leaders for Canter Club. I also coach the county Horse Project Bowl teams, the Hippology team, and the Horse Judging team. Besides the horse project, I also volunteer with the sheep project, 4-H Ambassadors, and have coordinated livestock judging practices. I have served on the Livestock PDC (Project Development Committee), Horse PDC, and Dog PDC. I'm also on the state horse project bowl and hippology committees.

As members of the county 4-H, we already do a lot of fundraising to pay for our activities as a club, and county. This past year, we have sold fruit, butter braids, and coupon books. Our family

has worked in the food stand and scooped ice cream at the county fair. We have written grants and asked community groups for donations. As 4-H families we do a lot of fundraising.

Also, as parents, we pay for our kids to show at shows like the Minnesota State Fair, the State 4-H Horse show, Northeast Livestock Show, and State 4-H Dog show. Some of these shows can cost us a few hundred dollars each, that we, as parents, pay for out of pocket.

We thank you for your support and consideration.

Sincerely,
Stacy (Soderstrom) Thoeny
Canter Club

Stacy's 2022 4-H Volunteer Hours

Horse Project Bowl – 25 hours
Horse Hippology – 10 hours
Chaperone for Winter Roundup – 20 hours
Club – 12 hours
County Leaders Council Meetings- 8 hours
Livestock/Horse/Dog Project Development Committee (PDC) Meetings – 12 hours
County Fair – announcing shows, food stand, etc - 8 hours
County Fair Set-up and Clean up – 6 hours
State Shows (counties are required to have volunteers work a shift or two)
    State Fair Sheep Showmanship Ring Steward – 2 hours
    State Horse Show Tabulations Booth – 3 hours
    State Dog Show Agility Computer - 2 hours
State Horse Committees (Hippology, Project Bowl) – 4 hours
Communication, after school 4-H – 6 hours
Thank you gifts and cards - 10 hours

Total as of October 13 – 128 Hours

October 20, 2022

To Kanabec County Board of Commissioners:

I wish to express my concern for the conversation to lessen or cut the Extension/4-H program in our county.

I grew up in 4-H in Dakota County, all in my large family were very active. My father grew up in Olmsted County 4-H, he was determined his children would have the same experiences. When I chose serving as a University of Minnesota Extension Educator for 4-H as my career, my dad overflowed with pride. This turned into the best career anyone could ask for – a place where I could make a difference in hundreds of children's lives, and their families. I served 35 years in Extension, the majority as the Isanti County 4-H Educator.

I was a parent of Kanabec County 4-H'ers years ago, until the Kanabec and Isanti fairs were at the same time. I was the leader of the Brunswick Livewires 4-H Club. We wanted to help our community and were very interested in the environment. So we organized the 1st Kanabec County Clean Up Day in 1992. I served as Chair of this event for 25 years, until I retired 3 years ago. I had found another place where 4-H and I could make a difference.

Life skills are one of the major strengths of 4-H. Public Speaking skills. Record keeping skills. Proper care of livestock and pets. Children, teens and adults all working together toward a common goal. Community service – a skill practiced by youth and adults alike; caring for each other in this chaotic world. To me, youth discovering their voice is one of the major strengths of the program. Youth can practice what they enjoy, find ways to turn it into a career, a hobby, a way of helping people, animals, the environment. Life skills are the building blocks we all need for successful adulthood. Schools no longer have the time or resources to teach these skills, but 4-H does.

But. None of this is possible with a full team effort, beginning with you as Commissioners and the 4-H Volunteers. 4-H started as a true grass-roots program, and still is today. Of course, the program could not achieve what it does solely at the grassroots level. We need the Kanabec County Extension Service, University of Minnesota Extension and the US Dept of Agriculture. These programs need the research base of the University and the local support of Kanabec County to be so successful.

We are requesting the Board keep the funding in place so youth and adult volunteers continue to have the opportunity to learn and grow together and be of service in our community.

The Kanabec County Extension Service is more than 4-H. I am a Kanabec County Master Gardener, right now serving in the Chairman role. There are 18 active Master Gardeners in this county, with 4 more beginning the training course right now. We teach horticulture and plant sciences to youth and adults throughout the county. Examples are the 5th grade gardens at the school, workshops such as growing fruit in your backyard, food preservation, mushrooms, invasive specie plants. We have radio programs on KBEK and WCMP, articles in the newspaper, answer consumer questions and so much more. We are all volunteers, managing our own program. But, we are under Kanabec County Extension and do need the resources Kelsey is able to provide. So this program must continue in order for the Master Gardeners to continue our work.

Thank you for your attention.

Valerie Prax
2149 Highway 70, Mora MN 55051
Valeriep704@gmail.com
612-205-1099

10-17-2022

To: County Commissioners
From: Laird Mork
Subject: County 4-H Leader

I'm writing to strongly support hiring a 4-H leader with as many hours a week as is possibly reasonable. I answered a poll a couple of years ago - with 60 hrs per week.

Talent is everywhere - Opportunity is Not.

We have to provide our kids the opportunity. I and my three boys are all Eagle Scouts, but I tell everyone of a report I read years ago - that said 4-H has a better record than Scouts, of make better men & women, out of boys & girls than Scouting.

Many kids, because of distance from town, or more often economics cannot be in Band, Hockey, Basketball etc etc.
4-H Projects can be done at home, by oneself and many have little money involved.

Rural Kids used to have work (chores - I did) to do when they get home - in a lot of case that is not nece. so now

Young People have to have something to build their self worth - you can help it be Something Constructive - or —

II

I think of "you can pay me now or you can pay me later." D. McNally talked to me about cost $90,000 for 300 kids.
Well you can do that or spend $100000 for one kid when they end up in jail. !!

Dairy has gone away, so has Beef — Put Goats, Horses, Robots and on and on have taken their place.
I am attaching some of the mentoring I + Jon have done. There are mentors for Shooting — Goats — Horses — Art, Gardening and all the other projects. But you need a leader.
I went to court house to find kids to take sheep — Nobody there — I did find one girl on my own and furnished and helped her with 2 sheep "Olivia Petersen"

I would be willing to meet with any or all on the Board to discuss. There may be those that don't know — but I sat on your side of the desk for 4 years myself — so I know there is Two sides to every Story

I went on Computer, to see if there was a County in MN w/o 4-H. Did not get answer — But found a statement that said it (4-H) was in every county in every State in U.S. !!

We don't want to set that record.

Sincerely + with Hope that you will do the right thing
Carol

4-H'ers I + Jay Have Provided Sheep + Helped over Last 30 years

Kanabec Count

1 Valarie Vannacheck – 2yrs
2 Stacy Soderstrom – She worked with flock at NRDS4
3 Ginger Kotki – 4yrs they sold lambs last year 1000
4 Katie Kotki – 4yr " " " " " "
5 Justin Telsing – 3yr
6 ? Sutter – 2yr Top at State Fair
7 Jill Hissinius – 3yrs Furnish with High Quality Pigs too
8 ? Hissinius – 2yrs " " " " "
9 Adam Kerr
10 Brian Kerr
11 Tim Fluegge – had his own flock for years
12 Bob Dahms – Son – 2 yrs
13 Don Doty's – Son – 2 years
14 Kim Merks – Stepdaughter – I bought Wool Mill and had Seamstress sew her any outfit
15 Tim Andersonn – Son
16 Steve Anderson – Son
17 Lindberg – girl
18 Lindberg – girls Cousin
19 Dale Hawkins – Kids – Ther had own flock for years
20 Girl 6 miles So on Hwy 65
21 ? Anastads girl
* 22 Julia Yates
23 Ralph Voges daughter – Bought 500 steer for – Sold it 300 # toher
24 Olivia Peterson 2022 she got 3000 from Besser

II

Isanti County

25 Tim McCarty's Niece
26 Boy South of Braham - Bob Bendickson neighbor
27 Kelly Torkelson - 2yrs ⇒ got their own flock

Mille Lacs Co.

28 Lee Todmens granddaughter from Morehead

Carlton County

29 Mark Wester son - 2yr then they got their own flock
30 " " daughter - 2yr " " " "

Pine County

31 Dairy Farmers son 1 mile west 3 miles So Pine City
32 Girl in Askov - 2022 She helped Show ours at State fair - and had trip to fair with sheep we provided her

Washington County

33 Brandon Hoffman - 3yr
34 Nick Sagdalin 3yr } Don's Step grandchildren
35 Maddie Sagdalin 3y
36 #1 Peterson Girl ← Furnished Pigs too.
37 " Peterson Girl
38 ? Lasgaard Kids

#36 Lives on 5 acres - Shows horse every week end
- Showed our sheep
- Plays Cello in Orch
- #1 in her Class

Went to River Falls College to learn how to inseminate her Sow - And then had it in garage and slept with them when she delivered Pigs

Wisconsin

39 — Mythole BIK girl from River Falls
40 — Langer Ellsworth } Have their own fleet
41 — Langer Ellsworth } now
42 — Coss Cannon Falls Mn.

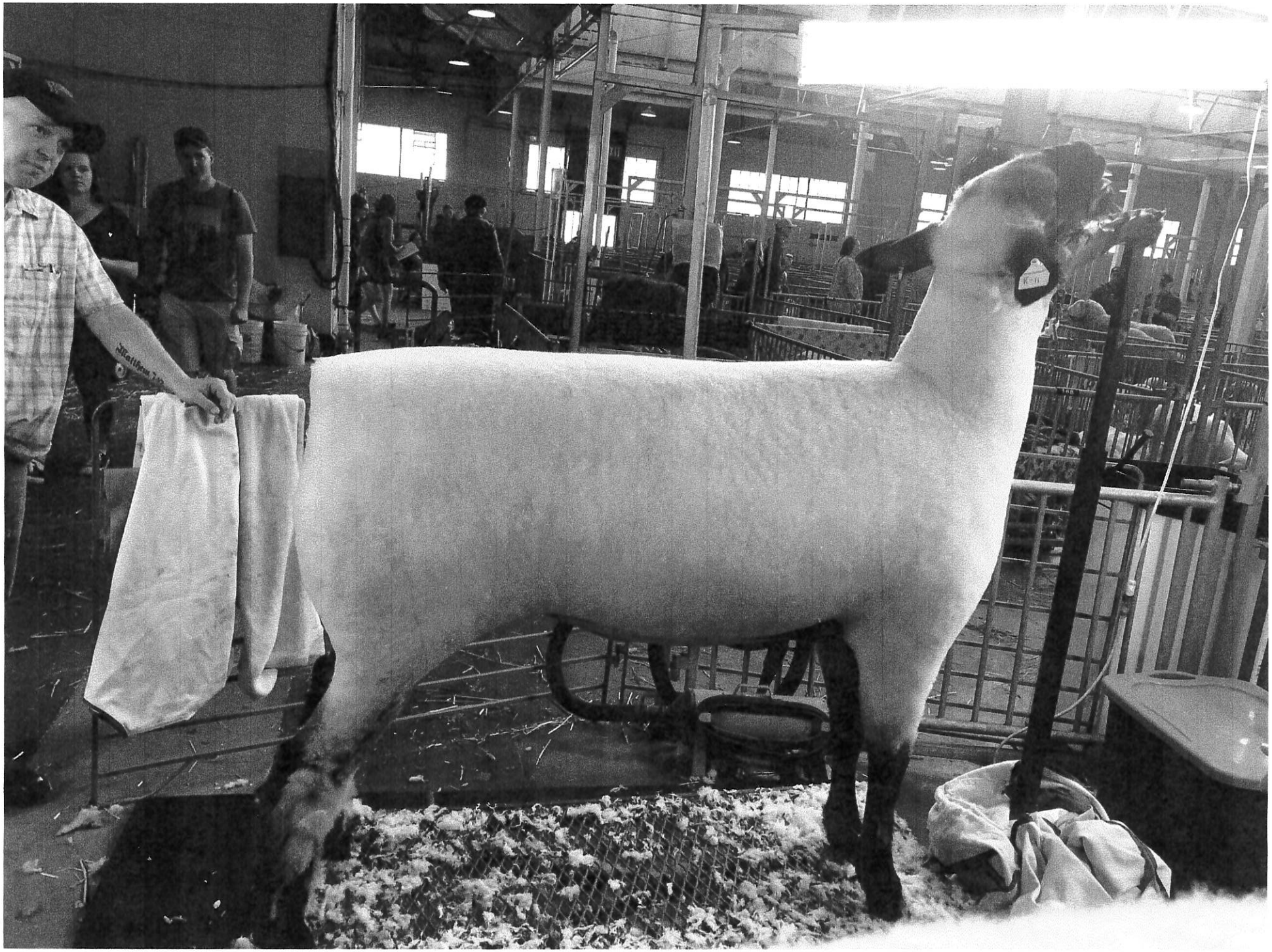
½ wether lambs that I would buy and sell to the 4-H-er for less then my cost

½ were our ewe lambs worth $500 — $1000 we would lease them for $1 per for 6 months

helped with feed costs at some of the places furnished hay, when all they had was Poor Hay

Helped wash + trim for show.

loved every minute of it — except #22
I struck out there — they brought it back to me the day before the fair



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www.ecv.vet

Dear Commissioners of Kanabec County:

Recently, it has come to the attention of some of your constituents that you are considering eliminating the line item in the Kanabec County budget that supports the 4-H extension agent. Please allow me to make some observations for you to consider.

The University of Minnesota is a land grant public university. It ranks 62nd out of 443 national universities and part of its mission is to provide for the opportunity for the citizens of our state to receive an education that is well recognized throughout the world. The University of Minnesota established and supports the 4-H program in Minnesota to provide an out of school, hands on learning program to explore educational opportunities that are often not provided within our school systems. These experiences include but are not limited to science, photography, agriculture, healthy living, sewing, cooking, shooting sports and animals. Most meetings allow the members to learn and practice parliamentary procedure which is core to most business, governmental, and professional meetings. The organization is dedicated to helping to raise healthy, well-adjusted adults. The organization focuses on the developmental skills of public speaking and leadership.

Each of you is an elected official of our county. You each represent the families of your constituents and need to lead the people you represent by making decisions to help your people be sound citizens. I was rather surprised that there was any question of the importance of the 4-H extension agent and the importance of funding this position. This person remains vital to coordinate the efforts of the very large population of adult leaders in our county that help our children in the 4-H program.

The 4-H program is a state wide program. It would be embarrassing to not have our county be a part of this vital program. The 4-H program is an important part of being a community that raises successful individuals. The saying "It takes a village to raise a child" is certainly representative of our county and the 4-H program is an integral part of that plan. I would urge you to continue to whole heartedly support and fund this program.

Sincerely,

Mary J Olson DVM

Dear Kanabec County Board of Commissioners,

I want to offer my insight on why it is essential to continue funding the Kanabec County Extension office, specifically the 4-H Educator Position.

All four of my children participated in 4-H from ages 8-16 in Kanabec County, Polk County, and/or at the Minnesota state or U.S. national levels. With professional guidance from the 4-H Extension Educator and trained volunteers, my children learned to speak with and work with donors, potential employers, elected officials, and community leaders. This experience in their teen years made them better citizens in their adult years. Completing records and budgets for their 4-H projects gave them above-average writing and financial planning skills to place them as leaders in their universities. It gave them an advantage over other entry-level peers in their first jobs...because once you've spent a few years in 4-H, you don't ever have to be an entry-level applicant. The networks they formed at county, state, and national 4-H experiences helped them land internships, jobs, and positions on Boards of Directors. The confidence they gained from the simple experience of choosing a project and completing an exhibit, then explaining what they learned through county and state fair judging helped them better understand what they bring to the table and how to articulate that to others.

It is important to use public dollars to support Extension and Kanabec County 4-H because 4-H and Extension are about improving the communities where we all live and work by educating and upskilling the youth and volunteers in our areas. 4-H, in particular, is a vehicle to get kids excited about learning through actual applied practice. This structured program instills Life Skills in ways that traditional classroom education and after-school clubs can't quite manage. 4-Hers are not just raising a pig or training a dog; they're managing a small business inclusive of expenses, risks, gains, and losses in the real world, reacting to actual marketplace and environmental fluctuations. The 4-H Extension Educators who administrate this program are professionals with years of education in experiential learning. They guide our community volunteers to provide our youth with a safe place to try, fail, try again, and succeed. The results of this program are clearly seen in our county and our state. Beyond becoming better citizens and more well-rounded contributors to our local economy and culture, as a group, typically each club completes a community service project in Kanabec County at least once each year. The public benefits from upskilling these youth and volunteers through 4-H and Extension.

Below I've included what each of my children sees as the most important thing they gained from their 4-H experience.

Tom: 4-H played a crucial role in my personal development, and the 4-H Extension Educator ensured I had the freedom to try, succeed and fail with a wide variety of projects, making me a more well-rounded person.

Achievements: Kanabec County 4-H (1992-2001), Founder, Kanabec County Arts-in (1997)

Summer: The most important thing I learned from my 4-H experience was how to build and run a business – and the confidence to try.

Achievements: Polk and Kanabec County 4-Her, Kanabec County Ambassador, County Leader's Council Vice President, County Arts-in Director, Key Award Winner, Minnesota State Ambassador, Minnesota State 4-H Federation President, State 4-H Public Speaking Contest First Alternate, State Arts-in Student Director, State Grants Committee Reviewer, National 4-H Council Grants Committee Reviewer

Jake: The most important thing I took from my 4-H experience was the chance to learn about leadership in a safe environment.

Achievements: Polk and Kanabec County 4-Her, Kanabec County Ambassador, County Leader's Council President, 4-H Camp Counselor, Key Award Winner

Larry: What I've continued to take from my 4-H experience with me throughout my life is the ability to work, compete, and strive to achieve as both an individual and as part of a group.

Achievements: Polk County 4-Her, 4-H Camp Counselor, Jr. Leadership Award Winner, Key Award Winner, National Silver Tray Award Winner, National Records Champion College Scholarship

Sincerely,

Lowell Sedlacek

Lowell Sedlacek,

Marshall County 4-H graduate, Adult leader Polk and Kanabec Counties
Long time resident Kanabec County

Oct 22, 2022

What get rid of 4H? When I heard this I was floored. We moved up here in 1978 from Brooklyn center. We live on a hobby farm a little of everything was bought at auctions until 1980. We knew nothing about animals well that how we got into 4H. I saw the Cafe at the Sales barn and Esther Portz said why not put the Kids in 4H. We had 3 sons and so we did. Best thing we ever did. It gave the boys something to do and they enjoyed it we to many shows around the area and meet many great people who gave us many help full hints.

In 1982 Donna Gally and I started a fundraiser for 4H its the annual sunmyer Sale. I retired from it before Covid but because the community wanted it back and I missed the people started it up in 2022. So we do raise money for many of our projects.

I am a 4H leader for my club, do a 4H afterschool program once a week at the library for 5yr olds to 6th grade. Run the 4H fundstand during the fair where we meet lots of very great people. Beside I think some of the Kids we have in the program are wonderful they are always there to help when I call. We host 4H day camp a week in the summer to try to keep kids involved and learn new things. Get rid of 4H. Lets think again some of these kids are in 4H because

its only as expensive as you want it to be and lots of families are hurting right now and so we a helping families be able to have an out for their kids. In the afterschool program we have 30 kids signed up. That should tell you something.

Lets keep it going we need it in Kennebec County.

Carlos A Stanchfield.

October 25, 2022

To Kanabec County Board of Commissioners,

As a part of your budgeting process I understand that you have under discussion changing your support for the full time extension/4H program. As a person that has had the benefit of over sixty years of involvement with 4H, ten years as a member, three years a 4H extension agent and forty-seven years as a volunteer and leader. The program has been a very positive influence on my life as with many volunteers. It has been a privilege to work with these wonderful young people.

The 4H program helps young people develop so many life skills such as making choices, setting goals, responsibility and technical skills. To helpfully organize volunteers, youth, community needs, and materials requires time. The 4H program needs a full time stable core individual to best serve the youth and community of Kanabec County. The program helps to develop the skills for our youth to become contributing members of our county and the world. Please accept this letter into consideration when making your final decision.

Thank you for listening.

Sincerely

Dan Schafer

Long time supporter of 4H

Dear Kanabec County Commissioners,

My name is Jesse Heitke, an alumni of the Kanabec County 4-H program. In my 13 years as a youth participant, 4-H granted me opportunities that would have otherwise been unavailable to a rural youth such as myself. From travel opportunities, to leadership opportunities, to the forging of lifelong friendships, 4-H has had a permanent and immense impact on my life.

My first exposure to 4-H was much the same as many kids who lived on farms, with my family's animals. My family has shown cows for 3 generations, so showing cows is very much a family affair. As a Cloverbud I showed a Guernsey named Eve, and since then I've been hooked! I had the opportunity to show cows at the county fair every year while in 4-H, sometimes bringing as many as 10 to help fill the dairy barn. Showing cows taught me that a strong work ethic was needed to prepare your animals to the best of one's abilities from a very young age. Showing cows gave me the confidence to compete at a high level, and to this day I participate in showing cows at the state fair and national show in Madison, WI every year with my sister Kristen.

Participating in 4-H allowed me to travel and meet people from the greater state of Minnesota and beyond. As mentioned before, I regularly participated in events such as BLU and YELLO. At YELLO, I was able to travel to the state fair grounds and meet youth from different regions of Minnesota from Thief River Falls to Rochester. I also had the opportunity to travel to Washington D.C. for Citizenship Washington Focus to learn about government and civic engagement, meeting people from Maine to Georgia.

4-H also provided me with leadership and personal development opportunities that have helped define both myself as a person, as well as my career. I was fortunate enough to participate in PICKM camp as both a camper and a counselor. As a counselor, I was put into the position from a young age to help make guiding decisions such as scheduling, events, and activities for the campers attending. As I got older, I was able to attend state 4-H events such as BLU and YELLO that gave me further experience with leading groups of people, dealing with conflict, and how to engage with people. As many people who knew me from a young age know, I was very shy and always found it difficult to work and interact in groups. Through the years in 4-H going to camps, participating as a county ambassador, and attending leadership events at the local and state levels, I eventually was able to learn how to effectively communicate and position myself as a leader.

These communication and leadership skills have carried into my professional career. I currently work as a Senior Study Director at NAMSA, a global contract research organization that specializes in medical device testing. In my role, I work directly with clients to design studies, manage internal resources, and communicate study results to the FDA. From dealing with clients from across the globe, to managing groups of people executing a study, to communicating results to regulatory groups, the interpersonal skills I gained from a young age in 4-H has enabled me to be successful in a career I can be proud of.

And most personally, 4-H allowed me to meet the group of people that I've considered my best friends for the majority of my life. From ninth grade until my freshman year of college, I participated in State Arts-In, where I got to live, work, and have fun for a week of preparation, before spending the whole 12 days at the Minnesota State Fair. It was here that I met a group of youth from wildly different backgrounds that I would have never had the opportunity to meet otherwise. Since our initial year of meeting, we've all kept in close contact over the years. Our friendships have lasted from high school, to going to college, to some of us moving across the country and back. Together we've celebrated graduations, weddings (see picture), and now the birth of our friend's children for going on nearly 20 years.

Without 4-H and the opportunities it presented, I wouldn't have had the opportunity to grow into the adult I've become. The personal effects of the lifelong friendships forged, and the leadership training instilled in me through leadership events, I know I would not otherwise have the personal and professional life that I have made for myself. To take away the broad opportunities that 4-H can provide would be a detriment to the youth of Kanabec County. I urge you to reconsider the decision to cut funding to the Extension Office.

October 25, 2022

To Kanabec County Board of Commissioners,

For thirty years I worked for the youth and other citizens of Kanabec County as an extension agent. During that time there were two of us who ran the extension office/4H program and one secretarial staff person. We were able to grow a larger and more active program, which we are seeing the results of this in our community. Members not only learned basic skills such as responsibility and teamwork they also learned subject skills, discipline, leadership and citizenship. Today I look around the county and see a lot of these 4H members I helped through the program in leadership positions and commerce. Not only have I seen these 4H members but I have seen their children and grandchildren be heavily involved in this program and see success during their time in 4H and after they graduate. What a joy it is for myself and others to see the impact this program has made.

One of the biggest rewards of the 4H program was to see the members grow and develop. In the twenty plus years since then only one person has been in charge of building and maintaining the program. This makes it a lot harder for that individual by cutting their time that will create more barriers. Please consider not cutting the 4H position; it is far too important for the youth AND community of Kanabec County.

Thank you for your time.

Sincerely,
Karen Schafer
Past Kanabec County Extension Agent

TO: Kanabec County Commissioners

Oct. 28,2022

RE: 4-H program funding

Dear Commissioners,

I would like to share with you the 4-H Pledge:

I pledge my Head to clearer thinking,

My Heart to greater loyalty,

My Hands to larger service,

And my Health to better living,

For my club, my community, my country and my world.

Head, Heart, Hands and Health are the four H's in 4-H, and they are the four values members work on through fun and engaging programs.

4-H is a quality program that is a positive influence for youth in our communities/county. Please support continuing this program.

Sincerely,

G. Troy Mork

2065 Joplin Street

Mora, Minnesota 55051

Minnesota Dairy Initiative

Established to Energize a Healthy and Vibrant Dairy Industry in Minnesota

MDI
Minnesota Dairy Initiative

10/27/2022

Dear Kanabec County Commissioners,

It was brought to my attention that some of the County Commissioners are in favor of the possibility of cutting funding for the 4-H program in Kanabec County 4-H gave me the chance to meet others with similar interests, do hands on projects, learn to communicate and problem solve in a group setting.

4-H teaches leadership by giving opportunities to lead. Some of the opportunities were being a council officer, being a County and State Ambassador, 4-H Arts In, regional camp counselor, dairy project bowl, dairy judging, and showing dairy cattle. The Washington D.C. trip gave me a chance to travel and meet other 4-Hers from around the U.S. and learn about the government.

The 4-H Dairy Project gave me the opportunity to be on the judging team and in dairy project bowl. It was at these contests where I met many of the people who are also vital to Minnesota's dairy industry today. This networking that was done at a very young age has given me huge advantages in life. As a Senior in high school, I received recruitment letters from the University of Minnesota, University of Wisconsin-Madison, Cornell, and Cal Poly. Colleges watch 4-H and recruit the best, no different from a college athlete being recruited. I cannot imagine not being given this opportunity.

4-H taught me to work hard, be confident, speak in front of a groups, and organize meetings and large events. These are all things that I still use in my job every day.

There is no doubt in my mind that without 4-H I would not be where I am today. Mora High School alone would not have given me the opportunities to network with the right people and learn about agriculture. It is the people from throughout Minnesota that I met at leadership trainings and events that I still call friend. Not the people from Mora that I just happened to grow-up nearby.

I am the owner of a grass-fed dairy farm that sells milk to a specialty creamery in the Twin Cities. On my farm we also have several national award-winning show-cows and sell their offspring around the country. My career path has always been dairy focused working in genetics, nutrition, and I now work under a grant through the Minnesota Dept of Agriculture focusing on Strategic Business Planning on Minnesota's Dairy Farms.

Taking the opportunity of belonging to 4-H away from the youth of Kanabec County would be a huge mistake. 4-H offers more than can just be learned in school along with lessons that will last a lifetime.

Kristen Salzl (Heitke)

Kristen Salzl

Jennifer Yates
2846 Jade St
Mora, MN 55051
10/25/2022

Dear Kanabec County Commissioners:

Thank you for your service to Kanabec County! Let me ask you a question: How do you build Champion youth? We give them opportunities to develop the skills needed to excel in life! That is the only way to build anything! Opportunities!

4H and all the moving parts within the program (STEM, agriculture, healthy living, and civic engagement) are centered around helping youth succeed. As a community, we need to stand behind the 4H program and the adult volunteers to continue the legacy of building Champion youth!

The opportunities given to our youth in the past have brought them across the country to Washington DC to participate in the democracy of our country by attending the Presidential Inauguration of our 45th President. This experience had a lengthy process for the youth to be accepted and only a select few were able to go. The process and trip taught this youth life skills that have taken this 4Her to several other political platforms to learn and develop.

And on the local level, there are youth and adults working together, building mentorships, and aiding in quality youth leadership opportunities on a weekly basis such as the Dog Project. We have had several youth start their 4H journey with the Dog Project and have taken those skills into their adult life to train other people's dogs.

Thank you for providing us the opportunity to speak about the impact 4H has, take this opportunity to see beyond the Extension line item, and into the real impacts that this program has for not only youth but our county's development and productivity. It is in the greatest interest of everyone to invest in the development of strong people, they are the leaders of today and tomorrow. The people behind 4H deserve to be heard and known for how we are helping youth become Champion contributors to our community, state, country, and world. Getting behind our youth and support Champion-ing our youth to make the best better!

Sincerely,

Jennifer Yates

Jennifer Yates 4-H Volunteer Hours

Dog Project Hours

133 hours

County Fair Hours

71 hours

State Fair Hours

102

Total Hours

306

I also have an agreement to use our training facility as a rental space (for free)

2022 dog training year - 19 days for a total of 57 hours

To Our Elected Kanabec County Commissioners:

My name is Mindy Stone, I have lived in Kanabec County my entire life and to say 4-H has been a huge part of my life would be an understatement. My Maiden name is Schafer, my dad is Dan Schafer who has been involved with 4-H most of his life, from selling a steer at the MN State Fair auction, working his first job out of college was as an Extension Agent in Jackson County, he has been a 4-H Leader for 50+ years. My mom is Karen Schafer, she became a Kanabec County Extension Educator when I was 2 years old and continued in that position for 30+ years until she retired. I became an official member of 4-H when I was 7 years old, I remained a member until I aged out. I the opportunities to exhibit beef, horse, sewing, photography, baking, crafts at the Kanabec County Fair, then at the MN State fair I exhibited a beef steer one year, went down with the general livestock judging team for Kanabec county and exhibited my Favorite Foods show exhibit, one year I spent the whole Mn State Fair at a camp for 4-H and FFA youth to work as ushers at the grand stand and coliseum shows, a once in a lifetime experience. I have had my name and picture in the Kanabec County Times more times than I can count for being involved in 4-H.

I married and had a daughter, Samantha Karen Stone, she joined 4-H when she was about 7 years old, and I became a 4-H Leader and a Beef Barn Superintendent at the Kanabec County Fair. My daughter has been very involved as a member, then 3 years as the summer intern. She went off to college at the University of Wisconsin – River Falls, achieved her Bachelor of Science Degree in Agricultural Education. Now she is interviewing for the position of Kanabec County 4-H Program Coordinator.

Thinking about what 4-H means to me, my family, my community, my state and my country. I thought about growing up and living in Kanabec County. There are not a lot of opportunity for youth to be involved in positive, productive, inclusive, affordable activities. 4-H provides a variety of opportunities to belong to something positive and often productive and affordable. Youth need a place to learn responsibilities, integrity, leadership, compassion, camaraderie, and life skills. They are our future, who are going to be the county commissioners of tomorrow if we decide to eliminate programs like 4-H.

I heard the argument was made that we provide the 4-H program to the youth, they learn all the leadership skills etc. and then they leave. I know of many that prove that argument wrong: myself, pharmacy technician at Coborn's for 25 years, my brother, Jeff Schafer, law enforcement, Paul Strunge, Auctioneer, Becky Ripka-Matoga, owner of Mora bakery, Rick Martens, Steve Anderson, Tim Anderson, Ryan Gunderson, Kyle Stanchfield, Chris Woolhouse, Laird Mork , Stephanie Porter-Paulson, Jed Lilienthal, Kristy Lilienthal, Kristi Linder-Johnstone to name a few.

In the scheme of things, the amount of money that goes to the 4-H program is a very small drop in the bucket, the impact made in the lives of the youth involved is priceless.

Sincerely,

Mindy Schafer-Stone

October 18, 2022

Dear Kanabec County Board of Commissioners,

I am writing you today to share my views on 4-H. It has been said, "It is better to develop a child than to mend an adult. As the chair of the Extension Committee, I know 4-H has a positive impact on our youth developing leaders and good citizens in our community.

In Kanabec County we have approximately 275 students benefiting from our 4-H program. Members learn life skills like planning, record keeping, and decision making as they work on their projects each year. Our volunteer 4-H leaders, numbering over 75 individuals, encourage our youth during meetings and events helping to enhance their social skills, work ethic, and discipline. In our area, youth do not have many opportunities outside of school, church, and sports to work with others, to manage their resources and enhance their decision-making ability.

Please know, I am grateful for my years in 4-H. In the 70's, we had three plus full-time individuals to include, two county extension agents, a 4-H program coordinator, and another individual in the office to assist in our growth and education.

Without a doubt, 4-H helped me to develop a strong character, and it offered me experience to grow as a public speaker. The program also spurred on my love of volunteering and learning. I was fortunate enough to have Lorene Sherman, Lucille Ostman, and Barb Strom as my 4-H leaders. Each one if them set a good example for myself and others. Without a doubt, my experience in 4-H is where I learned to sew, cook, bake, refinish furniture, show cattle, and speak in public.

It seems, youth who are involved in volunteering earlier in life continue this passion later in life. I am heavily involved in volunteering at my church, as a member of the church council, a volunteer at our vacation bible school and Sunday School programs. I serve on our Zion Lutheran Preschool board, I volunteer at the AWANA program at the Hillman Baptist Church, I chair the Kanabec County Extension Committee, I volunteer at Mora Elementary, I am on the committee for the Mora Education Foundation's annual fundraiser, and I am a board member of the Mora Dollars for Scholars organization.

Spending time with our 4-H youth and leaders, I can see that 4-H helps one's self-image. I was fortunate enough to judge the 4-H barns at the fairground, to participate in the 4-H auction, and to observe the dog show this year. The pride in the youth, leaders, and parents was apparent as they shared their knowledge and talents with their projects and animals.

Please know this program is very important to Kanabec County. There are many individuals who would miss this amazing program with all it has to offer in developing life-long skills and good citizens.

Thank you for your consideration,

Jean Mattson

Jean Mattson

11/05/2022

To: Kanabec County Commissioners,

I have been concerned about Kanabec County 4-H since I learned that several commissioners would like to reduce funding to the Extension Office and 4-H.

My involvement with 4-H started when I was 9 years old as a 4-Her. It continued as a 4-H assistant after college, Area Extension Youth Agent in 5 counties, and then as a 4-H parent and leader.

4-H offers rural youth opportunities they do not get in school. There are opportunities to attend camps, travel, attend leadership conferences and network with a diverse group of youth from across the country.

As I look around the community, I see many people that were active in 4-H as youth. I am sure 4-H played a large part in their life. I see city council members, County Commissioners, County Fair Board, Extension committee, townships boards, farm organization, teachers, nurses, physician's assistants, business owners, law enforcement and farmers that all were 4-H members. Some people I think of are Bob Jones, Jake Mathison, Chad Kehr, Angie Soederstrom-Tvedt, Jeff Schafer, Terri Huro, Aleathea Anderson, Allison Holland, Tony Munsterteiger, Rick Martens, Brook Gardener, Stephanie Porter Paulsen. These are all people who enrich our community.

I hope the county commissioners look at the good experience 4-H give our youth. Especially these that cannot take part in school and town activities.

Sincerely,

June Haveri Heitke

10:00am Appointment

Item a.

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: Renewal of Medical Examiner Contract Agreement	**b. Origination**: County Sheriff
c. Estimated time: 5 minutes	**d. Presenter**(s): Sheriff Smith

e. Board action requested: Review and approve the attached agreement for 2023 medical examiner services.

Resolution #___ – 11/15/22

Medical Examiner Contract

WHEREAS the terms of the contract with River Valley Forensic Services, P.A. expire December 31, 2022, and

WHEREAS River Valley Forensic Services, P.A. has agreed to contract for services in 2023; and

WHEREAS the County Sheriff is satisfied with the services provided by River Valley Forensic Services, P.A.; and

BE IT RESOLVED to approve the Medical Examiner Contract Agreement with River Valley Forensic Services, P.A. for services provided by or under Dr. Kelly Mills as Kanabec County Medical Examiner effective January 1, 2023 for a term ending December 31, 2023.

f. Background:

Supporting Documents: None **Attached: ☑**

Date received in County Coordinators Office:

Coordinators Comments:

MEDICAL EXAMINER CONTRACT AGREEMENT

Agreement entered into this **15th** day of **November 2022**, by and between the County of Kanabec, a political subdivision of the State of Minnesota, and River Valley Forensic Services, P.A. for the services of Dr. Kelly Mills, M.D. as Medical Examiner of Kanabec County.

I. **Relationship of Parties**

A. Pursuant to County Board action that took place on **11/15/22** and the authority of Minnesota Statutes Ch. 390, the board of Kanabec County commissioners designates Dr. Kelly Mills, M.D., as Medical Examiner for Kanabec County, hereinafter "the Medical Examiner."

B. It is agreed that nothing contained in the Agreement is intended or should be construed as creating the relationship of co-partners, joint ventures or an association or an employer/employee relationship between Kanabec County and Dr. Kelly Mills, M.D., River Valley Forensic Services, P.A., or their employees or designee. River Valley Forensic Services, P.A. is an independent contractor, and neither River Valley Forensic Services, P.A. it, its officers, agents or employees shall be considered agents or representatives of the County. The County is interested only in the results to be achieved. The manner and means of conducting the works are under the control of the Medical Examiner, except to the extent they are limited by statute or regulation and the express terms of this Agreement. None of the benefits provided by the County to its employees, including, without limitation, unemployment insurance, workers' compensation insurance, retirement and deferred compensation plans, vacation and sick leave, are available from the County to the Medical Examiner, River Valley Forensic Services, P.A., or the employees, agents or contractors of either. No civil service status shall attach to the Medical Examiner, Medical Staff, agent of contractors of the Medical Examiner or River Valley Forensic Services, P.A. and the County shall make no deductions from sums payable under the terms of this Agreement for state or federal income taxes, FICA, PERA or other payroll type deductions which are associated with an employer-employee relationship.

II. **Personnel**

A. The Medical Examiner will designate Dr. Kirstin Howell, Dr. Victor Froloff and Dr. Butch Huston to assist in performing the contract and shall be under the control and supervision of the Medical Examiner. Dr. Howell, Dr. Froloff and Dr. Huston shall not be considered employees of the County, nor have a contractual relationship with the County. The County shall be notified prior to the effective date of any changes thereto.

B. The non-medical personnel necessary to support the Medical Examiner in the performance of his duties under this Agreement shall be provided through the County Sheriff's Department. The compensation, benefits, and other terms of employment of these non-medical personnel shall be determined and paid solely by the county.

III. **Scope of Duties**

A. The Medical Examiner shall be responsible for conducting a modern medico-legal investigative system for Kanabec County applying the standards of the National Association of Medical Examiners, as they may be amended from time to time. The Medical Examiner shall periodically consult with the County Attorney's Office, police agencies, and others concerned with forensic pathology to review procedures and formats for preparing medical reports and protocols. The Medical Examiner shall perform all duties imposed by Minnesota Statutes Chapter 390, as well as the duties imposed by other statutes applicable to the Medical Examiner's activities. The Medical Examiner shall testify, as required, at inquests, hearings and trials.

B. The Medical Examiner shall be responsible for the final determination of the cause and manner of death, and the signing of certificates attesting the cause and manner of death. During the temporary absence of the Medical Examiner, a qualified person designated by the Medical Examiner may make the final determination of death, and sign a certificate attesting to the cause and manner of death.

C. The Medical Examiner shall be entitled to perform other gainful activities which do not interfere with the performance of her duties hereunder.

IV. **Compensation**

A. All payments made under this agreement for services rendered by or at the designation of Dr. Kelly Mills, M.D., shall be made to River Valley Forensic Services, P.A.

B. The County will be responsible for the payment for each complete autopsy or external examination performed by Dr. Kelly Mills, M.D., or her assistants, as the Medical Examiner pursuant to this agreement and billed to Kanabec County upon completion of each examination in keeping with the past practice of the County Medical Examiner's Office.

C. Compensation for the services under this contract shall be $250.00/month plus the following on a per service basis: (1) complete forensic autopsy with basic toxicology, at approximately $2,000, and (2) external examination with basic toxicology at approximately $1000.

D. Additionally, the County will be responsible for court related preparation / consultation and out of office charges, billed on an hourly basis of $300/hr., including travel to and from Kanabec County in order to provide testimony in legal proceedings arising out of the duties of the Medical Examiner.

V. **Facilities**

The facility, together with all the necessary equipment, the supplies, shall be the responsibility of Dr. Kelly Mills, M.D. It is represented by Dr. Kelly Mills, M.D., and understood by the County that Ramsey County Morgue shall be available to Dr. Kelly Mills, M.D., for the performance of this agreement.

VI. **Insurance and Indemnification**

A. River Valley Forensic Services, P.A. agrees to indemnify and hold harmless the County of Kanabec, its officials, employees and agents from any and all liability, loss or damage, that the County of Kanabec, its officials, employees and agents may suffer as a result of claims, demands, costs of judgments, including without limitation reasonable attorney's fees arising out of the provision of professional services by Dr. Kelly Mills, M.D., as the Medical Examiner of Kanabec County pursuant to Minnesota Statutes Ch. 390, provided, however, that this indemnification shall be limited to the extent of such claims, demands, costs or judgments, including, without limitation, reasonable attorney's fees are covered by insurance.

B. The County of Kanabec agrees to indemnify and hold harmless River Valley Forensic Services, P.A., Dr. Kelly Mills, M.D., its and their agents, officers or employees from any and all liability, loss or damage, it, he, its agents, officers or employees may suffer as a result of claims, demands, costs or judgments, including without limitation reasonable attorney's fees, arising from the Medical Examiner's or his agents' performance of his or their duties under this Agreement.

C. River Valley Forensic Services, P.A. shall obtain and keep in effect the following insurance coverage:

1) Comprehensive General Liability Insurance:

(a) Minimum Combined Single Limit
$2,000,000 per occurrence
$4,000,000 aggregate

(a) The following coverage must be specifically insured and certified with no internal sublimits.

1. Independent Contractors' Contingent Liability
2. Products/Completed Operations Liability
3. Contractual Liability
4. Personal Injury Liability including claims related to employment and coverage (a) through (e).
5. Broad Form Property Damage Liability, or deletion of the "Care, Custody and Control" Exclusion
6. Aircraft Liability (if applicable)
7. Watercraft Liability (if applicable)

(b) The Contractual Liability is to be either on a blanket basis for all written and oral contracts or specifically endorsed to acknowledge the contract between the insured and the County.

2. Professional Liability Insurance

Minimum Limits
$2,000,000 per occurrence
$4,000,000 aggregate

3. Automobile Liability Insurance on Vehicles Owned by River Valley Forensic Services, P.A., or Kelly Mills, M.D., Kirstin Howell, M.D., Victor Froloff, M.D., or Butch Huston, M.D.

D. All certificates of insurance shall provide that the insurance company shall give the County thirty (30) days prior written notice of cancellation, non-renewal or any material changes in the policy.

E. The above subparagraphs establish the minimum insurance requirements, and it is the sole responsibility of River Valley Forensic Services, P.A. to purchase and maintain additional insurance that may be necessary in connection with this contract.

F. The Medical Examiner shall provide a certificate of insurance to the County in a form acceptable to Kanabec County. All insurance policies shall be submitted to the County upon written request.

G. Nothing in this contract shall constitute a waiver by the County of any statutory limits or exceptions on liability.

VII. **Transportation**

A. Transportation of the deceased bodies from Kanabec County to the Ramsey County Morgue shall be the responsibility of Kanabec County.

VIII. **Miscellaneous Provisions**

A. The Medical Examiner and all the members of the Medical Staff must be licensed to practice in Minnesota, with the Medical Examiner holding certification by the American Board of Pathology.

B. At the termination of this Agreement, the Medical Examiner shall return all files, records and objects related to cases completed, or in progress, to the County upon written request.

IX. **Term and Termination**

A. This agreement shall continue for a period ending 12/31/2023 unless terminated sooner pursuant hereto.

B. This Agreement may be terminated by either party on forty-five (45) days written notice to the other.

C. This Agreement may be renewed on an annual basis upon agreement of both parties.

X. **Entire Agreement, Modification**

A. It is understood and agreed that the entire Agreement of the parties is contained herein, and that this Agreement supersedes all oral agreements and negotiations between the parties relating to the subject matter hereof, as well as any previous Agreements presently in effect between the parties relating to the subject matter hereof.

B. This Agreement shall be altered, varied, modified or amended only in writing duly executed by the parties and attached hereto.

COUNTY OF KANABEC

_____ By_____
(date) Kanabec County Board Chair

_____ By_____
(date) Kanabec County Administrator

_____ _____
(date) Kelly Mills, M.D.
Medical Examiner

River Valley Forensic Services, P.A.

_____ By_____
(date) Kelly Mills, President

10:00am Appointment

Item b.

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: b. Animal Control Services Agreement (Local Vendor)	**b. Origination**: Ordinance #34
c. Estimated time: 5-10 minutes	**d. Presenter**(s): Sheriff Smith

e. Board action requested: Review and approve the attached agreement for 2023 animal control services.

Resolution #___ – 11/15/22

Animal Control Agreement

WHEREAS the terms of the contract with Gratitude Farms in East Bethel for animal control services expire December 31, 2022, and

WHEREAS the Board requested the Sheriff's Office and Coordinator to seek a local vendor for this service; and

WHEREAS, Fox Run Kennels in Brook Park agreed to contract for services on a trial basis through June 30, 2023;

THEREFORE BE IT RESOLVED to approve the Animal Control Agreement with Fox Run Kennels for animal control services effective January 1, 2023 for a term ending June 30, 2023;

BE IT FURTHER RESOLVED that if both the Sheriff and vendor are satisfied with the service and terms of the agreement as of June 30, 2023, the duration of the agreement may be extended until December 31, 2023;

BE IT FURTHER RESOLVED that the Sheriff and Coordinator are authorized to sign the agreement and any extension thereof.

f. Background:

Supporting Documents: None **Attached: ☑**

Date received in County Coordinators Office:

Coordinators Comments:

The County Attorney reviewed the agreement and cited no issues.

Animal Control Agreement

THIS AGREEMENT effective this January 1, 2023 by and between Fox Run Kennels 22675 Quamba Street, Brook Park, MN 55007, hereinafter referred to as "Contractor", and the County of Kanabec, hereinafter referred to as "County".

WITNESSETH, that Contractor and County, for the consideration stated herein, mutually agree as follows:

1. STATEMENT OF WORK: Contractor shall furnish all labor, equipment, and services performed for the job of animal control officer for the County, as set forth below in an efficient and professional manner in accordance with this Agreement. Contractor shall comply with all federal, state, and local laws and ordinances in performing the duties as specified herein.

2. THE CONTRACT PRICE: The County will pay Contractor for performance of this Contact as follows:

   a. $500 per month

   b. $50 transport fee per dog

   All billing to the County will include the ICR number, status of dog (returned, adoption, etc.) and rate, mileage and boarding fees.

   c. Payments shall be mailed to:
   Fox Run Kennels
   2657 Rainbow St.
   Brook Park, MN 55007

3. DOG OWNER OR KEEPER PAID FEES: If the dog owner or keeper is found, said owner or keeper will be responsible for all fees including a $120 pick-up fee, $25 impound fee per day, and all veterinary expenses per dog.

4. Contractor shall have 2 hour to respond to a call from the County, and have up to 4 hours for a pickup of an animal. All calls from dispatch should leave all information on voicemail or text message to include the reporting party, physical address, type of dog, disposition/demeanor if known for safety, and ICR number.

   Contact Numbers are as follows:

   1- Shawnee (775) 750-5065
   2- Matt (320) 360-5568
   3- Deb (320) 250-5199

5. CONTRACTOR'S DUTIES: Contractor shall upon request of the members of the Kanabec County Sheriff's Office, take all reasonable steps to catch and take into custody

any animal determined to be in violation of any County Ordinance or Minnesota State Statute.

All apprehensions of dogs directed by a member of the Kanabec County Sheriff's Office shall be treated humanely and shall be delivered into the custody of the party or facility designed by the County and Contractor. The Contractor agrees to comply with all state laws regarding waiting periods. For all dogs picked up the Contractor shall post relevant information and pictures of the dogs on social media such as Lost Dogs MN Facebook page or similar sites in an attempt to locate the owner.

The Contractor shall not bill for any animal longer than required by County Ordinance (10 days). All animals unclaimed by the end of the impound period shall be surrendered to an appropriate facility for adoption or euthanasia.

Reclaiming: All animals conveyed to the pound shall be kept, with humane treatment and sufficient food and water for their comfort, at least ten regular business days, unless the animal is a dangerous animal as defined under §347.50 in which case it shall be kept for ten regular business days, and except if the animal is a cruelly-treated animal under §343.20 in which case it shall be kept for ten regular business days, unless sooner reclaimed by their owners or keepers as provided by this section.

Owners or keepers reclaiming their dogs will pay for all costs associated with picking up, boarding and veterinary care for the dog. Contractor will obtain verification from the owner as to proof of ownership of the dog such as a microchip, vet bills or photos as well as a photo identification of the person claiming the dog.

The address for animal reclamation is Fox Run Kennels 22675 Quamba Street, Brook Park, MN 55007.

6. VETERINARY CARE: Dogs that are picked up and are injured or severely neglected and require urgent veterinary care, shall be treated at East Central Veterinarians or Woods Edge Veterinary Clinic during business hours. Emergency cases will be referred to and emergency clinic on a case by case basis. Veterinarian's services are authorized to stabilize a dog up to $300 including euthanasia if required. The County is responsible for any and all necessary medical attention needed for unclaimed dogs.

7. IDENTIFICATION: The County shall provide Contractor with appropriate credentials and/or identification to identify them as the "Animal Control Official for the County of Kanabec".

8. IDEMNIFICATION/INSURANCE: Contractor agrees to indemnify and hold the County harmless against all claims, losses, causes of action, and expenses, including legal expenses arising relative to Contractor's performance of this Contract. County shall not be liable for any loss suffered by Contractor due to personal damages or any inconvenience resulting from the theft, damage to, or destruction of personal property. Contractor shall be solely responsible for and shall maintain general liability insurance

coverage specifically for the Contractor's duties and shall provide the County with a copy of the certificate of liability insurance naming the County as additionally insured.

9. LEGAL STATUS: The parties agree that the Contractor is in full control of the manner in which work is pursued and the Contractor shall not receive retirement benefits, PERA benefits, or any other fringe benefits offered to employees of the County and shall, in all respects be deemed an Independent Contractor.

10. TERMINATION: It is further agreed that in a case of violation, breach or non-performance by the Contractor of any of the agreements contained in this Contract, County shall have the right to declare this Contract immediately null and void upon written notice to Contractor.

11. REPRESENTATION: The Contractor represents that they employ employees who are properly trained to perform the Contract, and if required by the State, are certified by the State of Minnesota.

12. DURATION: This Contract shall become effective upon its execution and continue until June 30, 2023. Either party may terminate the contract with a 60-day written notification of intent to terminate. No amendment or modification of this Contract shall be effective unless made in writing and signed by both County and the Contractor.

IN WITNESS THEREOF, the parties have executed this Contract at County of Kanabec, Minnesota on the day and year first above written.

_____
Contractor

County of Kanabec

By: _____ By: _____
Sheriff Coordinator

10:00am Appointment

Item c.

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: Request to Implement a Temporary Dispatch Sergeant	**b. Origination**: Sheriff's Office- Dispatch Center
c. Estimated time: 10 minutes	**d. Presenter**(s): Sheriff Smith

e. Board action requested:

Approve the following resolution:

RESOLUTION #____-11/15/22

WHEREAS, the Sheriff's Office Dispatch Center is managed by the P.S.A.P. Administrator/Emergency Management Director; and

WHEREAS, the current P.S.A.P. Administrator/Emergency Management Director will be taking a medical leave of absence; and

WHEREAS, to ensure the highest level of continuity of operations the Sheriff is requesting temporary reinstatement of the Dispatch Sergeant position and authorization to promote an employee to said position in the near future through the duration of the P.S.A.P. Administrator/Emergency Management Director's leave of absence time; and

WHEREAS, the Dispatch Sergeant position job description has been reviewed and updated;

THEREFORE BE IT RESOLVED, the Board of Commissioners hereby approves the temporary reinstatement of the Dispatch Sergeant position and promotion of an employee for a period of time ending at the conclusion of the leave of absence of the current P.S.A.P. Administrator/Emergency Management Director.

BE IT FURTHER RESOLVED, the employee will return to hers/his previous position and wage at the end of the temporary promotion.

f. Background:

The Dispatch Sergeant position existed prior to 2008.

Supporting Documents: None **Attached: ☑**

Date received in County Coordinators Office:	Job Description Attached

Coordinators Comments:

Kanabec County Position Description

DISPATCH SERGEANT

Exemption Status: Non-Exempt **Date:** February 29, 2008

Department: Sheriff **Board Approval Date:** September 10, 2008

Job Specifications		
Education & Experience qualifications are a job-related combination substantially equivalent to the levels shown at right.	FACTOR	LEVEL
	Education:	High School
	Experience:	Three Years
	Other Requirements:	First Responder Certified, Criminal Justice Information/National Crime Information Certified, Emergency Medical Dispatch Certified, Criminal Justice Reporting System Certification
	Supervision given to:	Dispatchers
	Supervision received from:	P.S.A.P Administrator

Knowledge, Skills & Abilities Desired

- Knowledge of department and County organization and administrative policies, procedures, and practices.
- Knowledge of 9-1-1 Master Street Addressing System, and 9-1-1 mapping.
- Knowledge of emergency medical dispatch and certification.
- Knowledge of Criminal Justice Information System/National Crime Information System (FBI records) and certification requirements.
- Knowledge of the state mandated Criminal Justice Reporting System (reporting of all crime data).
- Knowledge of jail security controls.
- Knowledge of radio controls and maintenance.
- Knowledge of recording devices to ensure statutory requirements are met.
- Ability to interpret and apply policies and to develop and implement procedures; to plan, organize, coordinate, revise, and supervise the work of others.
- Ability to exhibit sound judgment, initiative and problem solving capabilities in dealing with dispatchers, other employees and the public.
- Ability to lead by example and complete tasks that are involved in the day to day operation of the communications center.
- Skilled in interpersonal communication, written communication, organizing, prioritizing, and delegating work.

- Ability to develop and maintain effective working relationships with supervisors, peers, subordinates, other county staff, citizens, community officials, and members of the public.
- Ability to think clearly and act quickly in emergency situations.
- Demonstrates and encourages professionalism and respect.

Job Summary

Performs the duties of a Dispatcher and supervises and assign tasks to others performing those same duties in order to maintain public safety in a proficient and professional manner: supports the administration in providing an effective public safety communication center. Additionally, to evaluate staff work performance, counsel subordinates on ways to improve performance, initiate employee recognition and/or disciplinary actions, and compile periodic statistical reports of shift operations.

To be responsible to the P.S.A.P Administrator for the overall operation of the communication center, ensuring that the assigned shift carries out the mission of the facility in a proficient and orderly manner which provides for the safety of the community and emergency responders.

Some Examples of Essential Duties

General 50%

1. Performs daily tasks of a Dispatcher.
2. Communicates with the P.S.A.P Administrator, the Sheriff's Office, DOC, court personnel, various law enforcement agencies, ambulances, fire departments, 9-1-1 map and data providers, and others in the criminal justice/emergency services system as necessary for public safety.
3. Maintains continual communication contact with the facility, the P.S.A.P Administrator and the Sheriff's Office except when properly relieved.
4. Performs all duties and responsibilities according to safety policy and procedure.

Supervisory 30%

5. Directs the assignment of Dispatchers ensuring they are properly instructed in and perform their duties in a manner consistent with all policies and procedures and department directives.
6. Assigns and supervises shift work duties.
7. Ensures that shift staff is in compliance with uniform and appearance policy and procedure, and that they are fit and capable to carry out their assigned duties and responsibilities.
8. Directs dispatch operations in the absence of the P.S.A.P Administrator
9. Monitors shift staff and identifies areas of neglect or misconduct, advises Administration, and takes appropriate steps to correct and/or assist the P.S.A.P Administrator with disciplinary action.
10. Works with the P.S.A.P Administrator and Sheriff's Office on future growth planning, budgeting, staffing plans and contract for services.

11. Evaluates shift staff performance, recommends appropriate action, prepares performance evaluations of subordinates and assists Jail Administration with annual employee performance reviews.
12. Assists the P.S.A.P Administrator in researching, writing, implementing and evaluating policies and procedures.
13. Attends administrative meetings, trainings and other administrative functions as directed.
14. Works with Jail Sergeants on writing schedules for persons classified as Dispatch/Jailers.
15. Works with Jail Sergeants on scheduling inmate jail time.
16. Conducts or coordinates the delivery of training sessions for assigned shift staff.
17. Assists the P.S.A.P Administrator in the selection process for Dispatch positions by participating in the interviewing and evaluating of potential candidates.
18. Coordinates and participates in new employee orientation and training.
19. Assists the P.S.A.P Administrator with planning and writing work schedules.
20. Reports all shift overtime, sick leave or other changes in the posted duty schedule to the P.S.A.P Administrator to ensure appropriate staffing levels.
21. Conducts a shift briefing to the oncoming shift, including: any unusual occurrences, search warrant information, employee directives or policies and procedures.
22. Reviews and signs all reports, logs and forms of shift staff to ensure accuracy and completeness. Ensures that all required reports, logs and forms are completed prior to being relieved.
23. When off-duty, responds to calls for staff shortage, operational questions and emergencies.
24. Serves as the commanding officer in dispatch in all emergency situations (severe storms, serious Part I crimes) until relieved by a superior.

Equipment/Facility 10%

25. Ensures that all communications radio equipment including repeaters and tower is in working order.
26. Ensures all updates are completed on recording equipment.
27. Reviews all security controls on a routine basis to ensure proper working order.
28. Updates 9-1-1 data as appropriate.
29. Ensures all map maintenance is down promptly and accurately.
30. Ensures working order for all door security controls.

Others 10%

31. Monitors and supervises inmate visitation, money receipting, and inmate scheduling.
32. Reviews and makes decisions on requests for special or official visits to the facility in coordination with the P.S.A.P Administrator.
33. Refers all press inquiries to the Sheriff.
34. Communicates as authorized and necessary with attorneys, judges, inmate relatives and others regarding inmate status and disposition.
35. Assists the P.S.A.P Administrator with the supply purchase orders as needed.
36. Performs other duties as assigned or necessary.

Physical Demands Analysis

In a typical 8 hour day, this person sits 6 hours, stands 1 hour and walks 1 hour. Some special physical demands include:

1. Occasional lifting and carrying up to 20 pounds.
2. Frequent requirement for verbal and written communication. Frequent requirement to hear normal conversation and hearing high pitched or low pitched sounds.
3. Repetitive manipulating with both hands in typewriter and computer keyboarding.
4. Repetitive grasping with hands due to continuous writing and operating telephones.
5. Repetitive pushing of buttons for jail security controls.
6. Occasional need to bend, stoop or crouch.
7. Occasional need to drive automotive equipment.
8. Frequent use of hands at waist height.

Work Environment

1. Occasional Hostile Situations.
2. Able to handle verbal abuse by the public and officers.
3. Noise is moderate.
4. Temperature and humidity controlled office with physical barriers between them and the public.

The duties listed above are intended only as illustrations of the various types of work that may be performed. The omission of specific statements of duties does not exclude them from the position if the work is similar, related or a logical assignment of the position.

The job description does not constitute an employment agreement between the employer and employee and is subject to change by the employer as the needs of the employer and requirements of the job change.

The County is an Equal Opportunity Employer. In compliance with Disabilities Act, the County will provide reasonable accommodations to qualified individuals with disabilities and encourages both prospective and current employees to discuss potential accommodations with the employer.

10:00am Appointment

Item d.

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: d. Quarterly Report	**b. Origination**: Sheriff's Office
c. Estimated time: 5-10 minutes	**d. Presenter**(s): Sheriff Smith

e. Board action requested:

Information only

f. Background:

Supporting Documents: None **Attached: ☑**

Date received in County Coordinators Office:	11/9/22 Report

Coordinators Comments:

Kanabec County Sheriff
18 N Vine St, Suite 143 | Mora, MN 55051 | Phone: (320) 679-8400

Annual Consolidated Monthly

Wednesday, November 9, 2022
1:47:13 pm

**** For official use only ****

Report covering 07/01/2021 through 09/30/2021

Compared to 7/1/2022 through 9/30/2022

	JAN			FEB			MAR			APR			MAY			JUN			JUL			AUG			SEP			OCT			NOV			DEC		
	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-
911 Hang-ups, Abandoned, & (	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	76	56	-26	75	45	-40	70	47	-33	0	0	0	0	0	0	0	0	0
Agency Assist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	41	37	-10	37	41	11	23	25	9	0	0	0	0	0	0	0	0	0
Alarms All (Home, Business, Bi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20	25	25	26	18	-31	19	20	5	0	0	0	0	0	0	0	0	0
Alcohol Compliance Checks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23	0	-100	0	0	0	0	0	0	0	0	0
Animal-All Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	56	47	-16	68	54	-21	63	49	-22	0	0	0	0	0	0	0	0	0
Animal Bites	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	100	0	1	0	3	0	-100	0	0	0	0	0	0	0	0	0
Animal Neglect	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	1	0	-100	0	0	0	0	0	0	0	0	0
County Dog Ordinance Violatio	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	-100	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Arson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Assault - All	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	8	-20	7	4	-43	2	9	350	0	0	0	0	0	0	0	0	0
ATV Complaints - All including	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	4	-33	7	5	-29	1	1	0	0	0	0	0	0	0	0	0	0
Bicycle Calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Boat and Water all calls includi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	-100	0	0	0	0	0	0	0	0	0
Building Security Checks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	7	1	-86	1	1	0	0	0	0	0	0	0	0	0	0
Burglary all calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	7	40	9	6	-33	4	7	75	0	0	0	0	0	0	0	0	0
City of Mora ordinance violatio	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	9	50	1	0	-100	1	2	100	0	0	0	0	0	0	0	0	0
Civil Assist calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	37	50	35	16	26	63	36	48	33	0	0	0	0	0	0	0	0	0
Civil Process calls including pap	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	-100	0	1	0	0	0	0	0	0	0	0	0	0
Community	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	1	-75	0	0	0	0	0	0	0	0	0	0	0	0
County Ordinance Violation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
All Court and Courthouse calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Criminal Sexual conduct calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	0	2	8	300	6	3	-50	0	0	0	0	0	0	0	0	0
Child Custody calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	6	-14	5	6	20	9	4	-56	0	0	0	0	0	0	0	0	0
Damage to Property calls inclu	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15	12	-20	7	23	229	22	5	-77	0	0	0	0	0	0	0	0	0
Sudden Deaths and Bodies fou	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0

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	JAN			FEB			MAR			APR			MAY			JUN			JUL			AUG			SEP			OCT			NOV			DEC		
	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-
Disorderly Conduct calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14	15	7	10	6	-40	7	8	14	0	0	0	0	0	0	0	0	0
Domestic Disturbance/Assaults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	9	29	13	13	0	10	11	10	0	0	0	0	0	0	0	0	0
Drug calls - All	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	2	-33	7	5	-29	6	4	-33	0	0	0	0	0	0	0	0	0
Escape / Flight	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	-100	0	0	0	0	0	0	0	0	0
Escorts - including Funerals, Ra	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	3	-40	5	4	-20	2	4	100	0	0	0	0	0	0	0	0	0
Fires- Deputy Only or Outside I	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	4	-64	5	3	-40	3	5	67	0	0	0	0	0	0	0	0	0
Fire- Pages DNR Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	-100	1	0	-100	0	0	0	0	0	0	0	0	0	0	0	0
Fire- Pages Mora Area Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	5	67	8	4	-50	2	7	250	0	0	0	0	0	0	0	0	0
Fire- Pages Ogilvie Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	100	1	2	100	1	2	100	0	0	0	0	0	0	0	0	0
Foot Patrol	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	28	36	29	28	26	-7	17	29	71	0	0	0	0	0	0	0	0	0
Found - All calls including anim	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	10	100	7	12	71	12	7	-42	0	0	0	0	0	0	0	0	0
Fraud	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	5	-17	10	6	-40	9	8	-11	0	0	0	0	0	0	0	0	0
Garbage Dumping complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4	0	3	2	-33	6	4	-33	0	0	0	0	0	0	0	0	0
Guns including permits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	-100	1	0	-100	0	0	0	0	0	0	0	0	0
Harassing communications call	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	12	9	10	9	-10	13	11	-15	0	0	0	0	0	0	0	0	0
Health and Safety	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	5	0	8	4	-50	8	5	-38	0	0	0	0	0	0	0	0	0
Secure Helipad	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13	7	-46	8	3	-63	5	11	120	0	0	0	0	0	0	0	0	0
Homicides	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Hospice Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	2	-60	2	12	500	4	6	50	0	0	0	0	0	0	0	0	0
Information and misc calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	46	65	41	54	51	-6	41	58	41	0	0	0	0	0	0	0	0	0
Jail Incidents - Non Criminal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	5	400	1	4	300	0	2	0	0	0	0	0	0	0	0	0	0
Jail-All OTHER (non-criminal)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jail-Crim Sex (PREA)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Juvenile Alcohol complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Juvenile Drug complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0

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Compared to 7/1/2022 through 9/30/2022

	JAN			FEB			MAR			APR			MAY			JUN			JUL			AUG			SEP			OCT			NOV			DEC		
	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-
Juvenile calls excluding tobacc	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16	7	-56	8	13	63	15	9	-40	0	0	0	0	0	0	0	0	0
Juvenile Tobacco complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	2	-33	0	0	0	0	0	0	0	0	0
All Lost calls including animals,	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4	300	0	2	0	0	0	0	0	0	0	0	0	0
Maltreatment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	13	-28	14	12	-14	20	31	55	0	0	0	0	0	0	0	0	0
Medical Emergency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	121	122	1	123	151	23	114	124	9	0	0	0	0	0	0	0	0	0
Medical - Drug Overdoses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	1	0	-100	0	0	0	0	0	0	0	0	0
Meetings and Presentations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	0	1	1	0	2	2	0	0	0	0	0	0	0	0	0	0
Missing Person(s)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	3	-25	2	3	50	0	4	0	0	0	0	0	0	0	0	0	0
Motorist Assist calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	3	-50	12	4	-67	10	8	-20	0	0	0	0	0	0	0	0	0
Neighborhood Disputes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	9	29	4	12	200	3	6	100	0	0	0	0	0	0	0	0	0
Noise complaints including loud	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22	19	-14	6	8	33	8	5	-38	0	0	0	0	0	0	0	0	0
Parking Violations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	-100	2	0	-100	1	0	-100	0	0	0	0	0	0	0	0	0
All Predatory Offender calls inc	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	88	1000	11	10	-9	8	13	63	0	0	0	0	0	0	0	0	0
All Public assist calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13	11	-15	18	11	-39	32	21	-34	0	0	0	0	0	0	0	0	0
Records checks including empl	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	10	43	7	11	57	7	96	1271	0	0	0	0	0	0	0	0	0
Recovered goods including pro	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1	2	100	1	1	0	0	0	0	0	0	0	0	0	0
Road hazards	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	8	0	7	8	14	11	15	36	0	0	0	0	0	0	0	0	0
Scams - All	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	8	0	6	6	0	11	6	-45	0	0	0	0	0	0	0	0	0
Search Warrants	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	100	1	0	-100	0	0	0	0	0	0	0	0	0
Shooting complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	6	50	5	2	-60	5	2	-60	0	0	0	0	0	0	0	0	0
Shoplifting complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	100	0	0	0	2	0	-100	0	0	0	0	0	0	0	0	0
Special Detail	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	-100	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stolen Property calls - all	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	100	2	2	0	1	3	200	0	0	0	0	0	0	0	0	0
Stop arm violations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	6	200	0	0	0	0	0	0	0	0	0
Sudden Deaths and Bodies fou	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0

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	JAN			FEB			MAR			APR			MAY			JUN			JUL			AUG			SEP			OCT			NOV			DEC		
	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-	2021	2022	+/-
Suicide-Death	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Suicide threats-attempts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	15	114	6	2	-67	6	7	17	0	0	0	0	0	0	0	0	0
Suspicious calls including persc	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	83	77	-7	98	72	-27	80	81	1	0	0	0	0	0	0	0	0	0
Theft calls - all not including m	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	32	22	-31	28	33	18	32	26	-19	0	0	0	0	0	0	0	0	0
All Threat calls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	8	-56	15	9	-40	10	3	-70	0	0	0	0	0	0	0	0	0
Tobacco compliance checks.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14	0	-100	0	0	0	0	0	0	0	0	0	0	0	0
Traffic / Driving complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	46	34	-26	41	36	-12	34	18	-47	0	0	0	0	0	0	0	0	0
Traffic Accidents including all p	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	19	16	-16	18	23	28	14	12	-14	0	0	0	0	0	0	0	0	0
Traffic violations all including ci	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	146	148	1	108	147	36	133	175	32	0	0	0	0	0	0	0	0	0
Transport all (jail) except medi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	10	43	11	5	-55	14	9	-36	0	0	0	0	0	0	0	0	0
Trespassing complaints	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	6	-14	4	1	-75	5	3	-40	0	0	0	0	0	0	0	0	0
TZD -All Towards Zero Death s	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21	0	-100	14	38	171	35	0	-100	0	0	0	0	0	0	0	0	0
Unwanted person non criminal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21	17	-19	18	14	-22	16	12	-25	0	0	0	0	0	0	0	0	0
Vandalism calls all except maill	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	-50	1	2	100	4	4	0	0	0	0	0	0	0	0	0	0
Vehicle theft all including moto	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	-50	2	1	-50	4	1	-75	0	0	0	0	0	0	0	0	0
Violation of Court orders all inc	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	8	0	10	2	-80	4	9	125	0	0	0	0	0	0	0	0	0
Vehicle off Road/Vehicle in Ditc	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	6	0	2	9	350	4	9	125	0	0	0	0	0	0	0	0	0
Warrant entry and arrests	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13	17	31	17	7	-59	17	6	-65	0	0	0	0	0	0	0	0	0
Weather - Monthly Test	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	1	1	0	0	0	0	0	0	0	0	0	0
Weather - Severe Storm Warni	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	-100	1	0	-100	0	0	0	0	0	0	0	0	0
Welfare checks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	42	50	19	31	47	52	40	28	-30	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1184	1223	3	1126	1122	0	1146	1171	2	0	0	0	0	0	0	0	0	0

10:20am Appointment

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: Safety Plan Update	**b. Origination**: Public Works Department
c. Estimated time: 10 minutes	**d. Presenter**(s): Chad Gramentz, Public Works Director

e. Board action requested:

Safety Plan Update, information only

f. Background:

Supporting Documents: None ☑ Attached:

Date received in County Coordinators Office:

Coordinators Comments:

KANABEC COUNTY PUBLIC WORKS DEPARTMENT
Chad T. Gramentz, PE, Public Works Director
903 Forest Avenue East, Mora, MN 55051
320-679-6300

Kanabec County Drainage Authority Board

To Be Held At:
Kanabec County Courthouse
18 N Vine St, Room 164
Mora, MN 55051

Date and Time:
November 15, 2022
10:45am

AGENDA:

1. Call Meeting to Order

2. Approval of Agenda

3. Construction Bids for Repair of County Ditch #2 – results to be presented at meeting

4. Adjourn

Agenda Item #1

PROCEEDINGS OF THE COUNTY BOARD

State of Minnesota
County of Kanabec
Office of the County Coordinator

UNAPPROVED MINUTES

November 1, 2022

The Kanabec County Board of Commissioners held a Regular Board Meeting in person and via telephone/video conference call at 9:00am on Tuesday, November 1, 2022 pursuant to adjournment with the following Board Members present on-site: Les Nielsen, Rick Mattson, Dennis McNally, Alison Holland, and Craig Smith. Absent: None. Staff present on-site: County Coordinator Kris McNally and Recording Secretary Kelsey Schiferli.

The meeting was held in the County Board Room and via WebEx for anyone wishing to participate remotely.

The Chairperson called the meeting to order and led the assembly in the Pledge of Allegiance.

Action #1 – It was moved by Dennis McNally, seconded by Craig Smith and carried unanimously to approve the agenda with the following changes: Remove agenda item #5, Resolution to Approve Local 106 Collective Bargaining Agreement and Memorandum of Understanding.

Action #2 – It was moved by Alison Holland, seconded by Rick Mattson and carried unanimously to approve the October 18, 2022 minutes as presented.

Action #3 – It was moved by Dennis McNally, seconded by Alison Holland and carried unanimously to approve the following paid claims:

Vendor	Amount
Braham Public Schools	51,347.95
Dearborn National Life Insurance Co	735.61
East Central Energy	1,192.14
East Central School District	17,986.34
Health Partners	6,476.42

Hinckley - Finlayson Schools	16,791.18
Isle Public Schools	16,181.78
Kanabec County	110,981.88
Kanabec County AT ACH_VISA	1,727.38
Life Insurance Company of North America	655.15
Milaca Public Schools	4,215.29
Minnesota Energy Resources Corp	9,705.25
MNPEIP	11,105.07
MNPEIP	144,447.49
Mora Public Schools	1,138,755.30
Office of MN.IT Services	706.00
Ogilvie Schools	159,713.16
Pine City Public Schools	176.42
The Hartford Priority Accounts	6,230.52
VC3, Inc.	1,306.00
VSP Insurance Co	497.92
22 Claims Totaling:	**$1,700,934.25**

Action #4 – It was moved by Craig Smith, seconded by Alison Holland and carried unanimously to approve the following claims on the funds indicated:

Revenue Fund

Vendor	**Amount**
Adam's Pest Control	125.00
Adam's Pest Control	125.00
Aspen Mills	579.83
Aspen Mills	68.96
Association of MN Counties	175.00
Assured Security	441.50
AT&T Mobility	1,421.67
AT&T Mobility	44.72
Attorney General's Office	119.87
Bakke, Joseph	100.00
Bakke, Joseph	100.00
Bob Barker	1,128.60
Children's Hospitals and Clinics of MN	895.00
Coborn's Inc.	820.97

Coborn's Inc.	9.07
Curtis, Michael	875.18
East Central Solid Waste Commission	68.37
EATI	31.18
Electric Motor Service, Inc	903.65
Frisch, Justin	200.43
Government Management Group	3,750.00
Granite Electronics	4,349.26
Griffin, Zach	30.00
Hoefert, Robert	1,354.38
J.F. Ahern Co	366.00
Kanabec County Highway Department	129.87
Kanabec County Highway Department	235.80
Kanabec Publications	822.69
Kanabec Publications	93.63
Marco	176.00
Marco	273.00
McGriff, Annabel	100.00
McGriff, Annabel	100.00
Methven Funeral and Cremation Services	400.00
Mora Motor Vehicle Inc.	350.00
Motorloa Solutions	6,345.00
ODP Business Solutions LLC (Office Depot)	68.09
ODP Business Solutions LLC (Office Depot)	20.00
O'Reilly Auto Parts	29.22
Oslin Lumber	79.25
Quality Disposal Systems	238.22
Quality Disposal Systems	28.97
Ramsey County	1,582.00
Renville County Civil Process	60.00
RS EDEN	6.80
Schmitt, Kelly	196.63
Schmitt, Kelly	376.36
Schmitt, Kelly	266.78
Scotts Lawn & Landscapes	150.00
Stafford Trucking	9,265.00
Stellar Services	199.89
Stellar Services	186.98

Stellar Services	97.80
Summit Food Service Management	4,116.68
Summit Food Service Management	4,140.13
SWIFT	175.61
Van Alst, Lillian	1,726.88
Von Eschen, Tina	579.91
Wickeham, Teresa	403.48
59 Claims Totaling:	**$ 51,104.31**

Road & Bridge

Vendor	**Amount**
DeJong, George	190.68
Diamond Mowers	921.82
H & L Mesabi	294.00
H & R Construction	23,817.40
Houston Engineering	4,277.00
Johnson Hardware and Rental	86.99
Kanabec County Highway Dept	90.55
Kanabec County Coordinator	66.03
Little Falls Machine	1,819.77
MN Dept of Transp	2,720.16
Morton Salt	17,266.41
North Central International	2,852.06
Northern States Supply	274.77
Safety-Kleen Systems	428.60
Sanitary Systems	160.00
Scientific Sales	59.50
Scott's Lawn & Landscapes	932.41
USIC Locating	90.00
Ziegler	132.22
19 Claims Totaling:	**$ 56,480.37**

Action #CH5 – It was moved by Craig Smith, seconded by Rick Mattson and carried unanimously to recess the meeting at 9:06am to a time immediately following the Community Health Board.

Action #CH6 – It was moved by Alison Holland, seconded by Rick Mattson and carried unanimously to approve the amended Community Health Board Agenda with the addition of an update regarding the Statewide Community Health Services Advisory Committee.

Community Health Director Kathy Burski gave the Director's Report.

Action #CH7 – It was moved by Craig Smith, seconded by Rick Mattson and carried unanimously to approve the following resolution:

Resolution #CH7 – 11/1/22

Clerk Typist to Case Aide Resolution

WHEREAS, Kanabec County Community Health had a vacant full-time case aide position in July, filled the position with a part-time person and within two months the newly hired person left and the case aide position was vacant again, and

WHEREAS, Community Health has a Clerk Typist available to provide case aide duties and that person is willing and able to complete the duties of the case aide, and

WHEREAS, the Community Health Director is recommending to promote the Clerk Typist to the full time Case Aide position and will not be refilling the Clerk Typist position at this time.

THEREFORE BE IT RESOLVED the Kanabec County Community Health Board approves the Community Health Director and HR Director promoting the Clerk Typist to the vacant Case Aide position. She would move from a Grade 5 Step F at a rate of $19.54/hour, to a Grade 6, Step F at a rate of $20.71/hour.

Action #CH8 – It was moved by Alison Holland, seconded by Craig Smith and carried unanimously to approve the following resolution:

Resolution #CH8 - 11/1/22

TTPT - Health Plans Transportation Agreement Resolution

WHEREAS, the Minnesota Department of Human Services has determined that it is in the best interest of counties and their residents to have a choice in the health plans available to them for public programs, and

WHEREAS, Kanabec County was notified that Blue Cross Blue Shield, Medica and U Care will be added to South Country Health Alliance as the health plans providing service in the County, and

WHEREAS, Timber Trails Public Transit is the main transportation provider within Kanabec County and as such would like to contract with the health plans to provide medical rides for county residents, and

WHEREAS the Transit Director is recommending to contract with the health plans to provide medical transportation services to county residents.

THEREFORE BE IT RESOLVED the Kanabec County Community Health Board approves the Transit Director contracting with Blue Cross Blue Shield, Medica and U Care to provide medical transportation for County residents for the contracted period per the health plans rate schedules.

Action #CH9 – It was moved by Rick Mattson, seconded by Alison Holland and carried unanimously to approve the payment of 82 claims totaling $39,291.53 on Community Health Funds.

Action #CH10 – It was moved by Rick Mattson, seconded by Dennis McNally and carried unanimously to adjourn Community Health Board at 9:25am and to meet again on Tuesday, November 15, 2022 at 9:05am.

The Board of Commissioners reconvened.

Barbara Chaffee, Tricia Biagaouette, and Diana Ristamaki and Troy Gilbertson from Central Minnesota Jobs and Training (CMJTS) met with the County Board to give an annual update. CMJTS Employment Specialist Troy Gilbertson introduced local success story, Rebekah Lane. Rebekah Lane presented her story of success with the MN Dislocated Worker/OMNI Program to the County Board. Information only, no action was taken.

County Assessor Tina Von Eschen met with the County Board to discuss matters concerning her department.

Action #11 – It was moved by Dennis McNally, seconded by Alison Holland and carried unanimously to approve the following resolution:

Resolution #11 – 11/1/22

WHEREAS Timothy Bowland has successfully obtained his Certified Minnesota Appraiser license from the State Board of Assessor's as of October 18, 2022; and

WHEREAS doing so qualified him for promotion from the Assessor Trainee Appraiser to Assessor Certified Appraiser;

THEREFORE BE IT RESOLVED that the Kanabec County Board of Commissioners hereby approves Mr. Bowland's promotion to Assessor Certified Appraiser and corresponding pay increase to Grade 11, Step A at $23.56 per hour effective 10/22/2022.

Action #12 – It was moved by Craig Smith, seconded by Alison Holland and carried unanimously to approve the following resolution:

Resolution #12 – 11/1/22

SCORE CLAIMS

WHEREAS the board has been presented with claims for recycling efforts to be paid from SCORE Funds, and

WHEREAS these claims have been reviewed, tabulated and approved by the Kanabec County Solid Waste Officer, and

WHEREAS SCORE Funds appear adequate for the purpose;

BE IT RESOLVED to approve payment of the following claims on SCORE Funds:

Waste Management	$1,355.86
Quality Disposal	$4,447.60
Arthur Township	$500.00
Total	$6,303.46

Action #13 – It was moved by Craig Smith, seconded by Alison Holland and carried unanimously to approve the following date correction in Resolution #13 – 10/18/22:

Resolution #13 – 11/1/22

WHEREAS the Deputy Auditor Property & Tax has presented the Kanabec County

Board of Commissioners with a recommended list of parcels to be included in a tax forfeited property sale; and

WHEREAS the minimum bids for the tax forfeited property sale have been set by the Board as follows:

Township	PID	Section	Legal Description	Acres	Conditions	Min Bid
Arthur	02.04900.00	24	Spring Brook Estates, Lot 20 Block 3	1.00		$12,000.00
Ford	05.00340.00	8	NE1/4 of NW1/4 of NW1/4 &N1/2 of SE1/4 of NW1/4 of NW1/4	15.00		$38,900.00
Haybrook	07.00105.20	4	NE1/4 of SW1/4	40.00		$12,000.00
Haybrook	07.00130.00	4	N1/4 of NW 1/4 of SW1/4	10.00		$3,000.00
Peace	12.02285.00	6	Plan of Warman, Lot 6, Block 3 ex hwy r/w	0.16		$500.00
Whited	15.01250.20	25	N1/2 of N1/2 of NE1/4 of SE1/4 lying S of RR r/w	9.93		$15,000.00
City of Ogilvie	23.00350.00	35	Ogilvie Plat, Lot 1, Block 2, 209 Hill Ave N, Ogilvie MN	0.16		$10,000.00

THEREFORE BE IT RESOLVED that the Board hereby authorizes the sale of said properties through an online format at www.publicsurplus.com beginning at 9:00a.m. on 11/~~2~~1/22 and ending at noon on 11/14/22.

Action #14 – It was moved by Alison Holland, seconded by Rick Mattson and carried unanimously to approve the following resolution:

Resolution #14 - 11/1/22

WHEREAS Clifton Larson Allen provides audit and non-audit services to Kanabec County, and

WHREAS the terms and conditions of the services are specified in the attached Master Services Agreement and Statement of Work- Audit Services, and

WHEREAS the Auditor Treasurer finds these terms and conditions acceptable; and

THEREFORE BE IT RESOLVED that the Kanabec County Board of Commissioners approves the Master Services Agreement with Clifton Larson Allen LLP for Audit and Non-Audit Services for 2022-2027;

BE IT FURTHER RESOLVED the Board Chair and Auditor Treasurer are authorized to sign said agreement.

Deputy Auditor Tax II Kathy Young met with the County Board to discuss matters concerning the TAX and CAMA system.

Action #15 – It was moved by Alison Holland, seconded by Rick Mattson and carried unanimously to approve the following resolution:

Resolution #15 -11/1/22

WHEREAS, Kanabec County is currently with Avenu for the TAX and CAMA system and is in process of converting to MCIS as the provider for the TAX and CAMA system beginning January 2023; and

WHEREAS, the current TAX and CAMA system is hosted and maintained internally by the Deputy Auditor Tax II; and

WHEREAS, the current payroll system is hosted externally with another vendor; and

WHEREAS, transitioning the TAX, CAMA, and Payroll systems to MCIS hosting will result in a cost savings to the County;

THEREFORE BE IT RESOLVED, that the County Board hereby approves the MCIS Hosting Agreement for 2023 and authorizes the Board Chair to sign said document.

Environmental Services Supervisor Teresa Wickeham met with the County Board to discuss matters concerning the usage of SCORE funds for the recycling of tires. Teresa will check with other counties to explore existing tire disposal program options and bring that information back to the Board for further consideration. Use of the Solid Waste Surcharge fund will also be examined as a potential funding source for a tire disposal program.

Public Works Director Chad Gramentz met with the County Board to discuss matters concerning his department.

Action #16 – It was moved by Alison Holland, seconded by Craig Smith and carried

unanimously to approve the following resolution:

Resolution #16 – 11/1/22

SP 033-603-029, Final Payment

WHEREAS the project SP 033-603-029 has in all things been completed and in accordance with the contract and the County Board being fully advised in the premises, and

THEREFORE BE IT RESOLVED that we do hereby accept said completed project for and on behalf of the County of Kanabec and authorize final payment to Knife River Corporation, in the amount of $33,851.41.

Action #17 - It was moved by Craig Smith, seconded by Dennis McNally and carried unanimously to approve the following resolution:

Resolution #17 – 11/1/22

City of Mora Maintenance Agreement

WHEREAS the City of Mora has provided routine maintenance on portions of CSAH No. 6 and CSAH No. 27 within the Mora City limits during 2021 and will continue services in 2022, and

WHEREAS this has been in the best interest of both units of government

BE IT RESOLVED that the Kanabec County Board of Commissioners approve the Maintenance Agreement with the City of Mora for 2021 and 2022.

BE IT ALSO RESOLVED that the Chairperson is directed to sign the agreement.

Public Works Director Chad Gramentz led discussions regarding Rural Intersections, Federal Funding, Driver's License Service, and TH 65/23 Corridor Study.

The Board expressed consensus to continue moving forward with the partnership with the City of Mora to convert the Driver's License Service to a shared City/County operation.

10:43am – The Chairperson called for public comment. Those that responded included:

Jeff Kramer	Comments regarding the safety of COVID-19 vaccines, the presentation from CMJTS, and funding for tire cleanup.

10:50am – The Chairperson closed public comment.

Environmental Services/GIS Technician Ryan Carda met with the County Board to request approval of an interim use permit.

Action #18 – It was moved by Dennis McNally, seconded by Alison Holland and carried unanimously to approve the Interim Use Permit application submitted by Anup & Sabina Dangol for a vacation rental at 2633 Pine Lane, Mora contingent upon the installation of an egress window in the loft area that meets the MN State Building Code requirements prior to its use as a sleeping area.

The Commissioners gave reports regarding the boards and committees in which they participate. Information only, no action was taken.

Future agenda items – none.

Action #19 – It was moved by Alison Holland, seconded by Rick Mattson and carried unanimously to close the meeting at 11:24am pursuant to the Open Meeting Law, MN Statute §13D.03 to discuss matters related to Union Negotiation Strategy. Those present during the closed portion of the meeting include Commissioners Les Nielsen, Rick Mattson, Dennis McNally, Alison Holland, and Craig Smith; as well as County Coordinator & Personnel Director Kris McNally and HR Specialist Kim Christenson.

Action #21 – It was moved by Craig Smith, seconded by Alison Holland and carried unanimously to return to open session at 12:05pm.

Action #22 – It was moved by Craig Smith, seconded by Alison Holland and carried unanimously to adjourn the meeting at 12:06pm. The Board will meet again in regular session on Tuesday, November 15, 2022 at 9:00am.

*Signed*_____

Chairperson of the Kanabec County Board of Commissioners,
Kanabec County, Minnesota

Attest: _____
Board Clerk

Agenda Item #2
Paid Bills

Vendor	Amount	Purpose	Dept
Kanabec County Auditor HRA	424.00	HRA Contributions	Various
Mora Municipal Utilities	14,740.92	Electric & Water Utilities	Various
Quadient Finance USA, Inc.	421.80	Postage Machine Ink, 3 Cartridges	Unallocated
Verizon Wireless Aircards	1,370.41	Aircards	Various
Besser, Blaine	500.00	Driveway Permit Refund	Highway
East Central Energy	317.92	Intersection Lighting	Highway
Gallagher, Stephanie	500.00	Driveway Permit Refund	Highway
Long, Devon	600.00	Driveway Permit Refund	Highway
Mora Municipal Utilities	834.83	Water Tower Antenna, Hwy Bldg, 205th Ave Metered	Highway
Price Custom Homes	500.00	Driveway Permit Refund	Highway
Wellnitz, Rosella	500.00	Driveway Permit Refund	Highway
Ann Lake Twp	30,564.71	October 2022 Settlement	Taxes & Penalties
Arthur Twp	109,146.00	October 2022 Settlement	Taxes & Penalties
Braham Public Schools	51,347.95	October 2022 Settlement	Taxes & Penalties
Brunswick Twp	54,704.49	October 2022 Settlement	Taxes & Penalties
City of Braham	16,868.85	October 2022 Settlement	Taxes & Penalties
City of Grasston	7,699.35	October 2022 Settlement	Taxes & Penalties
City of Isle	500.00	October 2022 Settlement	Taxes & Penalties
City of Mora	599,818.57	October 2022 Settlement	Taxes & Penalties
City of Ogilvie	49,209.08	October 2022 Settlement	Taxes & Penalties
City of Quamba	25,767.84	October 2022 Settlement	Taxes & Penalties
Comfort Twp	53,301.31	October 2022 Settlement	Taxes & Penalties
Comm of Finance-Treas Div	178.81	October 2022 Settlement	Taxes & Penalties
East Cent. Reg Dev Commission	9,891.57	October 2022 Settlement	Taxes & Penalties
East Central School District	17,986.34	October 2022 Settlement	Taxes & Penalties
Ford Twp	30,002.09	October 2022 Settlement	Taxes & Penalties

Grass Lake Twp	36,946.10	October 2022 Settlement	Taxes & Penalties
Haybrook Twp	27,199.05	October 2022 Settlement	Taxes & Penalties
Hillman Twp	23,678.84	October 2022 Settlement	Taxes & Penalties
Hinckley-Finalyson Schools	16,791.18	October 2022 Settlement	Taxes & Penalties
Isle Public Schools	16,181.78	October 2022 Settlement	Taxes & Penalties
Kanabec County	110,981.88	October 2022 Settlement	Taxes & Penalties
Kanabec Twp	35,990.19	October 2022 Settlement	Taxes & Penalties
Knife Lake Improvement District	18,154.98	October 2022 Settlement	Taxes & Penalties
Knife Lake Twp	51,912.01	October 2022 Settlement	Taxes & Penalties
Kroschel Twp	16,738.36	October 2022 Settlement	Taxes & Penalties
Milaca Public Schools	4,215.29	October 2022 Settlement	Taxes & Penalties
Mora Public Schools	1,138,755.29	October 2022 Settlement	Taxes & Penalties
Ogilvie Public Schools	159,713.15	October 2022 Settlement	Taxes & Penalties
Peace Township	56,164.99	October 2022 Settlement	Taxes & Penalties
Pine City Public Schools ISD 578	176.41	October 2022 Settlement	Taxes & Penalties
Pomroy Twp	37,334.34	October 2022 Settlement	Taxes & Penalties
Southfork Twp	16,318.13	October 2022 Settlement	Taxes & Penalties
St Paul Port Authority	1,917.39	October 2022 Settlement	Taxes & Penalties
Whited Township	31,411.65	October 2022 Settlement	Taxes & Penalties
Kwik Trip Inc	13,984.43	Gas Credit Cards	Various
Midcontinent Communications	465.34	Utilities	Various
Quadient Finance USA, Inc.	2,500.00	PSB Postage	Unallocated
Spire Credit Union	4,727.16	See Below	
VC3, Inc.	3,224.40	Monthly Service Backup	ARPA
Verizon Wireless Cell Phones	2,903.44	Cell Phones	Various
Chamberlain Oil	4,118.40	Shop Supplies	Highway
East Central Energy	186.34	Intersection Lighting	Highway
46 Claims Totaling:	**$ 2,910,387.36**		

Spire Credit Union	105.06	Checksforless - Deposit Slips	Auditor
	199.60	Synametrics - Software	IS
	99.99	GODADDY Renewal	IS
	10.57	Amazon - Roller Kit	IS
	22.90	Amazon - Compressed Air	IS

15.99	Amazon - Legal Pads	IS
150.00	MLS Qrtly Service Fees	Assessor
38.75	MN DOR State Brd of Assessors	Assessor
526.60	Hilton Inn - Assessor Conf	Assessor
374.01	Radisson - Assessor Fall Conf	Assessor
240.00	IAAO Membership Dues	Assessor
127.78	Craguns - Veterans Conf	VSO
14.99	Amazon - Prime Membership	Sheriff
60.00	Ammunition for Training	Sheriff
72.36	Amazon - Baskets, Pencils, Etc.	Sheriff
259.75	Amazon - Magnets	Sheriff
8.99	Amazon - Coax Adapter	Sheriff
26.97	Amazon - Coax Adapter	Sheriff
29.00	Emma's Pizza - Taser Training	Jail
72.62	Amazon - Jail Supplies	Jail
153.28	Amazon - Toner Cartridges	Jail
20.38	Amazon - Jail Supplies	Jail
59.45	Amazon - Jail Supplies	Jail
213.08	Kalahari Resorts Conf - KS	E911
181.40	Fortune Bay Casino Conf - KS	E911
23.99	Amazon - Web Camera	Probation
21.99	Amazon - Web Camera	Probation
136.98	Amazon - Brother Toner	Extension
24.74	Amazon - Phone Case Etc.	Highway
0.99	Apple - Storage	Highway
138.51	Breezy Point Lodging Conf	Community Health
148.02	Amazon - Mini Fridge (Lactation)	Community Health
88.59	Amazon - Office Supplies	Community Health
15.18	Amazon - Dry Erase Markers	Community Health
468.00	Survey Monkey - Membership	Community Health
25.60	Availity Subscription	Community Health
91.05	Target.com - MIECHV Supplies	Community Health
28.77	Amazon - MIECHV Supplies	Community Health
19.28	Amazon - Phone Case Etc.	Community Health

	175.77	Control Solutions - Vaccine Moni	Community Health
	22.40	Availity Subscription	Community Health
	32.00	Availity Subscription	Community Health
	65.98	Amazon - Silicone Foam Dressing	Community Health
	-59.99	Amazon - Refund Foam Dressings	Community Health
	175.79	Walmart - Wellness Supplies	Employee Wellness
45 Claims Totaling:	**$ 4,727.16**		

Agenda Item #3a
Regular Bills - Revenue Fund
Bills to be approved: 11/15/22

Department Name	Vendor	Amount	Purpose
ASSESSOR	Koenings, Katie	20.80	USPS Postage, Toner Return
ASSESSOR	Marco, Inc.	159.00	Standard Payment
		179.80	
AUDITOR	Minnesota Pollution Control Agency	37,898.64	Clean Water Partnership Septic Upgrade Loans (2)
AUDITOR	RT Vision	3,583.13	Timecard Basic Software, Support & Maintenance 2023
		41,481.77	
BUILDINGS MAINTENANCE	Ace Hardware	115.67	Batteries, Valve Core Remover, Tri Flow, Lubricant, Tote, Brushes, Varnish, Link - Courthouse
BUILDINGS MAINTENANCE	Ace Hardware	5.04	Brushes - Jail
BUILDINGS MAINTENANCE	Auto Value	27.37	Lubricant, Belt - Courthouse
BUILDINGS MAINTENANCE	Electric Motor Service, Inc	213.51	Labor & Parts to Repair Condenser Motor for Liebert Unit - Jail
BUILDINGS MAINTENANCE	FBG Service Corporation	4,829.00	October Cleaning Services for Courthouse
BUILDINGS MAINTENANCE	FBG Service Corporation	2,543.00	October Cleaning Services for PSB
BUILDINGS MAINTENANCE	FBG Service Corporation	672.00	October Cleaning Services for Jail
BUILDINGS MAINTENANCE	G & N Enterprises	185.76	Lightbulbs - Jail
BUILDINGS MAINTENANCE	Granite City Jobbing Co	1,197.03	TP, Paper Towels, Handsoap, Cleaning Spray - PSB
BUILDINGS MAINTENANCE	Ideal Service, Inc.	407.00	Labor, Travel & Supplies to Replace Two Heatsink Fans on the AHU #4 VFD - Courthouse
BUILDINGS MAINTENANCE	J.F. Ahern Co	180.14	Annual Sprinkler Inspections - PSB
BUILDINGS MAINTENANCE	J.F. Ahern Co	837.02	Annual Sprinkler Inspections - Courthouse
BUILDINGS MAINTENANCE	Mid-American Research Chemical	800.00	Urinal Screens, Roach & Ant Insecticide, Weed Killer, Toilet Cleaner - Courthouse
BUILDINGS MAINTENANCE	Quality Disposal	222.65	Solid Waste Fee - Courthouse
BUILDINGS MAINTENANCE	Quality Disposal	235.62	Solid Waste Fee - PSB
		12,470.81	

COMMISSIONERS	Association of MN Counties	35.00	2022 District 5 Fall Meeting - RM
		35.00	
COMPUTER EXPENSES	MNCCC Lockbox	1,240.00	Tax Extract for 10-3-2022
		1,240.00	
COUNTY ATTORNEY	LexisNexis (RELX Inc.)	189.08	LexisNexis Oct 2022 Charges
COUNTY ATTORNEY	MCAA	325.00	MCAA 2022 Annual Meeting, 3 Day Registration - BM
COUNTY ATTORNEY	Minnesota County Attorney's Association	175.00	2022 Leadership Forum - MCAA Member Registration - BM
COUNTY ATTORNEY	ODP Business Solutions LLC	50.80	Tape, Pens, Plates, Envelopes, Exhibit Labels
		739.88	
COUNTY COORDINATOR	McNally, Kris	75.00	Mileage to MACA HR Conference in Deerwood
		75.00	
COUNTY CORONER	River Valley Forensic Services	750.00	Contract Monthly Medical Examiner Sept. '22, Post Mortem Exam
		750.00	
ECONOMIC DEVELOPMENT	Hartshorn, Jim	62.50	Mileage & Parking for MNCAR Expo
ECONOMIC DEVELOPMENT	JCF Properties LLC	2,100.00	2022 Tax Rebate 22.08134.00, 6 of 10, 21 units @ $100/unit
ECONOMIC DEVELOPMENT	Kanabec Publications	502.30	Marketing for Manufacturers Month (October)
		2,664.80	
ELECTIONS	DS Solutions	928.20	G2022 Test Deck Creation
ELECTIONS	Sea Change Print Innovations	3,358.65	G2022 OmniBallot Programming
		4,286.85	
ENVIRONMENTAL SERVICES	Bracewell, Earl	88.13	Planning Commission Per Diem & Mileage
ENVIRONMENTAL SERVICES	McNally, Dennis	85.00	Planning Commission Per Diem & Mileage
ENVIRONMENTAL SERVICES	O'Brien, Pat	108.75	Board of Adjustments Per Diem, Site Visit, Mileage
ENVIRONMENTAL SERVICES	O'Brien, Pat	92.50	Planning Commission Per Diem & Mileage
ENVIRONMENTAL SERVICES	Olson, Rhonda	85.00	Planning Commission Per Diem & Mileage

ENVIRONMENTAL SERVICES	Peterson, Ronald	139.38	Board of Adjustments Per Diem, Site Visit, Mileage
ENVIRONMENTAL SERVICES	Sabinash, Douglas	86.25	Planning Commission Per Diem & Mileage
ENVIRONMENTAL SERVICES	Sawatzky, Fred	106.25	Board of Adjustments Per Diem, Site Visit, Mileage
ENVIRONMENTAL SERVICES	Zaudtke, Wayne	78.75	Planning Commission Per Diem & Mileage
		870.01	
HUMAN RESOURCES	American DataBank	113.35	Background Study for New Employees (3)
HUMAN RESOURCES	RT Vision	3,583.12	Timecard Basic Software, Support & Maintenance 2023
HUMAN RESOURCES	SwipeClock LLC	362.00	Monthly Subscription
		4,058.47	
INFORMATION SYSTEMS	Marco	3,267.40	Phone Lease
		3,267.40	
LAW LIBRARY	LexisNexis (RELX Inc.)	225.00	Law Library Invoice
		225.00	
PROBATION & JUVENILE PLACEMENT	Cook, Brandon	69.38	Mileage to Attend Rraining in St. Cloud
PROBATION & JUVENILE PLACEMENT	East Central Regional Juvenile Center	4,335.00	October 2022 Contracted Beds at East Central Juv.Center
PROBATION & JUVENILE PLACEMENT	RS EDEN	716.95	Rapid Test Cups (100)
PROBATION & JUVENILE PLACEMENT	Schumacher, Sarah	69.38	Mileage to Attend Training in St. Cloud
		5,190.71	
PUBLIC TRANSPORTATION	A and E Cleaning Services	550.00	Cleaning Timber Trails Offices
PUBLIC TRANSPORTATION	Auto Value	220.42	Bus Parts
PUBLIC TRANSPORTATION	Curtis, Michael	536.88	Volunteeer Mileage
PUBLIC TRANSPORTATION	Glen's Tire	955.02	Bus Tires & Repairs
PUBLIC TRANSPORTATION	Hoefert, Robert	1,204.38	Volunteeer Mileage
PUBLIC TRANSPORTATION	Industrial Health Services Network Inc	45.90	Drug Screen
PUBLIC TRANSPORTATION	Innovative Office Solutions, LLC	29.73	Office Supplies
PUBLIC TRANSPORTATION	Kanabec County Highway Dept	597.46	Van Repairs
PUBLIC TRANSPORTATION	Kanabec Publications	562.00	Advertising
PUBLIC TRANSPORTATION	Novus Glass	60.00	Bus Windshield Repair
PUBLIC TRANSPORTATION	Quality Disposal	33.97	October Service

PUBLIC TRANSPORTATION	Van Alst, Lillian	1,412.50	Volunteeer Mileage
PUBLIC TRANSPORTATION	Welia Health	47.00	Drug Screen
		6,255.26	
SHERIFF	Ace Hardware	27.70	Keys (2), Glue, 1/4" Mag Driver
SHERIFF	Aspen Mills	255.17	Uniform - Under Vest Shirts (2) - JK
SHERIFF	Certified Crime Fighter	1,656.00	Annual Subscription
SHERIFF	Galls	54.34	Deputy Flashlight - AG
SHERIFF	Glen's Tire	901.27	Mount/Dismount/Disposal/Oil Change & Flat Repair
SHERIFF	Michael Keller, Ph.D., L.P.	650.00	New Employee Psych Eval
SHERIFF	O'Reilly Auto Parts	29.22	Squad Headlight
SHERIFF	Tinker & Larson Inc	61.90	Squad Oil Change
		3,635.60	
SHERIFF - 911 EMERGENCY	Granite Electronics	225.00	Plantronics Headset (2)
SHERIFF - 911 EMERGENCY	IAEMD	110.00	EMD Recertification (2)
SHERIFF - 911 EMERGENCY	IT SAVVY	1,502.21	Microsoft Pro Signature Keyboard & Tablet
SHERIFF - 911 EMERGENCY	Motorola Solutions	2,115.00	VESTA
		3,952.21	
SHERIFF - JAIL/DISPATCH	Adam's Pest Control, Inc.	250.00	Prevention Plus
SHERIFF - JAIL/DISPATCH	Advanced Correctional Healthcare	18,464.14	December 22 On Site Medical & MH Services
SHERIFF - JAIL/DISPATCH	Aspen Mills	243.27	Uniform - Brown Pants (2), Boots - CB
SHERIFF - JAIL/DISPATCH	Aspen Mills	52.95	Uniform - Brown Pants - AG
SHERIFF - JAIL/DISPATCH	Daniels Health	284.33	Sharp Disposal Service
SHERIFF - JAIL/DISPATCH	DataWorks Plus LLC	2,388.23	Livescan Maintenance Fee: SW&HW (11/15/22 - 11/14/23)
SHERIFF - JAIL/DISPATCH	Granite City Jobbing Co	287.16	Jail Supplies - Trash Bags (4)
SHERIFF - JAIL/DISPATCH	J.F. Ahern Co	434.06	Annual Sprinkler Inspection
SHERIFF - JAIL/DISPATCH	Mille Lacs County Jail	1,045.00	Inmate Boarding
SHERIFF - JAIL/DISPATCH	Quality Disposal	238.22	October Services
SHERIFF - JAIL/DISPATCH	Reliance Telephone, Inc	2,100.00	$5 Phone Cards (200), $10 Phone Cards (50), $20 Phone Cards (30)
SHERIFF - JAIL/DISPATCH	Stellar Services	147.08	Canteen
SHERIFF - JAIL/DISPATCH	Stellar Services	114.63	Canteen

SHERIFF - JAIL/DISPATCH	Summit Food Service Management	4,196.80	Inmate Meals 10/29/22 - 11/4/22
SHERIFF - JAIL/DISPATCH	Summit Food Service Management	4,150.82	Inmate Meals 10/22/22 - 10/28/22
		34,396.69	
STATE FISCAL RECOVERY ARP	Ace K9	168.00	Monitor System for K9 Vital Signs
STATE FISCAL RECOVERY ARP	Henry Schein	523.33	At-Home COVID Tests 25 tests/box x 2
		691.33	
UNALLOCATED	Clifton Larson Allen LLP	2,625.00	FY2021 Audit Services
UNALLOCATED	Kanabec Publications	345.41	County Board Minutes 9/6/22 & 9/20/22
		2,970.41	
VETERAN SERVICES	Marco Technologies, LLC.	100.00	Contract Overages
		100.00	
	95 Claims Totaling:	**$ 129,537.00**	

Agenda Item #3b
Regular Bills - Road & Bridge
Bills to be approved: 11/15/22

Vendor	Amount	Purpose
A & E Cleaning Services	1,100.00	Cleaning offices
Ace	636.00	Shop supplies
Aramark	405.36	Coveralls and janitorial supplies
Auto Value	1,693.10	Repair parts
Beaudry Oil & Propane	30,700.55	Diesel fuel
Blum Sand and Gravel	2,120.00	Sand
Central McGowan	307.63	Shop supplies
Central Pension Fund	350.40	Training center use fee
City of Mora	16,235.20	Agreement 2021 and 2022 road maintenance
Crawford's Equipment	328.80	Repair parts
Diamond Mowers	245.66	Repair parts
East Central Energy	354.00	Fix junction box
Glens Tire	1,061.90	Tire repair
Gopher State One-Call	27.00	Locates
H&L Mesabi	44,861.50	Shop supplies
Houtsma, Wes	350.00	Beaver removal
Jamar Technologies	229.37	Repair parts
Johnson Hardware and Rental	1,422.74	Shop supplies
Kanabec County Highway Dept	117.04	Petty cash, postage
Kanabec Publications	189.30	Ditch 2 ad
Kanabec County Times	83.00	Newspaper
Knife River Corporation	1,124,353.86	SAP 033-620-011 and sand
Little Falls Machine	1,137.44	Repair parts
Locators & Supplies	2,026.86	Maintenance supplies
Marco	330.89	Printer fee
Mora Chev	264.35	Labor
Morton Salt	20,788.08	Salt
Newman Traffic Signs	76.02	Sign supplies
North Central International	6,984.08	Repair parts
Northpost	531.60	Shop supplies
Nuss Truck Equipment	13,379.83	Repair parts
ODP	58.03	Office supplies
Owens Auto Parts	137.80	Repair parts
Pomp's Tire Service	3,343.04	Tire order
Power Plan	1,436.35	Repair parts
Premier Outdoor Services	7,117.50	Paving
RTVision	3,000.00	E-time
Trueman Welters	6,069.33	Repair parts
Usic Locating	100.00	Locates
Vault Health	237.52	DOT drug screening
Wiacom	675.30	GPS
41 Claims Totaling:	**1,294,866.43**	

Agenda Item #4

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: Snake River Comprehensive Watershed Management Plan Update	**b. Origination**: Snake River 1W1P Policy Committee
c. Estimated time: 5- 10 minutes	**d. Presenter**(s): Commissioner Smith

e. Board action requested:

Update on the Snake River 1W1P Policy Committee's Comprehensive Watershed Management Plan status.

Information only.

f. Background:

Supporting Documents: None **Attached: ☑**

Date received in County Coordinators Office:	Memo from Deanna P. from 11/2/22

Coordinators Comments:

Snake River Watershed Planning Partnership

Memo Subject: Seeking approval to submit our final draft plan to the Board of Water & Soil Resources (BWSR) for their final 90-day review.

To: Local Govt. Units (LGU) – Counties and SWCDs (Aitkin, Pine, Kanabec & Mille Lacs)
Snake River Watershed Planning Partnership
From: Deanna Pomije, Planning Coordinator 11/2/22

Request: (Correction below)

Our state agency comment period and the final public hearing have ended with the responses to submitted comments reviewed and approved by our policy committee. Any changes to the plan based on these approved comment responses have been added to the final plan. The latest version of the plan is dated 11/2/22.

The plan can is located on this website:
https://www.millelacsswcd.org/snake-river-one-watershed-one-plan/

We are seeking all our Snake Watershed's LGU's board's approval on the final draft Snake River Comprehensive Watershed Management Plan for submission to the Board of Water & Soil Resources (BWSR) for their final 90-day review. The Policy Committee plans to act on this at their 11/28/22 meeting. We are seeking action from your boards. You may submit your board action in a simple motion or resolution on the underlined text above, which ever form you choose.

To Note: Based on the last Mille Lacs Band language in the Plan approved by the Policy Committee on 10/24, this is the only remaining language in the plan:
"The Snake River Watershed Plan Partnership acknowledges that there is tribal land within the Snake River Watershed." P. 2-5
~~"Mille Lacs Band of Ojibwe owns land in the watershed, which is used for multiple purposes and is important to tribal natural resource, economic, and environmental programs~~." P. 2-5 (pulled the language from the wrong version of the plan)

Please send your response to Deanna@KanabecSWCD.org as you're able. Our next Policy Committee meets 11/28 to vote on plan submission. Attached are updated power point slides for any board presentation, as you wish to use. Feel free to reach out to myself or staff to present or speak on the plan. Please let me know if you have any questions.

Sincerely
Deanna Pomije, District Manager

Deanna@KanabecSWCD.org
(320) 679-1391
Kanabec SWCD
2008 Mahogany St Ste 3
Mora MN 55051

Agenda Item #5

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: Consider Changing the Address of the Kanabec County Courthouse	**b. Origination**: Auditor/Treasurer
c. Estimated time: 10 minutes	**d. Presenter**(s): Kris McNally, Coordinator

e. Board action requested:

Consider authorizing the process to change the address of the Kanabec County Courthouse to a Maple Avenue address.

The existing address of the Kanabec County Courthouse is 18 North Vine Street, Mora, MN 55051. This is the address that is displayed on internet searches and mapping apps for directions to the entrance of the Courthouse. This is the address used for deliveries to the Courthouse as well. This leads individuals to the Vine Street entrance which is accessible for employees only and is not handicap accessible.

This has led to numerous problems with accessibility issues, as well as individuals and delivery drivers not knowing where the main entrance is located.

Staff are requesting authorization to begin the process of re-addressing the Courthouse to a Maple Avenue address.

f. Background:

Supporting Documents: None **Attached: ☑**

Date received in County Coordinators Office:

Coordinators Comments:

This is the entrance per the current address on Vine Street. The door is locked for building security and a sign directs people to the Maple Ave entrance.

This is the main entrance on Maple Avenue.

Agenda Item #6

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: Request to Revise and Update the Travel Expense & Reimbursement Policy	**b. Origination**: Department Head Meeting
c. Estimated time: 10 minutes	**d. Presenter**(s): Kris McNally, Coordinator

e. Board action requested:

Staff is requesting authorization to begin the process to revise and update the existing Travel Expense & Reimbursement Policy.

f. Background:

During the most recent Department Head meeting, the existing Travel Expense and Reimbursement Policy was discussed. Multiple concerns were raised with the existing policy as it conflicts with the allowable expenses for various grants, does not set limits for authorized expenses, does not include a variable for high cost geographical areas, and does not specifically exclude alcohol, etc.

Supporting Documents: None **Attached: ☑ Existing Policy**

Date received in County Coordinators Office:

Coordinators Comments:

EXPENSE & TRAVEL REIMBURSEMENT

If you incur costs as a result of conducting County business, you may seek reimbursement. Kanabec County reimburses employees for reasonable expenses that were incurred while conducting business on behalf of the County.

All business expenses and/or business travel must be pre-approved by your supervisor. Such expenses include transportation, meals and lodging. You must complete a voucher with the original receipts or other documentation attached in order to be reimbursed. These expense reports require the approval of your supervisor and must be forwarded to the Auditor/Treasurer's Office for reimbursement.

Kanabec County will reimburse county employees for meal expenses only while attending a multi-day meeting or conference that requires the employee to stay overnight.

The Internal Revenue Service required employers to furnish a W-2 to all employees for the amount of reimbursed meal expenses to the employee for work related trips that do not require a stop for sleep or rest, but do not require a W-2 for reimbursement of meal expenses when the trip does require a stop for sleep or rest.

Out of State Travel

Out of state travel is appropriate when the time and cost of such travel are outweighed by the benefit to Kanabec County. Expenses are limited to reasonable and proper. All non-grant funded out of state travel requires prior approval by the County Board.

Airline Travel Credit

Whenever county funds are used to pay for airline travel by an elected official or public employee, any credits or other benefits issued by any airline must accrue to the benefit of the public body providing the funding. In the event the issuing airline will not honor a transfer or assignment of any credit or benefit, the individual passenger shall report receipt of the credit or benefit to the public body issuing the initial payment within 90 days of receipt.

Falsification of expense reports will be grounds for immediate corrective action, up to and including discharge.

Agenda Item #7

November 15, 2022

REQUEST FOR BOARD ACTION

a. Subject: Proposed FY2023 Budget and Levy	**b. Origination**: County Coordinator's Office
c. Estimated time: 10 minutes	**d. Presenter**(s): Kris McNally, Coordinator

e. Board action requested:

Discuss any final changes to the FY2023 Budget and Levy before the Truth in Taxation meeting and final certification.

Preliminary levy at 4.16%

The Truth in Taxation meeting is Thurs, Dec 8th at 6:00PM in meeting rooms 3 & 4.

f. Background:

Supporting Documents: None ☑ Attached:

Date received in County Coordinators Office:

Coordinators Comments: