Pennington County Human Service Committee

Meeting Agenda

December 20, 2022

12:00 pm

Members Present

_____Bruce Lawrence _____ Dave Sorenson _____ Seth Nelson

_____ Neil Peterson _____ Darryl Tveitbakk

Section A

Minutes: Review of 11/15/2022 HSC Meeting minutes

I. Personnel:
   - A. Update on Social Worker Positions
   - B. Retirement

III. General:
   - A. CY 2023 Behavioral Health (Community-Based Services/Residential/Temporary Confinement) Purchase of Service Agreements between Sanford Behavioral Health and Pennington County Human Services.
   - B. UCare Contract
   - C. Out-of-Home Cost Report
   - D. Month's End Cash Balance
   - E. Other

Section B

I. Special Case Situations (Social Services)
II. Income Maintenance Update
III. Special Case Situations (Public Assistance)
IV. Payment of Bills

Section C

I. Dates of Upcoming Committee Meetings:

01/17/2023	02/21/2023	03/21/2023
12:00 pm	12:00 pm	12:00 pm

A regular meeting of the Pennington County Human Service Committee was held at 12:00 pm, November 15, 2022, at the Pennington County Justice Center.

COMMITTEE MEMBERS PRESENT:
Bruce Lawrence
Neil Peterson

STAFF MEMBERS PRESENT:
Julie Sjostrand, Director
Maureen Monson
Elizabeth Gerhart
Tammy Johnson
Stacy Anderson

SECTION A

I. MINUTES:

The October 18, 2022, Human Service Committee Meeting Minutes were electronically posted for review. Noting no corrections or changes, a recommendation was made to forward the Minutes to the Consent Agenda.

II. PERSONNEL:

A. The Director announced that Roxane Gilbertson has transferred internally to fill the Social Worker/Certified Assessor position. Roxane starts her new position on December 05, 2022. Upon conclusion of the announcement a recommendation was made to forward this item to the Consent Agenda.

B. The Director presented a request to post, interview and hire for the Disability Waiver Social Worker vacancy. Upon conclusion of the presentation a recommendation was made to forward this item to the Consent Agenda.

C. The Director announced the resignation of Laurie Hamness, Social Worker/ -MSHO/MSC+/Elderly Wavier Case Manager, effective December 30, 2022. Upon conclusion of the announcement a recommendation was made to forward this item to the Consent Agenda.

D. The Director presented a request to post, interview and hire for the Social Worker/ -MSHO/MSC+/Elderly Wavier Case Manager vacancy. Upon conclusion of the presentation a recommendation was made to forward this item to the Consent Agenda.

III. GENERAL:

A. The CY 2023 Pennington County Family Services/Children's Mental Health Collaborative Supportive Services Agreement with Alluma, Inc. was presented for consideration. Pennington County will serve as a fiscal host for this agreement and costs will be paid through collaborative funds. Upon conclusion of the presentation a recommendation was made to forward this item to the Consent Agenda.

B. The CY 2023 AC/SWS Support Services Agreement between Pennington County and TriMin System, INC. to provide Professional Services for maintenance of our systems (ACS and SWS) was presented for consideration. Upon conclusion of the presentation a recommendation was made to forward this item to the Consent Agenda.

C. The Director presented a report on the Adult Protection and Child Support Performance Report.

D. The Out-of-Home Cost Report through October 2022 was presented for Review.

E. Month's end cash balance for October 2022 stands at $ 3,609,060.10.

SECTION B

I. No Social Service cases were presented for special case review.

II. Tammy Johnson, Financial Assistant Supervisor presented the Emergency Assistance/Emergency General Assistance October 2022 report of activity. She reported the Income Maintenance open case count stands at 2146.

III. No Income Maintenance cases were presented for special case consideration.

IV. A listing of bills presented for payment was reviewed. A recommendation for payment of the bills was forwarded to the Consent Agenda.

SECTION C

Be it resolved that the foregoing record is a true and accurate recording of the official actions and recommendations of the Human Service Committee for Pennington County and, as such, constitutes the official minutes thereof.

Chair: _____

Attest: _____

NEXT COMMITTEE MEETING: December 20, 2022, at 12:00 p.m.

PURCHASE OF SERVICES AGREEMENT

THIS AGREEMENT is made for the period January 1, 2023, to December 31, 2023, between Sanford Health Network North dba Sanford Behavioral Health Center ("Sanford") and Pennington County Human Services ("Agency").

WHEREAS, Sanford provides, inter alia, Chemical Dependence and Temporary Confinement Services, collectively "the Services"; and

WHEREAS, the Agency wishes to purchase the Services from Sanford; and

WHEREAS, this Agreement will serve as a lead/host county agreement for other financially responsible agencies utilizing the Services.

NOW THEREFORE, in consideration of the covenants herein contained, the parties hereto have entered into this Agreement under the terms and conditions set forth below:

Agency hereby contracts with Sanford, and Sanford agrees to provide the Services to the Agency pursuant to the terms of this Agreement.

1 Temporary Confinement (72 Hour & Judicial Holds)

1.1 As Sanford capacity allows, Sanford agrees to provide mental health inpatient stays for Agency referrals under MS 253B.05 and 253B.07 as enacted as of the signing of this Agreement. Agency and Sanford agree that MS 253B.045 § 2 a and MS 256G.08 are interpreted to mean that the County of Fiscal Responsibility as defined therein is responsible for all charges not covered, including patient copays and deductibles, after third party payment sources (excluding the patient) have been exhausted. Sanford will make all reasonable efforts to collect reimbursement from third party insurers prior to billing the County of Fiscal Responsibility.

1.2 Agency agrees to the following rates for all stays covered under the above statutes.

1.2.1 01/01/2023 – 12/31/2023 $1,817/day

1.3 Upon the admission of an involuntary patient, pursuant to MN Statutes, Chapter 253B, Sanford will determine the insurance status of the patient. If the patient is not covered by an insurance plan, Sanford will encourage the patient to start an application process and provide the technology necessary for him or her to do so. If a patient does not agree to seek insurance coverage, Sanford will inform the County of Fiscal Responsibility of the patient's refusal. Sanford cannot apply for insurance on a patient's behalf.

1.4 In the event that a patient's visit to the Sanford Medical Center Thief River Falls emergency department results in a temporary confinement, and no suitable behavioral health inpatient bed is available after reasonable efforts to secure, Sanford will attempt to make, but will be under no obligation to provide, appropriate accommodation for the patient's needs in one of its medical/surgical rooms until more suitable

accommodations can be located by Sanford or Agency. The County of Fiscal Responsibility's payment obligation in this situation is dependent upon the type of care on the medical/surgical floor deemed medically necessary.

2.4.1 Observation status – If the patient has third-party insurance coverage, the first 48 hours of the observation stay will be billed to third-party insurance. Portions of the patient stay after the first 48 hours will be the responsibility of the County of Fiscal Responsibility at the daily rates defined above. If the patient does not have third-party insurance, the entire stay will be the responsibility of the County of Fiscal Responsibility at the daily rates defined above.

2.4.2 Inpatient status – If the patient has third-party insurance coverage, such insurance will be billed first, with the remaining balance being the responsibility of the County of Fiscal Responsibility.

1.5 Sanford shall bill each patient's County of Financial Responsibility for temporary confinement costs. If the patient's County of Financial Responsibility is unknown, Sanford shall bill the county which initiated the confinement.

1.6 In the event that following a patient's visit the patient receives third party insurance coverage that is retroactive to a date on or before the patient's visit, and Agency notifies Sanford of the change at least five business days prior to the third party payor's timely filing deadline, Sanford will refund to Agency an amount equivalent to the amount previously paid by Agency minus the patient responsible balance reported by the third party insurance carrier for that visit. Coverage notifications occurring after this time will result in charges on those dates of service remaining the responsibility of Agency.

1.7 Agency agrees that charges for patient transfer to/from facilities other than Sanford Health Network North dba Sanford Medical Center Thief River Falls and Sanford Health Network North dba Sanford Behavioral Health Center are not included in the daily rate.

1.8 This agreement will serve as a lead/host county agreement for temporary confinements initiated by other financially responsible agencies.

2 Miscellaneous

2.1 Additional Sanford commitments – Sanford shall:

2.1.1 Inform Agency of any developments which may have a significant bearing on Sanford's ability to deliver any of the Services covered by this Agreement.

2.1.2 Charge fees for Services which do not unreasonably exceed the actual cost of providing such Services.

2.1.3 Provide Services in a manner consistent with sound business/medical practice and in compliance with Sanford's policies and procedures, including any compliance programs and business conduct codes.

2.1.4 Reasonably cooperate with Agency in attempting to maximize the Agency's opportunity to make use of non-Agency sources of funding.

2.1.5 Not do any work nor furnish any material not covered by this Agreement on behalf of Agency unless it is approved in writing by the Agency.

2.2 Additional Agency commitments – Agency shall:

2.2.1 Where Services provided by Sanford cannot be billed within the current Agreement period, Sanford will bill and Agency agrees to remit funding for those Services from the following Agreement period's funds.

2.3 General liability insurance - Sanford will at all times during the term of this Agreement have and keep in force a general liability insurance policy in the amount of one million dollars ($1,000,000) for bodily injury or property damage to any one person and three million dollars ($3,000,000) for total injuries or damages arising from any one occurrence.

2.4 Professional liability insurance - Sanford must also maintain professional liability insurance with a minimum aggregate amount of one million dollars ($1,000,000).

2.5 Indemnity – Sanford and Agency agree to indemnify and hold each other harmless against any and all cost, damage, expense, claim, liability, civil fine and penalty, including (but not limited to) court costs and reasonable attorneys' fees incurred by the other party arising out of or in connection with that party's negligence or failure to comply with all such laws, ordinances, rules and regulations. The indemnity provisions set forth in this section shall survive the expiration or early termination of this Agreement, and shall include but not be limited to any claims arising:

2.5.1 By reason of any Service client's suffering personal injury, death, or property loss or damages either while participating in or receiving from Sanford the Services to be furnished by Sanford under this Agreement, or while on premises owned, leased or operated by Sanford, or while being transported to or from said premises in any vehicle owned, operated, chartered, or otherwise contracted for by Sanford when the cause of such injury or loss is due to Sanford's negligent or intentional acts; or

2.5.2 By reason of any Service client's causing injury to, or damage to, the property of another person during any time when Sanford or its assign, or employee thereof has undertaken or is furnishing the care and Service called for under this Agreement when the cause of such injury or loss is due to Sanford's negligent or intentional acts.

2.6 Bonding – Sanford shall obtain and maintain at all times during the term of this Agreement, a fidelity bond covering the activity of its personnel authorized to receive or distribute monies. Such bond shall be in the amount of not less than $100,000.

2.7 Confidential information – Both Sanford and Agency agree that all information with respect to the operations and business of the other party gained during the negotiations leading up to this Agreement, and from the performance of the Agreement, will be held in confidence and will not be divulged to any unauthorized person without prior

written consent of the other, except for access required by law regulation, and third party reimbursement agreements.

2.8 HIPAA and HITECH - Sanford agrees that it is a "covered entity" as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, and is in compliance with privacy regulations, 45 C.F.R. § 165.500, et seq. ("Privacy Regulations") and all requirements with respect to individual identifying health information (IIHI) as defined in HIPAA. Use and disclosure of IIHI will require that all IIHI be: appropriately safeguarded; misuse appropriately reported; satisfactory assurances from any subcontractor(s) secured; individuals granted access and ability to amend their IIHI; accounting of disclosure made available; and applicable records released to the Agency or Department of Human Services. The provisions of this paragraph shall survive the termination of this Agreement.

2.9 Equal employment opportunity, civil rights, and nondiscrimination - (When applicable) Sanford agrees to comply with the Civil Rights Act of 1964, Title VII (423 USC 2000e), including Executive Order No. 11246, and Title VI (42 USC 200d); and the Rehabilitation Act of 1973, as amended by Section 504; (When applicable) Sanford certifies that it has received a certificate of compliance from the Commissioner of Human Rights pursuant to Minnesota Statutes, section 363.073 (1982).

2.10 Fair hearing and grievance procedures – Agency agrees to provide for a fair hearing and grievance procedure in conformance with Minnesota Statues, section 256.045, and in conjunction with the fair Hearing and Grievance Procedures established by administrative rules of the State Department of Human Services.

2.11 Distinction of entities – This Agreement shall not be construed in any manner to make Sanford personnel employees of Agency. Agency shall not be responsible for withholding of any taxes related to the contracting with Sanford, including, but not limited to, State and Federal income tax and FICA taxes. Agency shall not be responsible for worker's compensation benefits, unemployment compensation premiums, or any other benefits or obligations either required by law or provided by Agency to its own employees. Sanford is an independent contractor with respect to Agency.

2.12 Staff selection and management - Sanford agrees to furnish Agency with personnel who have the academic preparation, personal qualities, skills, licensure and experience necessary to meet relevant requirements and provide high quality Services to eligible residents in Agency's jurisdiction. Selection of staff that will complete each Service covered under this Agreement is under Sanford's discretion and may change throughout the Agreement term as needs dictate. Sanford will provide administrative and clinical supervision as necessary for personnel providing Services under this Agreement and assume full responsibility for their conduct. Clinical supervision will be provided by a mental health professional.

2.13 Subcontracting – Sanford may enter into subcontracts for any of the Services covered by this Agreement upon providing written notice to Agency. All subcontracts shall be subject to the requirements of this Agreement.

2.14 Audit and record disclosures – Sanford shall:

2.14.1 Allow the personnel of Agency, the Minnesota Department of Human Services, and the Department of Health and Human Services, or their designee, access to Sanford's facility and records at reasonable hours and upon reasonable notice to exercise their responsibility to monitor purchased Services.

2.14.2 Maintain all records pertaining to this Agreement (program and fiscal) for four years for audit purposes.

2.14.3 Comply with policies of the Minnesota Department of Human Services regarding social services recording and monitoring procedures, as defined in the Department of Human Services Social Services Manual, and the administrative rules of the State agency.

2.14.4 Make the results of any audits conducted by Sanford, insofar as they pertain to Services covered by this Agreement, available to the Agency at the latter's request.

2.15 Conditions for termination

2.15.1 Medicare and Medicaid eligibility – Sanford certifies as of the execution of this Agreement and continuing through the term of this Agreement, that neither it, its member, nor employed physicians providing services under this Agreement have been excluded from participation in any federal or state Medicare, Medicaid, or other third party payor program, nor is any such action pending. Sanford shall notify Agency as soon as reasonably possible if such action is threatened or proposed. If at any time Sanford, its member or employed physicians providing services under this Agreement have been excluded, as described above, then Agency may immediately terminate this Agreement.

2.15.2 Statutory changes - It is agreed that the terms and conditions of this Agreement will be changed to reflect any change in and status of any state or federal law, rule, regulation, guideline or safe harbor regulation that has any material impact on either of the parties and of the parties' ability to legally carry out the spirit of the Agreement and their good faith intentions. If such amendments materially change the rights and obligations of the parties hereto, either party may then terminate this Agreement upon written notice of termination which shall be effective on the effective date of the state or federal law, rule, regulation, guideline or safe harbor regulation that necessitated the amendment or the expiration date of the then current term, whichever date is earlier.

2.15.3 Funding changes - The Agency agrees to inform Sanford of any developments which may have a significant bearing on the Agency's ability to provide funds in accord with the amounts and principles contained in this Agreement. Should the Agency be unable to fulfill its financial obligations to Sanford due to specific reductions in federal or state funds, the obligation of both parties shall cease following a 60 day advance notice.

2.15.4 Other – Unless otherwise specified above, either party may terminate this Agreement with or without cause upon sixty (60) days prior written notice to the other party.

2.16 Conditions for modification

2.16.1 Any alterations, variation, modifications, or waivers of provisions of this Agreement will be valid only when they have been reduced to writing, and duly signed.

2.16.2 Unless otherwise specified above, if Sanford is unable to or is going to be unable to provide the required quality or quantity of Services it must notify Agency thirty (30) days before the service line is discontinued.

2.17 General terms

2.17.1 No waiver by either party or any term or provision of this Agreement shall be deemed to be a waiver of any other term or provision.

2.17.2 If any term or provision of this Agreement is now or hereafter determined to be invalid or unenforceable, such determination shall not impair the validity of the remainder of this Agreement.

2.17.3 The terms and provisions hereof shall be binding on and inure to the benefit of the successors and permitted assigns of the parties hereto.

2.17.4 This Agreement shall be construed in accordance with the laws of the State of Minnesota.

2.17.5 The Agreement is not assignable by either party without the prior written consent of the other party.

2.17.6 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 relating to the subject matter hereof.

Pennington County Human Services

By: _____

Its: _____

Date: _____

Sanford Health Network North

By: _____

Its: _____

Date: _____

Reviewed and Approved:

By: _____

Pennington County Attorney

Date: _____

PURCHASE OF SERVICES AGREEMENT

THIS AGREEMENT is made for the period January 1, 2023, to December 31, 2023, between Sanford Health Network North dba Sanford Behavioral Health Center ("Sanford") and Pennington County Human Services ("Agency").

WHEREAS, Sanford provides a variety of behavioral health services, collectively "the Services"; and

WHEREAS, the Agency wishes to purchase the Services from Sanford.

NOW THEREFORE, in consideration of the covenants herein contained, the parties hereto have entered into this Agreement under the terms and conditions set forth below:

Agency hereby contracts with Sanford, and Sanford agrees to provide the Services to the Agency pursuant to the terms of this Agreement.

1 Clinic Behavior Health Services (Sanford Medical Center Thief River Falls).

1.1 In order to provide county residents with access to formal outpatient mental health services, the Agency agrees to make fee subsidies available on a case-by-case basis to eligible residents.

1.2 The parties understand and agree that the eligibility of the client to receive services under this section from Sanford is to be determined in accordance with eligibility criteria mutually agreed upon by Sanford and Agency. Sanford's interest in helping to craft eligibility criteria is to ensure that chosen criteria can be expeditiously applied by Sanford staff at the time the patient registers, and will not result in unsatisfactory billing workflows.

1.3 When a patient arrives at registration and indicates that he does not have third party insurance or would be unable to pay his third party copay or deductible, Sanford registration staff will encourage the patient to fill out a subsidy application form. Sanford staff will assume that the information entered by the patient is truthful, but inform the patient that a copy will be forwarded to Agency. It is Agency's responsibility to review the applications and make a final determination regarding patient eligibility for future visits. Direct contact by Agency to Sanford regarding a patient's qualification or disqualification for future subsidized visits will supersede the determination made using the agreed upon eligibility criteria.

1.4 Sanford staff will compare the information submitted by the patient to the program eligibility criteria. If the patient is eligible to receive a subsidy and would like their application processed, Sanford will charge the patient a nonrefundable application fee. This fee will be levied when the patient applies for the subsidy program, and be based on a sliding fee scale using the agreed upon eligibility criteria. Application fees collected by Sanford will remain the sole property of Sanford.

1.5 If Agency contacts Sanford to schedule an appointment on a patient's behalf and indicates that the patient's visit(s) should be part of the fee subsidy arrangement, Sanford will waive the application fee. Agency agrees to disclose to the patient prior to service commencing that they intend to cover the patient's copays and deductibles and that Sanford will provide Agency with the information necessary to facilitate that payment.

1.6 Agency's financial responsibility:

1.6.1 Patients without third party insurance coverage who meet the eligibility criteria, and have paid the application fee will receive a 30% discount from the current listed rate for the service provided. Agency agrees to pay the remaining patient balance.

1.6.2 If the patient has third party insurance, Sanford will bill the insurance, and after insurance remittance, will bill the remaining balance to Agency. For example: (current listed rate) – (insurance reimbursement and discount) = (Agency responsibility).

1.6.3 In the event that following a patient's visit the patient receives third party insurance coverage that is retroactive to a date on or before the patient's visit, and Agency provides Sanford the sufficient and pertinent coverage information at least five business days prior to the third party payor's timely filing deadline, Sanford will refund to Agency an amount equivalent to the amount previously paid by Agency minus the patient responsible balance reported by the third party insurance carrier for that visit. Coverage notifications occurring after this time will result in charges on those dates of service remaining the responsibility of Agency.

1.6.4 Total annual Agency liability under this section will be a maximum of $13,000. Agency will be responsible for notifying Sanford of the date it predicts the maximum will be exceeded in each calendar year so that Sanford can notify patients of the change in fiscal responsibility for their visits.

1.7 In order that Sanford receives all fee subsidies to which it is entitled for services provided during the contract term and to allow time for third party insurance payments to be remitted, Agency agrees to reimburse Sanford for fee subsidy visits that occurred during the contract term up to 90 days after the contract expires.

1.8 Primary responsibility for helping uninsured patients successfully obtain insurance coverage lies with Agency, however Sanford will make an effort to point that individual in the direction necessary to obtain such coverage.

1.9 Sanford will assume responsibility for charting and other administrative-clinical tasks, and records will be the property of Sanford.

2 Community Based Services - Adult

2.1 Community Support Program Services (CSP) –MS 245.4721

2.1.1 Agency's Areas of Responsibility

2.1.1.1 The parties understand and agree that all Services provided to eligible clients under the terms of this Agreement shall be in accordance with the Individual Community Support Plan (ICSP), developed with, for and on behalf of the individual client by Agency (MS 245.4711 § 4 a). The Agency will not delegate the development of Individual Community Support Plans to Sanford.

2.1.1.2 Agency will assist Sanford in obtaining a copy of the diagnostic assessment/update completed by a qualified mental health professional. Although the diagnostic assessment may be performed by Sanford at Agency's request, Agency and Sanford understand and agree that diagnostic assessments are not a purchased Service covered by this agreement.

2.1.1.3 Agency is responsible for assuring that funding streams used to pay for Services offered under this section are appropriate to the clients/Services being offered.

2.1.2 Sanford's Areas of Responsibility

2.1.2.1 Sanford will work collaboratively with Agency staff to serve clients effectively and achieve treatment objectives. Sanford personnel will provide Services outlined in MS 245.4721§1 a-b, attend Individual Community Support Program meetings scheduled by Agency's case managers, and maintain regular verbal contact with county case managers regarding clients' progress.

2.1.2.2 Sanford will develop an individual treatment plan for each client. Individual treatment planning will be based upon a diagnostic assessment performed by a qualified mental health professional and the ICSP provided by Agency.

2.1.2.3 When discharging or terminating Services to a client who requests that such services be continued, Sanford shall prepare a summary of findings for the Agency and submit it in a timely manner.

2.1.3 Eligibility

2.1.3.1 Clients admitted to the CSP program must meet the eligibility criteria of serious and persistent mental illness (SPMI) dictated in MS 245.462 § 20 c. The parties understand and agree that a preliminary eligibility check will be the responsibility of the Agency. If the client is found by Agency to meet all criteria of the statute, the county will refer the patient to Sanford for a final eligibility check. Sanford will determine admission to the program.

2.1.3.2 If either Agency or Sanford determines that a client is no longer eligible to receive Services or no longer requires the Services, the party

making the determination will notify the other party ten (10) days prior to discontinuing Services. Sanford shall not discharge or terminate Services to a client prior to the proposed termination date unless delay would seriously endanger the health, safety, or well-being of other Service recipients or Sanford staff.

2.2 Adult Rehabilitative Mental Health Services (ARMHS) –MS 256B.0623

2.2.1 Agency understands that whenever appropriate, Sanford will bill the State of Minnesota for Adult Mental Health Rehabilitation Services (ARMHS) provided to county residents who are covered by an eligible insurance plan.

2.2.2 Agency agrees that Sanford will be the primary provider of ARMHS services.

2.2.3 Agency will file the appropriate paperwork designating Sanford as an approved ARMHS provider within Agency's jurisdiction.

2.2.4 Agency agrees that Sanford's practitioners/clinicians are responsible for evaluating initial eligibility, ongoing eligibility, and making determinations regarding discharge from the program.

2.2.5 Sanford realizes that ARMHS clients are best served when a close connection is maintained between ARMHS Services and companion Services/programs offered by Agency. Sanford will make available to the Agency statistics regarding the number of ARMHS Service hours delivered to county residents and share information pertinent to the joint delivery of care.

2.3 Targeted Case Management Service (TCM)

2.3.1 Targeted case management Services are outside the scope of this agreement, and Sanford does not assume clinical or fiduciary responsibility for providing these Services.

2.4 Invoicing and Payment

2.4.1 Sanford shall submit to Agency two invoices each month for adult community based services. The two-invoice system allows Agency to determine which funding source (CSP, Northwest 8, county dollars, etc.) to associate with each client served and/or infrastructure funded. Agency will be solely responsible for tracking the number of clients served by each funding source and the dollar values of service provided under each source. Total Agency liability to Sanford, between the two invoices, for each month during the contract period will be:

2.4.1.1 January 1, 2023 – December 31, 2023 $17,265 monthly

2.4.1.2 Fee-for-service - This invoice will present the portion of total monthly Agency liability (if any) that is most directly assignable on an individual service unit basis. The invoice will include an account of the number of billable service units, by patient name and account

number, rendered to each client served during the previous calendar month and the associated costs. One service unit is equivalent to 15 minutes (unless otherwise specified) of practitioner time spent serving clients as defined under the Minnesota ARMHS and CSP statutes. The dollar value charged per service unit will be equivalent to the current charges per unit Sanford bills for clients enrolled in its ARMHS program, and will vary as payor fee schedules are updated.

2.4.1.2.1 Individual identifying heath information (IIHI) will be provided for service lines where HIPAA regulations allow.

2.4.1.3 Infrastructure – This invoice will present the balance of Agency liability that was not directly assignable on a fee-for-service basis. Because fee-for-service billings will naturally vary between months, this will also vary each month and will be calculated as follows: (total monthly Agency liability – monthly fee for service invoice amount = infrastructure invoice amount). In the event that the monthly fee-for-service invoice amount is greater than the total monthly Agency liability, zero dollars will be billed for infrastructure that month. Agency will be responsible for paying balance due within 30 days of receipt of the invoice.

2.4.1.3.1 The statement will include statistics regarding the number of hours of each service rendered during the previous calendar month as well as year to date totals. Totals will be summarized by service line.

2.4.2 Sanford certifies that it does not provide to others the Services covered by this Agreement at no cost; that rates for Services do not exceed amounts reasonable and necessary to assure quality of Services.

2.4.3 Sanford will assume financial responsibility for all supplies, facilities (other than Agency's facility), outside services and staff travel necessary to provide quality program Services.

2.4.4 Reimbursement by Medical Assistance and other third-party payers for services billable to those payers will be retained by Sanford for the delivery of said services.

2.5 Program Capacity

2.5.1 Sanford agrees to provide enough staff and resources to accommodate a caseload of approximately 55 clients. The actual capacity of the program at a given time may be slightly lower or higher than this number depending on the acuity of already enrolled clients.

2.5.2 Client capacity may be temporarily reduced due to staff turnover or leave.

2.5.3 If Sanford determines that the program is at full capacity and a new referral is made, the referral will be placed on a waiting list until capacity in the program becomes available.

3 Miscellaneous

3.1 Additional Sanford commitments – Sanford shall:

3.1.1 Inform Agency of any developments which may have a significant bearing on Sanford's ability to deliver any of the Services covered by this Agreement.

3.1.2 Charge fees for Services which do not unreasonably exceed the actual cost of providing such Services.

3.1.3 Provide Services in a manner consistent with sound business/medical practice and in compliance with Sanford's policies and procedures, including any compliance programs and business conduct codes.

3.1.4 Reasonably cooperate with Agency in attempting to maximize the Agency's opportunity to make use of non-Agency sources of funding.

3.1.5 Not do any work nor furnish any material not covered by this Agreement on behalf of Agency unless it is approved in writing by the Agency.

3.2 Additional Agency commitments – Agency shall:

3.2.1 Where Services provided by Sanford cannot be billed within the current Agreement period, Sanford will bill the Agency and the Agency agrees to remit funding for those Services from the following Agreement period's funds.

3.3 General liability insurance - Sanford will at all times during the term of this Agreement have and keep in force a general liability insurance policy in the amount of one million dollars ($1,000,000) for bodily injury or property damage to any one person and three million dollars ($3,000,000) for total injuries or damages arising from any one occurrence.

3.4 Professional liability insurance - Sanford must also maintain professional liability insurance with a minimum aggregate amount of one million dollars ($1,000,000).

3.5 Indemnity – Sanford and Agency agree to indemnify and hold each other harmless against any and all cost, damage, expense, claim, liability, civil fine and penalty, including (but not limited to) court costs and reasonable attorneys' fees incurred by the other party arising out of or in connection with that party's negligence or failure to comply with all such laws, ordinances, rules and regulations. The indemnity provisions set forth in this section shall survive the expiration or early termination of this Agreement, and shall include but not be limited to any claims arising:

3.5.1 By reason of any Service client's suffering personal injury, death, or property loss or damages either while participating in or receiving from Sanford the Services to be furnished by Sanford under this Agreement, or while on

premises owned, leased or operated by Sanford, or while being transported to or from said premises in any vehicle owned, operated, chartered, or otherwise contracted for by Sanford when the cause of such injury or loss is due to Sanford's negligent or intentional acts; or

3.5.2 By reason of any Service client's causing injury to, or damage to, the property of another person during any time when Sanford or its assign, or employee thereof has undertaken or is furnishing the care and Service called for under this Agreement when the cause of such injury or loss is due to Sanford's negligent or intentional acts.

3.6 Bonding – Sanford shall obtain and maintain at all times during the term of this Agreement, a fidelity bond covering the activity of its personnel authorized to receive or distribute monies. Such bond shall be in the amount of not less than $100,000.

3.7 Confidential information – Both Sanford and Agency agree that all information with respect to the operations and business of the other party gained during the negotiations leading up to this Agreement, and from the performance of the Agreement, will be held in confidence and will not be divulged to any unauthorized person without prior written consent of the other, except for access required by law regulation, and third party reimbursement agreements.

3.8 HIPAA and HITECH - Sanford agrees that it is a "covered entity" as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, and is in compliance with privacy regulations, 45 C.F.R. § 165.500, et seq. ("Privacy Regulations") and all requirements with respect to individual identifying health information (IIHI) as defined in HIPAA. Use and disclosure of IIHI will require that all IIHI be: appropriately safeguarded; misuse appropriately reported; satisfactory assurances from any subcontractor(s) secured; individuals granted access and ability to amend their IIHI; accounting of disclosure made available; and applicable records released to the Agency or Department of Human Services. The provisions of this paragraph shall survive the termination of this Agreement.

3.9 Equal employment opportunity, civil rights, and nondiscrimination - (When applicable) Sanford agrees to comply with the Civil Rights Act of 1964, Title VII (423 USC 2000e), including Executive Order No. 11246, and Title VI (42 USC 200d); and the Rehabilitation Act of 1973, as amended by Section 504; (When applicable) Sanford certifies that it has received a certificate of compliance from the Commissioner of Human Rights pursuant to Minnesota Statutes, section 363.073 (1982).

3.10 Fair hearing and grievance procedures – Agency agrees to provide for a fair hearing and grievance procedure in conformance with Minnesota Statues, section 256.045, and in conjunction with the fair Hearing and Grievance Procedures established by administrative rules of the State Department of Human Services.

3.11 Distinction of entities – This Agreement shall not be construed in any manner to make Sanford personnel employees of Agency. Agency shall not be responsible for

withholding of any taxes related to the contracting with Sanford, including, but not limited to, State and Federal income tax and FICA taxes. Agency shall not be responsible for worker's compensation benefits, unemployment compensation premiums, or any other benefits or obligations either required by law or provided by Agency to its own employees. Sanford is an independent contractor with respect to Agency.

3.12 Staff selection and management - Sanford agrees to furnish Agency with personnel who have the academic preparation, personal qualities, skills, licensure and experience necessary to meet relevant requirements and provide high quality Services to eligible residents in Agency's jurisdiction. Selection of staff that will complete each Service covered under this Agreement is under Sanford's discretion and may change throughout the Agreement term as needs dictate. Sanford will provide administrative and clinical supervision as necessary for personnel providing Services under this Agreement and assumes full responsibility for their conduct. Clinical supervision will be provided by a mental health professional.

3.13 Subcontracting – Sanford may enter into subcontracts for any of the Services covered by this Agreement upon providing written notice to Agency. All subcontracts shall be subject to the requirements of this Agreement.

3.14 Audit and record disclosures – Sanford shall:

3.14.1 Allow the personnel of Agency, the Minnesota Department of Human Services, and the Department of Health and Human Services, or their designee, access to Sanford's facility and records at reasonable hours and upon reasonable notice to exercise their responsibility to monitor purchased Services.

3.14.2 Maintain all records pertaining to this Agreement (program and fiscal) for four years for audit purposes.

3.14.3 Comply with policies of the Minnesota Department of Human Services regarding social services recording and monitoring procedures, as defined in the Department of Human Services Social Services Manual, and the administrative rules of the State agency.

3.14.4 Make the results of any audits conducted by Sanford, insofar as they pertain to Services covered by this Agreement, available to the Agency at the latter's request.

3.15 Conditions for termination

3.15.1 Medicare and Medicaid eligibility – Sanford certifies as of the execution of this Agreement and continuing through the term of this Agreement, that neither it, its member, nor employed physicians performing services under this Agreement have been excluded from participation in any federal or state Medicare, Medicaid, or other third party payor program, nor is any such action pending. Sanford shall notify Agency as soon as reasonably possible if such

action is threatened or proposed. If at any time Sanford, its member or employed physicians performing services under this Agreement have been excluded, as described above, then Agency may immediately terminate this Agreement.

3.15.2 Statutory changes - It is agreed that the terms and conditions of this Agreement will be changed to reflect any change in and status of any state or federal law, rule, regulation, guideline or safe harbor regulation that has any material impact on either of the parties and of the parties' ability to legally carry out the spirit of the Agreement and their good faith intentions. If such amendments materially change the rights and obligations of the parties hereto, either party may then terminate this Agreement upon written notice of termination which shall be effective on the effective date of the state or federal law, rule, regulation, guideline or safe harbor regulation that necessitated the amendment or the expiration date of the then current term, whichever date is earlier.

3.15.3 Funding changes - The Agency agrees to inform Sanford of any developments which may have a significant bearing on the Agency's ability to provide funds in accord with the amounts and principles contained in this Agreement. Should the Agency be unable to fulfill its financial obligations to Sanford due to specific reductions in federal or state funds, the obligation of both parties shall cease following a 60 day advance notice.

3.15.4 Other – Unless otherwise specified above, either party may terminate this Agreement with or without cause upon sixty (60) days prior written notice to the other party.

3.16 Conditions for modification

3.16.1 Any alterations, variation, modifications, or waivers of provisions of this Agreement will be valid only when they have been reduced to writing, and duly signed.

3.16.2 Unless otherwise specified above, if Sanford is unable to or going to be unable to provide the required quality or quantity of Services it must notify Agency thirty (30) days before the service line is discontinued.

3.17 General terms

3.17.1 No waiver by either party or any term or provision of this Agreement shall be deemed to be a waiver of any other term or provision.

3.17.2 If any term or provision of this Agreement is now or hereafter determined to be invalid or unenforceable, such determination shall not impair the validity of the remainder of this Agreement.

3.17.3 The terms and provisions hereof shall be binding on and inure to the benefit of the successors and permitted assigns of the parties hereto.

3.17.4 This Agreement shall be construed in accordance with the laws of the State of Minnesota.

3.17.5 The Agreement is not assignable by either party without the prior written consent of the other party.

3.17.6 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 relating to the subject matter hereof.

Pennington County Human Services

By: _____

Its: _____

Date: _____

Sanford Health Network North

By: _____

Its: _____

Date: _____

Reviewed and Approved:

By: _____

Pennington County Attorney

Date: _____

PURCHASE OF SERVICES AGREEMENT

THIS AGREEMENT is made for the period January 1, 2023, to December 31, 2023, between Sanford Health Network North dba Sanford Behavioral Health Center ("Sanford") and the Pennington County Human Services ("Agency").

WHEREAS, Sanford provides a variety of behavioral health services, collectively "the Services"; and

WHEREAS, the Agency wishes to purchase the Services from Sanford.

NOW THEREFORE, in consideration of the covenants herein contained, the parties hereto have entered into this Agreement under the terms and conditions set forth below:

Agency hereby contracts with Sanford, and Sanford agrees to provide the Services to the Agency pursuant to the terms of this Agreement.

1 Northern Lights (Intensive Residential Treatment (IRTS) and Residential Crisis Stabilization (CS))

1.1 Sanford has the necessary resources and is fully capable of providing Intensive Residential Treatment Services and Residential Crisis Stabilization Services. This contract fulfills the Medical Assistance program requirements by establishing a relationship between Agency and Sanford. Further, this contract serves as a host county contract for other Agencies wishing to purchase the services covered under this section.

1.2 Program services

1.2.1 Intensive Residential Treatment Services (IRTS) (MS 256B.0622 § 2(b)) include: client supervision and direction, individualized assessment and treatment planning, living skills development, illness management and recovery, integrated dual diagnosis treatment, family education, crisis assistance, development of health care directives and crisis prevention plans, nursing services, inter-agency case coordination, and client transition and discharge planning.

1.2.2 Residential Crisis Stabilization Services (MS 256B.0624 § 2(e)) include: recipient supervision and direction, crisis relapse recovery and prevention planning services, illness management and recovery services, recipient supervision and direction, individualized crisis assessment and stabilization, treatment and discharge planning, supportive and short-term problem-solving counseling, medication monitoring, skills training, collaboration and coordination with other agencies, providers, family members and significant others in the community, and referral and linkage services to other needed continuing services.

1.3 Adherence to Regulations and MA Requirements – Sanford must:

1.3.1 Maintain a Rule 36 license, including applying and being approved for the variance developed by the Department which includes the applicable requirements contained in Minnesota Statutes 256B.0622 and Minnesota Rules 9520.0500 to 9520.0630.

1.3.2 Enroll as a Medical Assistance provider and comply with Medical Assistance policies and procedures.

1.3.3 Ensure that any adult requesting or receiving Intensive Residential Treatment Services is informed of their appeal rights under MS 245.477.

1.4 Daily Rates

1.4.1 Program Services - The daily rate for Intensive Residential Treatment Services and Crisis Stabilization will be the approved Medicaid rate established by the Minnesota Department of Human Services.

1.4.2 Room and Board - The room and board rate for the facility is based upon the Integrated Behavioral Health Care Room and Board rate established by the Department of Human Services.

2 Miscellaneous

2.1 Additional Sanford commitments – Sanford shall:

2.1.1 Inform Agency of any developments which may have a significant bearing on Sanford's ability to deliver any of the Services covered by this Agreement.

2.1.2 Charge fees for Services which do not unreasonably exceed the actual cost of providing such Services.

2.1.3 Provide Services in a manner consistent with sound business/medical practice and in compliance with Sanford's policies and procedures, including any compliance programs and business conduct codes.

2.1.4 Reasonably cooperate with Agency in attempting to maximize the Agency's opportunity to make use of non-Agency sources of funding.

2.1.5 Not do any work nor furnish any material not covered by this Agreement on behalf of Agency unless it is approved in writing by the Agency.

2.2 Additional Agency commitments – Agency shall:

2.2.1 Where Services provided by Sanford cannot be billed within the current Agreement period, Sanford will bill the Agency and the Agency agrees to remit funding for those Services from the following Agreement period's funds.

2.3 General liability insurance - Sanford will at all times during the term of this Agreement have and keep in force a general liability insurance policy in the amount of

one million dollars ($1,000,000) for bodily injury or property damage to any one person and three million dollars ($3,000,000) for total injuries or damages arising from any one occurrence.

2.4 Professional liability insurance - Sanford must also maintain professional liability insurance with a minimum aggregate amount of one million dollars ($1,000,000).

2.5 Indemnity – Sanford and Agency agree to indemnify and hold each other harmless against any and all cost, damage, expense, claim, liability, civil fine and penalty, including (but not limited to) court costs and reasonable attorneys' fees incurred by the other party arising out of or in connection with that party's negligence or failure to comply with all such laws, ordinances, rules and regulations. The indemnity provisions set forth in this section shall survive the expiration or early termination of this Agreement, and shall include but not be limited to any claims arising:

2.5.1 By reason of any Service client's suffering personal injury, death, or property loss or damages either while participating in or receiving from Sanford the Services to be furnished by Sanford under this Agreement, or while on premises owned, leased or operated by Sanford, or while being transported to or from said premises in any vehicle owned, operated, chartered, or otherwise contracted for by Sanford when the cause of such injury or loss is due to Sanford's negligent or intentional acts; or

2.5.2 By reason of any Service client's causing injury to, or damage to, the property of another person during any time when Sanford or its assign, or employee thereof has undertaken or is furnishing the care and Service called for under this Agreement when the cause of such injury or loss is due to Sanford's negligent or intentional acts.

2.6 Bonding – Sanford shall obtain and maintain at all times during the term of this Agreement, a fidelity bond covering the activity of its personnel authorized to receive or distribute monies. Such bond shall be in the amount of not less than $100,000.

2.7 Confidential information – Both Sanford and Agency agree that all information with respect to the operations and business of the other party gained during the negotiations leading up to this Agreement, and from the performance of the Agreement, will be held in confidence and will not be divulged to any unauthorized person without prior written consent of the other, except for access required by law regulation, and third party reimbursement agreements.

2.8 HIPAA and HITECH - Sanford agrees that it is a "covered entity" as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, and is in compliance with privacy regulations, 45 C.F.R. § 165.500, et seq. ("Privacy Regulations") and all requirements with respect to individual identifying health information (IIHI) as defined in HIPAA. Use and disclosure of IIHI will require that all IIHI be: appropriately safeguarded; misuse appropriately reported; satisfactory assurances from any subcontractor(s) secured; individuals granted access and ability to amend their IIHI; accounting of disclosure made available; and applicable records

released to the Agency or Department of Human Services. The provisions of this paragraph shall survive the termination of this Agreement.

2.9 Equal employment opportunity, civil rights, and nondiscrimination - (When applicable) Sanford agrees to comply with the Civil Rights Act of 1964, Title VII (423 USC 2000e), including Executive Order No. 11246, and Title VI (42 USC 200d); and the Rehabilitation Act of 1973, as amended by Section 504; (When applicable) Sanford certifies that it has received a certificate of compliance from the Commissioner of Human Rights pursuant to Minnesota Statutes, section 363.073 (1982).

2.10 Fair hearing and grievance procedures – Agency agrees to provide for a fair hearing and grievance procedure in conformance with Minnesota Statues, section 256.045, and in conjunction with the fair Hearing and Grievance Procedures established by administrative rules of the State Department of Human Services.

2.11 Distinction of entities – This Agreement shall not be construed in any manner to make Sanford personnel employees of Agency. Agency shall not be responsible for withholding of any taxes related to the contracting with Sanford, including, but not limited to, State and Federal income tax and FICA taxes. Agency shall not be responsible for worker's compensation benefits, unemployment compensation premiums, or any other benefits or obligations either required by law or provided by Agency to its own employees. Sanford is an independent contractor with respect to Agency.

2.12 Staff selection and management - Sanford agrees to furnish Agency with personnel who have the academic preparation, personal qualities, skills, licensure and experience necessary to meet relevant requirements and provide high quality Services to eligible residents in Agency's jurisdiction. Selection of staff that will complete each Service covered under this Agreement is under Sanford's discretion and may change throughout the Agreement term as needs dictate. Sanford will provide administrative and clinical supervision as necessary for personnel providing Services under this Agreement and assumes full responsibility for their conduct. Clinical supervision will be provided by a mental health professional.

2.13 Subcontracting – Sanford may enter into subcontracts for any of the Services covered by this Agreement upon providing written notice to Agency. All subcontracts shall be subject to the requirements of this Agreement.

2.14 Audit and record disclosures – Sanford shall:

2.14.1 Allow the personnel of Agency, the Minnesota Department of Human Services, and the Department of Health and Human Services, or their designee, access to Sanford's facility and records at reasonable hours and upon reasonable notice to exercise their responsibility to monitor purchased Services.

2.14.2 Maintain all records pertaining to this Agreement (program and fiscal) for four years for audit purposes.

2.14.3 Comply with policies of the Minnesota Department of Human Services regarding social services recording and monitoring procedures, as defined in the Department of Human Services Social Services Manual, and the administrative rules of the State agency.

2.14.4 Make the results of any audits conducted by Sanford, insofar as they pertain to Services covered by this Agreement, available to the Agency at the latter's request.

2.15 Conditions for termination

2.15.1 Medicare and Medicaid eligibility – Sanford certifies as of the execution of this Agreement and continuing through the term of this Agreement, that neither it, its member, nor employed physicians providing services under this Agreement have been excluded from participation in any federal or state Medicare, Medicaid, or other third party payor program, nor is any such action pending. Sanford shall notify Agency as soon as reasonably possible if such action is threatened or proposed. If at any time Sanford, its member or employed physicians providing services under this Agreement have been excluded, as described above, then Agency may immediately terminate this Agreement.

2.15.2 Statutory changes - It is agreed that the terms and conditions of this Agreement will be changed to reflect any change in and status of any state or federal law, rule, regulation, guideline or safe harbor regulation that has any material impact on either of the parties and of the parties' ability to legally carry out the spirit of the Agreement and their good faith intentions. If such amendments materially change the rights and obligations of the parties hereto, either party may then terminate this Agreement upon written notice of termination which shall be effective on the effective date of the state or federal law, rule, regulation, guideline or safe harbor regulation that necessitated the amendment or the expiration date of the then current term, whichever date is earlier.

2.15.3 Funding changes - The Agency agrees to inform Sanford of any developments which may have a significant bearing on the Agency's ability to provide funds in accord with the amounts and principles contained in this Agreement. Should the Agency be unable to fulfill its financial obligations to Sanford due to specific reductions in federal or state funds, the obligation of both parties shall cease following a 60 day advance notice.

2.15.4 Other – Unless otherwise specified above, either party may terminate this Agreement with or without cause upon sixty (60) days prior written notice to the other party.

2.16 Conditions for modification

2.16.1 Any alterations, variation, modifications, or waivers of provisions of this Agreement will be valid only when they have been reduced to writing, and duly signed.

2.16.2 Unless otherwise specified above, if Sanford is unable to or going to be unable to provide the required quality or quantity of Services it must notify Agency thirty (30) days before the service line is discontinued.

2.17 General terms

2.17.1 No waiver by either party or any term or provision of this Agreement shall be deemed to be a waiver of any other term or provision.

2.17.2 If any term or provision of this Agreement is now or hereafter determined to be invalid or unenforceable, such determination shall not impair the validity of the remainder of this Agreement.

2.17.3 The terms and provisions hereof shall be binding on and inure to the benefit of the successors and permitted assigns of the parties hereto.

2.17.4 This Agreement shall be construed in accordance with the laws of the State of Minnesota.

2.17.5 The Agreement is not assignable by either party without the prior written consent of the other party.

2.17.6 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 relating to the subject matter hereof.

Pennington County Human Services

By: _____

Its: _____

Date: _____

Sanford Health Network North

By: _____

Its: _____

Date: _____

Reviewed and Approved:

By: _____

Pennington County Attorney

Date: _____

PROVIDER PARTICIPATION AGREEMENT

by and between

UCARE MINNESOTA

and

PENNINGTON COUNTY HUMAN 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 **Pennington County Human Services** ("Participant"), (each a "Party" and collectively, the "Parties") and shall be effective as of January 1, 2023 (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	**Pennington County Human Services** 318 Knight Ave N PO Box 340 Thief River Falls, MN 56701
_____	_____
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

- Qualified Health Plan Products, including but not limited to:
  - UCare Individual & Family Plans

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EXHIBIT B
to the
PROVIDER PARTICIPATION AGREEMENT

SERVICES PROVIDED UNDER THIS AGREEMENT

Care Coordination

Mental Health Services (including Targeted Case Management Services)

Substance Use Disorder Services (including Comprehensive Assessments, Rule 25)

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EXHIBIT C
to the
PROVIDER PARTICIPATION AGREEMENT

SITE LISTING

Practice Name and Address	Fed ID / NPI	Billing Name and Address
Pennington County Human Services 318 Knight Ave N PO Box 340 Thief River Falls, MN 56701 Phone: 218-681-2880 Practice County: Pennington	Tax ID #: 416005862 NPI #: 1649594425	Pennington County Human Services 318 Knight Ave N PO Box 340 Thief River Falls, MN 56701

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EXHIBIT D
to the
PROVIDER PARTICIPATION AGREEMENT

DELEGATED CARE COORDINATION SERVICES

REIMBURSEMENT SCHEDULE

UCare shall reimburse Participant for Covered Services provided to Enrollees (also referred to as Members) 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	$185 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	$25 Per Member Per Month (PMPM)
	Enrollee unable to be reached by Participant	$25 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.	$185 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: **Pennington County**

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.

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EXHIBIT D1
to the
PROVIDER PARTICIPATION AGREEMENT

UCARE SPECIAL NEEDS BASIC CARE (SNBC) CARE COORDINATION BONUS PROGRAM

The UCare Special Needs Basic Care (SNBC) Care Coordination Bonus Program (hereinafter "Program") is a value-based agreement that will reward Participant for increasing the percentage of assigned Enrollees (also referred to as Members) open to Care Coordination.

Term of the Program: The term of the Program shall begin January 1, 2023 and shall continue until terminated by either party. In the event the Participation Agreement between UCare and Participant terminates, these provisions will also terminate.

UCare Product Membership under this Program:

- Minnesota Special Needs Basic Care, dually eligible, integrated
- Minnesota Special Needs Basic Care

Member Attribution Method: Enrollees eligible for the Program will be identified on the monthly enrollment roster provided to Participant by UCare.

Value Based Bonus Calculation and Payment:

- Participant will be eligible to receive a bonus payment based on the Engagement Rate for eligible Enrollees, by county. Engagement Rate will be calculated as follows:

  Denominator: Total Number of Enrollees assigned to Participant, by county
  Numerator: Total Number of Enrollees open to Care Coordination, by county

  - UCare will determine the Number of Enrollees open to Care Coordination using the Health Status Code reported to UCare by Participant via the Monthly Activity Log. For the purposes of this Program, members in Health Status Codes HP and GH are considered open to Care Coordination. UCare reserves the right to modify such Health Status Codes, upon notification to Participant.

  - Engagement Rate calculations will not be separated by SNBC product.

- Bonus payment amount will be calculated by multiplying the specified dollar amount per Incremental Member, by the number of Incremental Members, based on the Engagement Rate threshold attained by Participant, as outlined in the table below.

  - Incremental Members are defined as the number of additional members that need to be opened to Care Coordination, in order for Participant to reach the next Engagement Rate threshold.

Engagement Rate Threshold	35% of eligible members open to Care Coordination	50% of eligible members open to Care Coordination	65% of eligible members Open to Care Coordination	80% of eligible members Open to Care Coordination
Bonus Payment (per Incremental Member)	$300	$300	$300	$300

- For the entire term of the Program, only one bonus payment will be issued per Engagement Rate threshold, per county.
- UCare reserves the right to increase bonus payments and/or reduce percentages, upon written notice to Participant.
- Engagement Rate will be calculated in January, April, July and October of each year, using the enrollment rosters and activity logs produced/returned that month. Any bonus payment earned will be issued the month following the calculation (i.e., February, May, August, and November).

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EXHIBIT D2
to the
PROVIDER PARTICIPATION AGREEMENT

CARE COORDINATION SERVICES

REIMBURSEMENT SCHEDULE

UCare shall reimburse Participant for Covered Services provided to Enrollees (also referred to as Members) according to the following schedule:

Product	**Reimbursement**
Minnesota Senior Health Options (MSHO) Care Coordination 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 $ 151.00 Per Member Per Month (PMPM) Community Based, with EW Services $ 159.00 Per Member Per Month (PMPM) Institutional $ 78.00 Per Member Per Month (PMPM)
Initial Health Risk Assessment	$ 180.00

Product	**Reimbursement**
Minnesota Senior Care Plus (MSC+) Care Coordination 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 $ 78.00 Per Member Per Month (PMPM) Community Based, with EW Services $ 109.00 Per Member Per Month (PMPM) Institutional $ 78.00 Per Member Per Month (PMPM)
Initial Health Risk Assessment	$ 180.00

UCare will make payment only for eligible Enrollees.

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.

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

Scope of Services. Participant will perform services according to the provider manual, case management manual, care coordination grids and 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

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EXHIBIT D3
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	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

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.			
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:	Not Applicable	Not Applicable	Not Applicable

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.			
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(s):
Qualified Health Plan Products, including but not limited to:

- UCare Individual & Family Plans

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	100% of the UCare Standard fee schedule	50% of eligible billed charges	Not Applicable

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.			

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 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
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

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Products:

Qualified Health Plan Products, including but not limited to:

- UCare Individual & Family Plans

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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Pennington County Human Services
Income Maintenance Unit
2022 Active Cases by Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cash												
MFIP	39	41	40	39	36	37	36	37	37	38	39	
DWP	0	0	0	0	0	0	0	1	4	5	5	
GA	35	32	37	39	38	37	38	35	41	43	38	
GRH	51	51	52	54	55	56	57	56	54	51	48	
MSA	52	50	48	49	47	45	48	49	52	51	52	
EA	0	0	0	0	0	4	0	3	2	3	2	
EGA	1	0	0	0	0	0	0	0	1	0	0	
TOTAL	**178**	**174**	**177**	**181**	**176**	**179**	**179**	**181**	**191**	**191**	**184**	**0**
Food												
SNAP	545	541	543	539	536	539	528	548	562	579	575	
TOTAL	**545**	**541**	**543**	**539**	**536**	**539**	**528**	**548**	**562**	**579**	**575**	**0**
Health Care												
MA (MAXIS)	527	532	531	535	534	543	544	543	547	553	551	
IMD	5	5	5	5	5	5	5	5	5	5	5	
QMB	244	246	247	247	247	246	253	252	259	257	259	
SLMB	57	59	58	60	58	60	60	61	57	61	58	
QI-1	18	19	18	17	18	18	18	18	18	18	18	
MA (METS/MNsure)	1002	1017	1020	1026	1,032	1,031	1041	1047	1079	1084	1084	
MCRE (METS)	56	64	66	67	66	66	66	66	63	62	58	
TOTAL	**1,909**	**1,942**	**1,945**	**1,957**	**1,960**	**1,969**	**1,987**	**1,992**	**2,028**	**2,040**	**2,033**	**0**
Total Active Programs												
	2,632	**2,657**	**2,665**	**2,677**	**2,672**	**2,687**	**2,694**	**2,721**	**2,781**	**2,810**	**2,792**	**0**
Total Active Cases												
	1,992	**2,024**	**2,025**	**2,026**	**2,034**	**2,040**	**2,055**	**2,070**	**2,125**	**2,146**	**2,131**	**0**

Pennington County Human Services
Income Maintenance Unit
Active Cases by Program
Nov-22

Cash	# Cases	## in HH	# Adults	# Children	
MFIP	39	94	33	61	Minnesota Family Investment Program
DWP	5	18	6	12	Diversionary Work Program
GA	38	38	38	0	General Assistance
GRH	48	48	48	0	Group Residential Housing
MSA	52	52	52	0	Minnesota Supplement Aid
EA	2	7	2	5	Emergency Assistance
EGA	0	0	0	0	Emergency General Assistance
TOTAL	**184**	257	179	78	

Food					
SNAP	575	,058	667	391	Supplemental Nutrition Assistance Program
TOTAL	**575**				

Health Care					
MA (MAXIS)	551	562	458	104	Medical Assistance
IMD	5	5	5	0	Institute for Mental Disease
QMB	259	260	259	1	Qualified Medicare Beneficiary (Medicare Savings Program)
SLMB	58	61	61	0	Service Limited Medicare Beneficiary (Medicare Savings Program)
QI-1	18	21	21	0	QI-1 (Medicare Savings Program)
MA (METS/MNsure)	1,084				Medical Assistance (as of 11/6/2022
MCRE (METS)	58				MinnesotaCare (as of 11/6/2022
TOTAL	**2,033**	909	804	105	

TOTAL ACTIVE PROGRAMS:	**2,792**
TOTAL ACTIVE CASES:	**2,131**

Pennington County Human Services
Out Of Home Placement Costs
Year Ending December 31, 2022 & 2021

SS ss

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD	YTD 2021	Change
Expense															
Foster Care	13,569.61	13,572.11	23,485.54	12,341.42	13,533.23	20,574.68	16,978.75	16,809.44	14,812.71	25,661.57	17,868.40	-	**189,207.46**	150,806.97	25.5%
Rule 4	-	-	10,719.42	2,449.44	5,691.40	8,108.44	4,002.00	4,256.00	1,271.00	15,306.00	6,014.00		**57,817.70**	-	
Rule 8	-	-	-	-	-	-	-	-	-	-	-	-	**-**	-	
Rule 5	-	-	-	-	-	-	-	-	-	-	-	-	**-**	1,062.04	-100.0%
Corrections	16,531.00	5,173.00	12,769.00	15,149.00	31,967.80	16,562.00	20,854.00	-	56,588.28	12,174.00	51,456.00	-	**239,224.08**	256,694.78	-6.8%
Adoption Aid	-	-	-	-	-	-	-	-	-	-	-	-	**-**	-	
Totals	**30,100.61**	**18,745.11**	**46,973.96**	**29,939.86**	**51,192.43**	**45,245.12**	**41,834.75**	**21,065.44**	**72,671.99**	**53,141.57**	**75,338.40**	**-**	**486,249.24**	**408,563.79**	**19.0%**
Revenue															
Reimburse	-	-	-	-	-	-	-	-	-	-	-	-	**-**	10.89	-100.0%
MH Recovery	-	-	19,374.40	4,471.02	7,451.69	10,929.16	5,961.36	6,458.13	5,464.58	9,485.42	14,780.36	-	**84,376.12**	63,987.44	31.9%
4E Recovery	-	-	-	-	4,082.00	-	-	-	-	18,145.00	36,914.00	-	**59,141.00**	5,245.00	1027.6%
NFC Settlement	-	127.37	100.07	-	20,779.00	15,017.00	-	-	-	7,596.00	-	-	**43,619.44**	25,754.00	69.4%
Totals	**-**	**127.37**	**19,474.47**	**4,471.02**	**32,312.69**	**25,946.16**	**5,961.36**	**6,458.13**	**5,464.58**	**35,226.42**	**51,694.36**	**-**	**187,136.56**	**94,997.33**	**97.0%**
														-	
Net Expense	**30,100.61**	**18,617.74**	**27,499.49**	**25,468.84**	**18,879.74**	**19,298.96**	**35,873.39**	**14,607.31**	**67,207.41**	**17,915.15**	**23,644.04**	**-**	**299,112.68**	**313,566.46**	**-4.61%**
2020 Totals	**34,219.98**	**10,302.40**	**44,553.50**	**16,609.54**	**39,683.65**	**5,826.50**	**13,780.89**	**64,202.74**	**45,053.18**	**16,563.13**	**22,770.95**	**26,938.13**			
YTD Change	**(4,119.37)**	**4,195.97**	**(12,858.04)**	**(3,998.74)**	**(24,802.65)**	**(11,330.19)**	**10,762.31**	**(38,833.12)**	**(16,678.89)**	**(15,326.87)**	**(14,453.78)**	**(41,391.91)**			

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
Expense													
Foster Care	9,692.77	8,333.69	11,414.65	10,466.25	11,317.63	11,421.21	19,884.21	22,525.23	13,538.77	17,626.96	14,585.60	12,936.99	**163,743.96**
Rule 4	-	-	-	-	-	-	-	-	-	-	-		**-**
Rule 8	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Rule 5	1,062.04	-	-	-	-	-	-	-	-	-	-	-	**1,062.04**
Corrections	27,294.00	5,689.98	40,768.00	11,738.00	37,521.00	-	-	65,128.51	31,514.41	23,591.88	13,449.00	14,154.39	**270,849.17**
Adoption Aid	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Totals	**38,048.81**	**14,023.67**	**52,182.65**	**22,204.25**	**48,838.63**	**11,421.21**	**19,884.21**	**87,653.74**	**45,053.18**	**41,218.84**	**28,034.60**	**27,091.38**	**435,655.17**
Revenue													
Reimburse	-	-	-	-	-	-	-	-	-	10.89	-	153.25	**164.14**
MH Recovery	1,525.83	3,560.27	7,629.15	5,594.71	9,154.98	5,594.71	6,103.32	-	-	24,644.82	179.65	-	**63,987.44**
4E Recovery	-	161.00	-	-	-	-	-	-	-	-	5,084.00	-	**5,245.00**
NFC Settlement	2,303.00	-	-	-	-	-	-	23,451.00	-	-	-	-	**25,754.00**
Totals	**3,828.83**	**3,721.27**	**7,629.15**	**5,594.71**	**9,154.98**	**5,594.71**	**6,103.32**	**23,451.00**	**-**	**24,655.71**	**5,263.65**	**153.25**	**95,150.58**
												-	
Net Expense	**34,219.98**	**10,302.40**	**44,553.50**	**16,609.54**	**39,683.65**	**5,826.50**	**13,780.89**	**64,202.74**	**45,053.18**	**16,563.13**	**22,770.95**	**26,938.13**	**340,504.59**

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1176.53
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1002
1217.1
1431.9
1324.5
84.88
1109.4
1273.2
358.53
259.02
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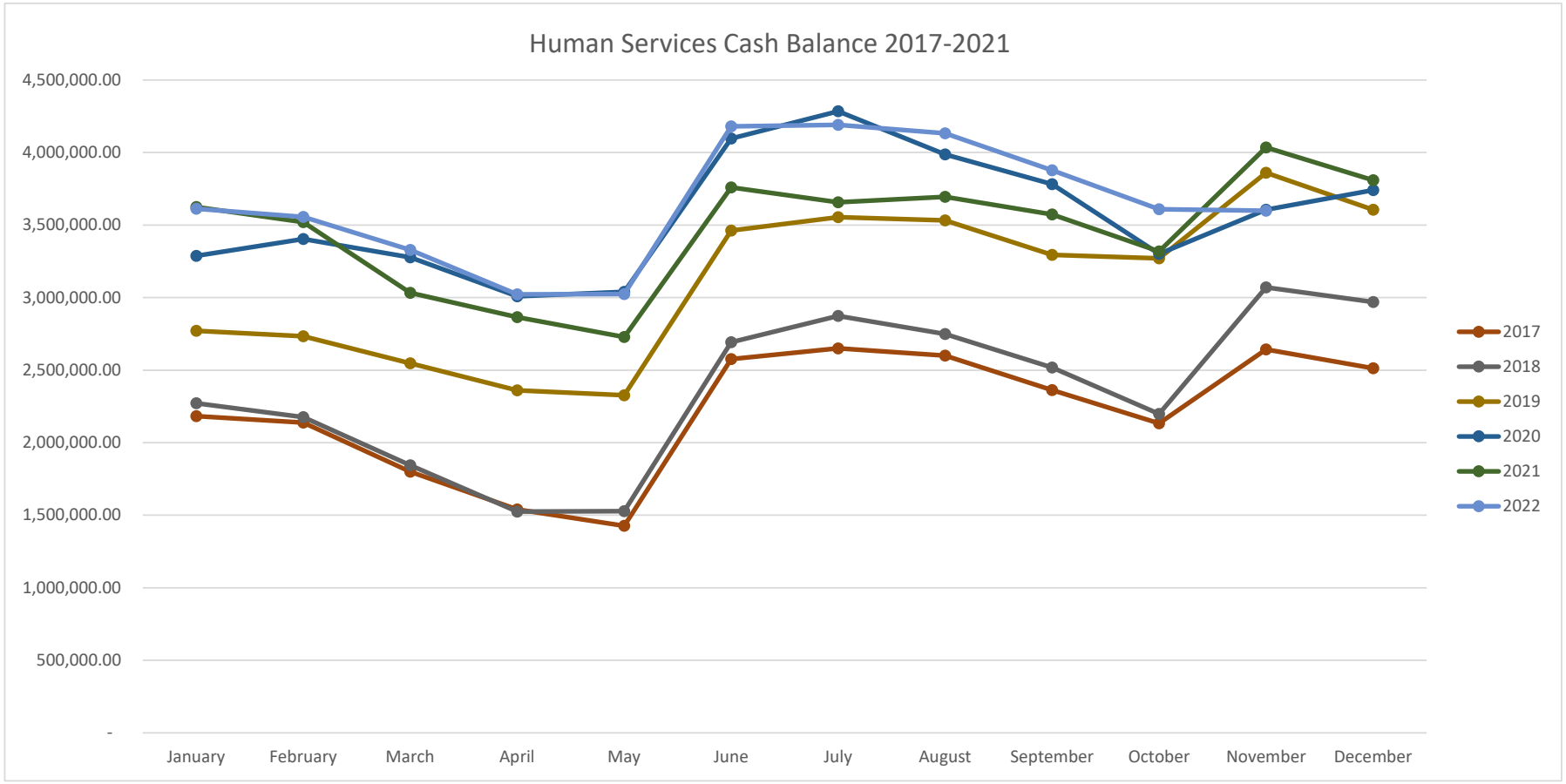
259.02
358.53
259.02

Human Service's Month End Balance

	2015	2016	2017	2018	2019	2020	2021	2022	% of Budget
January	1,647,300.14	1,814,014.90	2,182,630.66	2,271,729.26	2,772,063.80	3,288,028.76	3,624,301.56	3,612,634.01	65.45%
February	1,618,976.04	1,801,985.24	2,138,616.83	2,176,762.19	2,732,919.27	3,403,266.76	3,521,041.97	3,555,431.44	64.41%
March	1,375,360.09	1,655,070.89	1,800,227.71	1,844,672.30	2,547,429.81	3,277,046.86	3,033,593.35	3,329,525.51	60.32%
April	1,088,964.93	1,347,248.60	1,539,707.40	1,525,256.03	2,361,226.50	3,009,330.45	2,865,586.09	3,022,501.53	54.76%
May	961,748.47	1,294,231.42	1,426,858.37	1,528,544.15	2,327,158.79	3,038,957.98	2,728,273.46	3,023,675.98	54.78%
June	1,932,135.73	2,330,176.40	2,576,374.42	2,692,513.93	3,462,928.17	4,095,797.92	3,759,448.23	4,180,077.80	75.73%
July	2,047,715.90	2,367,725.88	2,650,496.79	2,874,408.12	3,554,336.75	4,284,273.43	3,656,785.80	4,190,786.57	75.92%
August	2,097,897.09	2,427,610.70	2,600,332.14	2,749,859.99	3,531,954.80	3,987,655.57	3,694,899.51	4,132,301.59	74.86%
September	1,844,296.27	2,121,578.06	2,362,913.96	2,518,750.84	3,294,188.08	3,781,078.10	3,573,442.34	3,878,451.23	70.26%
October	1,492,630.60	1,866,987.16	2,133,041.74	2,198,557.64	3,270,530.55	3,301,898.06	3,318,688.76	3,609,060.10	65.38%
November	2,213,985.52	2,638,930.35	2,642,643.71	3,070,756.97	3,860,836.73	3,606,171.73	4,035,310.35	3,599,570.32	65.21%
December	2,083,484.81	2,395,704.36	2,513,770.14	2,970,003.64	3,606,171.73	3,741,217.85	3,808,445.10		0.00%

Expense Budget 5,519,935.00


Human Services Cash Balance 2017-2021
4,500,000.00
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January
February
March
April
May
June
July
August
September
October
November
December
2017
2018
2019
2020
2021
2022

Pennington County Human Services
Emergency Assistance/Emergency General Assistance
Emergency Requests Related to Potential Evictions/Housing and Utilities
November-22

Approvals

Eligibility Worker	File Date	Case	Request	Employment Status	Number of Children	Amount and Purpose	Agency Action	Date of Action
X157550	11/17/2022	2487388	Rent - 1st month	Part-time	4	$411.71 rent, 1/2 month prorated rent for 11/22	Approved $411.71, vendor payed to landlord Ted Bowen	11/18/2022
X157517	11/28/2022	2523578	Rent -	Part-time	2	rent	approved $720	11/28/2022
TOTAL						EA	$1,371.71	
						EGA	$0.00	

Denials

Eligibility Worker	File Date	Case	Request	Employment Status	Number of Children	Amount and Purpose	Agency Action	Date of Action
x157540	10/5/2022	2539336	Unknown	1 adult - unknown	0	Unknown	EGA Denied - Case pended 30 days, no interview	11/7/2022
x157540	10/25/2022	2529008	Eviction	1 adult - starting employment 11/2022	0	$1,235.00		
x157540	11/2/2022	1756278	Homelessness	1 adult - unemployed	0	Unknown	EGA Denied - Not Cost Effective	11/3/2022
X157540	11/2/2022	2494622	Unknown	1 adult - unemployed	0	Unknown	EGA Denied - No Emergency	11/3/2022
x157540	11/3/2022		Unknown	1 adult - unemployed	0	Unknown		

x157540	11/17/2022	2530567	None	1 adult - employed	0	None	EGA Denied - No Emergency	11/17/2022