Aitkin County Health & Human Services

204 First St. NW
AITKIN, MINNESOTA 56431
PHONE 1-800-328-3744 or 1-218-927-7200 - FAX # 927-7210

DATE: August 21, 2012

TO: Aitkin County Board of Commissioners
Commissioner Wedel
Commissioner Marcotte
Commissioner Napstad
Commissioner Niemi
Commissioner Westerlund
Patrick Wussow, Aitkin County Administrator

FROM: Julie Lueck per Tom Burke, Director

RE: Medica Disclosure of Ownership and Management Information & Exclusions Statement for Providers

I am attaching the supporting documentation for providing specific information from each Aitkin County Commissioner for the Disclosure of Ownership and Management Information & Exclusions Statement for Providers requested by Medica at this time and in anticipation of the same request from UCare, Blue Cross/Blue Shield, Health Partners, South Country, Prime West, and other health insurance providers.

Please complete the following portion of this memo and return it to Julie in the attached envelope marked "Confidential".

Full Legal Name of Commissioner: ______________________________

Home Address of Commissioner: ______________________________

____

Date of Birth of Commissioner: ______________________________

Social Security Number of Commissioner: ______________________________

JAMES P. RATZ
AITKIN COUNTY ATTORNEY
217 SECOND STREET N.W., ROOM 231
AITKIN, MINNESOTA 56431

TELEPHONE (218) 927-7347
TOLL FREE 1-888-422-7347
FAX (218) 927-7365

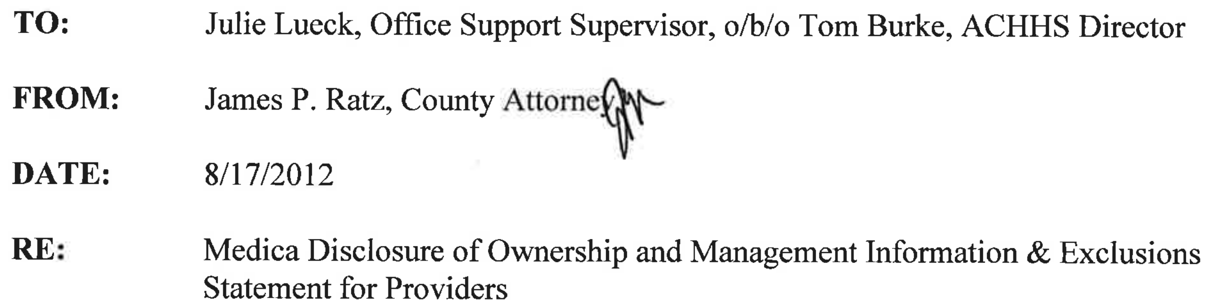
SENIOR ASSISTANT COUNTY ATTORNEY
LISA ROGGENKAMP RAKOTZ

ASSISTANT COUNTY ATTORNEYS
SARAH WINGE
REBECCA A. TRAPP

PARALEGALS
MICHELE J. MOTHERWAY
TAMMY K. SPELDRICH

CRIME VICTIM COORDINATOR
JESSICA L. BROWN
TELEPHONE (218) 927-7446

MEMORANDUM



TO: Julie Lueck, Office Support Supervisor, o/b/o Tom Burke, ACHHS Director

FROM: James P. Ratz, County Attorney

DATE: 8/17/2012

RE: Medica Disclosure of Ownership and Management Information & Exclusions Statement for Providers

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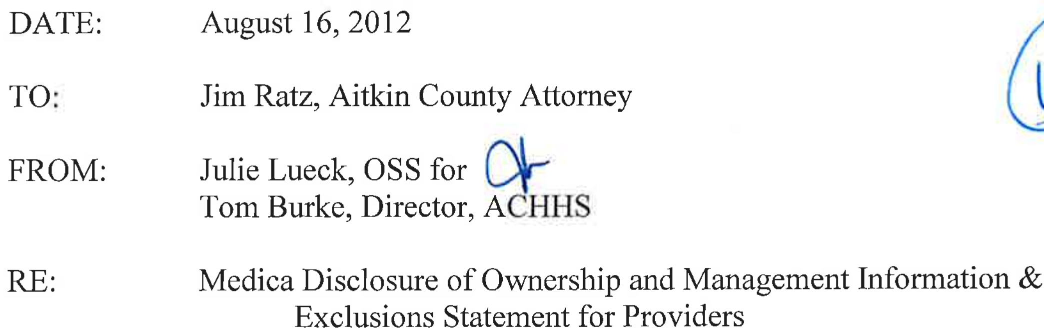
In order to meet and fulfill the requirements of the Minnesota DHS and the Federal Government, I approve and support the submission of the above-referenced documentation to Medica.

Aitkin County Health & Human Services

204 First St. NW
AITKIN, MINNESOTA 56431
PHONE 1-800-328-3744 or 1-218-927-7200 - FAX # 927-7210



DATE: August 16, 2012

TO: Jim Ratz, Aitkin County Attorney

FROM: Julie Lueck, OSS for
Tom Burke, Director, ACHHS

RE: Medica Disclosure of Ownership and Management Information & Exclusions Statement for Providers

I am herewith enclosing the cover letter and the blank Medica Disclosure of Ownership and Management Information & Exclusions Statement for Providers form for your review. I am also enclosing copies of the two completed documents we submitted to Medica in June and August.

All other counties are providing this information to Medica as a requirement by DHS and Federal guidelines, but we are seeking your approval prior to submitting the additional requested information which includes the Social Security Numbers of the County Commissioners.

Please note the following paragraphs we received via e-mail from Joel Christensen, Provider Compliance Specialist in the Law Department at Medica:

"We have received a little over half of the counties disclosure information. As an organization it is my responsibility not to release information of providers to another provider. The requirement that is asked of is for all of our providers in our network and not limited to counties."

"The data elements that are sent to Medica are protected at the highest level of security. The information is only entered by me. There are only two other individuals that would have access to the information that would be my Director and my back-up when I'm out of the office. The information is only used if a match comes up on our monthly sanction report. Otherwise the information is never viewed unless DHS or CMS audits us and you are one of the providers they ask to see."

This form will require that the County Board members provide not only their names, addresses, dates of birth but also their social security numbers.

Please advise us in writing, if we have your approval to submit this information to Medica.

Thanks for your assistance and guidance with this request.

PO Box 9310
Minneapolis, MN 55440-9310

June 27, 2012

Attention: Administrator
Aitkin County Health & Human Services
204 1st St NW
Aitkin, MN 56431

MEDICA®

RE: Medica Health Plans ("Medica"):
1. **Disclosure of Ownership and Management Information & Exclusions Statement for Vendors ("Disclosure Form"); and**
2. **Attestation of Compliance Training and Standards of Conduct ("Attestation")**

Dear Administrator:

This letter pertains to the two above referenced forms. Please review the following information and complete the enclosed forms and **return them to Medica by July 27, 2012.**

1. Disclosure Form. The Minnesota Department of Human Services ("DHS") requires the Disclosure Form to be completed by counties and state agencies in addition to corporations and partnerships. For Counties and State Agencies, individuals such as County Commissioners, County Board Members, Directors or Health Directors are considered persons with ownership or control interest or managing employees. It is being sent to you in accordance with regulatory agency requirements. DHS and the Centers for Medicare & Medicaid Services ("CMS") require Medica to have measures in place to ensure that its subcontractors (also known as first tier and downstream entities): (i) meet certain obligations pertaining to disclosure of ownership and management information; and (ii) check certain lists described below to ensure that items and services are not provided by individuals or entities excluded from participation in government programs. As a result, please complete and submit the enclosed Disclosure Form by the due date noted in this letter. The Disclosure Form includes definitions at the end of the form in Section VII for your reference and to assist you with completion of the form.

Please note that in order to complete the questions in Section V about excluded individuals and entities, you will need to search (1) the General Services Administration ("GSA") Excluded Parties List System (EPLS), *and* (2) either the Office of Inspector General ("OIG") List of Excluded Individuals/Entities ("LEIE") or the Medicare Exclusion Database. Also, please note that CMS and DHS require that those lists be checked *monthly* by you to ensure that no providers, agents, persons with an ownership or control interest, or managing employees are excluded from participation in Medicare, Medicaid or other federally funded government programs. Finally, please keep in mind that you are also required to report to Medica within five days of learning any information regarding individuals or entities specified above that have: (i) been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, Title XX (social services block grants), or Title XXI (child health assistance) in Minnesota or any other state or jurisdiction since the inception of those programs; (ii) been excluded from participation in Medicare or any of the State health care programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (federal fraud and abuse law civil monetary penalty provisions).

Medica® is a registered service mark of Medica Health Plans. "Medica" refers to the family of health plan businesses that includes Medica Health Plans*, Medica Health Plans of Wisconsin, Medica Insurance Company*, Medica Self-Insured*, and Medica Health Management, LLC.
*Accredited by the National Committee for Quality Assurance in the states of MN, ND, SD and WI
An Equal Opportunity Employer
Medica Commercial HMO/POS and Medicaid Plans
SPP1113-50611

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PO Box 9310
Minneapolis, MN 55440-9310

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2. Training and Attestation. CMS requires that Medicare providers complete compliance awareness training and fraud, waste and abuse awareness training at the time of contract and annually thereafter. This training requirement applies to all provider organizations and downstream entities that provide healthcare or administrative services for Medicare-eligible individuals under the Medicare Advantage program, including Medicare Part D. All employees of your organization, and those of any downstream entities, that are involved in the administration or delivery of services to Medicare members, must complete the required training.

Medica's training is available at Medica.com at the Fraud, Waste and Abuse page, or you can choose to administer your own entity's training as long as it meets the CMS requirements. Providers certified through the Medicare program or accredited as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies provider are exempt from Medica's fraud, waste and abuse awareness training, but are still required to complete the annual compliance awareness training and the Attestation form. You can access this training by visiting Medica.com. Scroll to the bottom of the page, click the Fraud & Abuse link, scroll to the section titled "Compliance Awareness and Fraud, Waste and Abuse Awareness Training for Medica Providers and Business Partners" and click on the "Complete the Compliance Awareness Training" and "Complete the Fraud Waste and Abuse Awareness Training" links.

CMS also expects that Medicare providers comply with Standards of Conduct that articulate a commitment to comply with all applicable state and federal standards. Medica's Standards of Conduct and Compliance Reporting policy may be found on Medica.com as described in the preceding paragraph.

Medica expects that you provide written attestation that your organization and any downstream entities are in compliance with the requirements composed by CMS. Please maintain the applicable attestations and any other records of training that have been completed, including documentation of dates and methods of training, the materials used for the training and logs identifying the employees that completed the required training. Medica, CMS, or agents of CMS may request such records to verify that training occurred.

3. Return of Disclosure Form and Attestation. Please complete and return the Disclosure Form and Attestation by July 27 2012 through one of the following means: (a) emailing a scanned copy of the completed and signed forms to providercertifications@medica.com; (b) mailing the forms to Medica Health Plans, Mail Route CP250, P.O. Box 9310, Minneapolis, MN 55440-9310; or (c) faxing the forms to 952-992-8666. If you have any questions, please call 952-992-8638, or send an email to the above email address.

Thank you.

Sincerely,

Glenn Andis
Senior Vice President, Government Programs

Mary Lippert
Vice President, Compliance & Privacy

SPP1113-50611

Medica® is a registered service mark of Medica Health Plans. "Medica" refers to the family of health plan businesses that includes Medica Health Plans*, Medica Health Plans of Wisconsin, Medica Insurance Company*, Medica Self-Insured*, and Medica Health Management, LLC.

*Accredited by the National Committee for Quality Assurance in the states of MN, ND, SD and WI.

An Equal Opportunity Employer

Medica Commercial HMO/POS
and Medicaid Plans

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MEDICA®

Disclosure of Ownership and Management Information & Exclusions Statement for Providers ("Disclosure Form")

I. Instructions

This form must be completed and submitted to Medica. A new disclosure form is required and must be submitted when any information in your original form has changed.

This disclosure form is to be completed to ensure compliance with government program requirements pertaining to: (1) disclosure of ownership and control; and (2) exclusions of individuals and entities from government programs as set forth in your contract with Medica.

The disclosure and exclusion requirements apply to partnerships and both non-profit and for-profit corporations, including without limitation limited liability companies. The requirements also apply to counties and Minnesota state agencies. For Counties and State Agencies, individuals such as County Commissioners, County Board Members, Directors or Health Directors are considered persons with ownership or control interest or managing employees. Section VII (Definitions) clarifies which entities must complete this disclosure form. The definitions also clarify which individuals and entities you must provide information about in the form. The definitions are based on law, regulation, and instructions from regulatory authorities.

Note: For the purposes of this disclosure, the term "Person with an Ownership or Control Interest" is not limited to persons or corporations with an ownership interest. For example, it also includes:
- **(i) senior officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies; and**
- **(ii) partners of a partnership, including without limitation limited liability partnerships.**

See Section VII for a complete definition of "Person with an Ownership or Control Interest" as well as definitions of other key terms such as "Managing Employee," "Provider," and "Agent."

Please complete this disclosure form whether or not you have any information to report. If more space is needed, please attach additional information on a separate page.

For assistance in completing this disclosure form, please reference the Definitions provided under Section VII.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS	DBA (Doing Business As), if applicable		
ADDRESS			NPI/UMPI
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER ( )
FEDERAL EMPLOYER ID (FEIN)	MN TAX ID		

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship ☐ Partnership ☐ Other Partnership (i.e., LP, LLP, LLLP) ☐ Limited Liability Co.

☐ For Profit Corporation ☐ Non-Profit Corporation ☐ County ☐ State ☐ Other ____________

IV. Ownership, Control and Management Information

A. Please provide the following information for each **Managing Employee**, and **Person with an Ownership or Control Interest** in you as a Provider, or in any Subcontractor in which you as a Provider have direct or indirect ownership of 5% or more. For entities with ownership or control interest, include primary business address, every business location, and P.O. Box address. All fields must be completed. The date of birth and social security number (SSN) are required if a *person's* name is provided, and the federal employer identification (FEIN) number is required if an *entity's* name is provided.

No.	Full Legal Name	Address	Date of Birth	SSN or FEIN	% Ownership Interest, if applicable
1					
2					
3					

B. If any Person with an Ownership or Control Interest listed in subsection IV(A) is related to another Person with an Ownership or Control Interest listed in subsection IV(A) as a spouse, parent, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name	SSN	Name of Person Related To	Related Person's SSN	Relationship
1					
2					
3					

C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in an organization other than that indicated in subsection IV(A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	SSN or FEIN	Name of Other Organization	% Ownership Interest
1					
2					
3					

V. Excluded Individuals or Entities

A. Are there any employees, Persons with an Ownership or Control Interest in you as a Provider, or any of your Managing Employees or Agents who are or have ever:

- Been excluded from participation in Medicare or any of the State health care programs?

  ☐ Yes ☐ No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs?

  ☐ Yes ☐ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (that is, federal fraud and abuse law civil monetary penalty provisions)?

  ☐ Yes ☐ No

B. Do you as a Provider have any agreements for the provision of items or services related to Medica's obligations under its contracts with the Minnesota Department of Human Services (DHS) or the Centers for Medicare and Medicaid Services (CMS) with an individual or entity who: (i) has been excluded from participation in Medicare or any of the State health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or other state or jurisdiction since the inception of those programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

  ☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and social security number (SSN) or federal employer identification number (FEIN) of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in, or exclusion from participation in, Medicare, Medicaid, or other federally funded government health care programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN	Reason
1			
2			
3			
4			

VI. Certification

I am authorized to bind the entity named in this document and I certify that the above information is true and correct. I will notify Medica of any changes to this information.

NAME (Print)	TITLE
SIGNATURE	DATE
EMAIL ADDRESS	

Return a completed, signed disclosure form to Medica as follows:

Email a scanned copy of the signed form to: providercertifications@medica.com. You may also mail the form to: Medica Health Plans, Mail Route CP250, P.O. Box 9310, Minneapolis, MN 55440-9310; or Fax the form to: 952-992-8666. If you have any questions, please call 952-992-8638, or send an email to the above email address.

VII. DEFINITIONS

For the purpose of this disclosure, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider.

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

3. **Person with an Ownership or Control Interest** means a person or corporation that:
   A) has an ownership interest, directly or indirectly, totaling 5% or more in the Provider;
   B) has a combination of direct and indirect ownership interests equal to 5% or more in the Provider;
   C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least 5% of the value of the property or assets of the Provider;
   D) is an officer or director of a Provider organized as a corporation (this includes senior officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies); or
   E) is a partner in a Provider organized as a partnership, including without limitation limited liability partnerships.

4. **Provider** means an individual or entity that: A) is engaged in the delivery of health care services and is legally authorized to do so by the state in which the individual or entity delivers services; and B) has entered into an agreement with Medica to provide health care services to Medica members, including members enrolled through Medica's contracts with DHS or CMS. For purposes of this disclosure, "Provider" also means a vendor providing non-health services through an agreement with Medica to members enrolled through Medica's government program contracts with DHS or CMS, provided those services are significant and material to Medica's obligations under the respective government program contract.

5. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted (or a person with an employment, consulting or other arrangement with the Provider) for the provision of items and services that are significant and material to the Provider's contract with Medica and Medica's obligations under its contracts with DHS or CMS.

Julie Lueck

From: Julie Lueck [jllueck@co.aitkin.mn.us]
Sent: Thursday, August 02, 2012 4:34 PM
To: Molly.Sikorski@medica.com
Cc: Tom Burke

Subject: FW: Medica - Disclosure Form
Attachments: DISCLOSURE FORM_001.pdf

Hi Molly - Attached to this e-mail is the Disclosure of Ownership Form which has been completed.

Julie Lueck at Aitkin County Health & Human Services

MEDICA®

Disclosure of Ownership and Management Information & Exclusions Statement for Providers ("Disclosure Form")

I. Instructions

This form must be completed and submitted to Medica. A new disclosure form is required and must be submitted when any information in your original form has changed.

This disclosure form is to be completed to ensure compliance with government program requirements pertaining to: (1) disclosure of ownership and control; and (2) exclusions of individuals and entities from government programs as set forth in your contract with Medica.

The disclosure and exclusion requirements apply to partnerships and both non-profit and for-profit corporations, including without limitation limited liability companies. The requirements also apply to counties and Minnesota state agencies. For Counties and State Agencies, individuals such as County Commissioners, County Board Members, Directors or Health Directors are considered persons with ownership or control interest or managing employees. Section VII (Definitions) clarifies which entities must complete this disclosure form. The definitions also clarify which individuals and entities you must provide information about in the form. The definitions are based on law, regulation, and instructions from regulatory authorities.

Note: For the purposes of this disclosure, the term "Person with an Ownership or Control Interest" is not limited to persons or corporations with an ownership interest. For example, it also includes:

(i) senior officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies; and

(ii) partners of a partnership, including without limitation limited liability partnerships.

See Section VII for a complete definition of "Person with an Ownership or Control Interest" as well as definitions of other key terms such as "Managing Employee," "Provider," and "Agent."

Please complete this disclosure form whether or not you have any information to report. If more space is needed, please attach additional information on a separate page.

For assistance in completing this disclosure form, please reference the Definitions provided under Section VII.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS	DBA (Doing Business As), if applicable		
Aitkin County	Aitkin County Health and Human Services		
ADDRESS			NPI/UMPI
204 1st Street NW			1255436721/A000001900
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER
Aitkin	MN	56431	(218) 927-7200
FEDERAL EMPLOYER ID (FEIN)	MN TAX ID		
41-6005749	8026245		

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship ☐ Partnership ☐ Other Partnership (i.e., LP, LLP, LLLP) ☐ Limited Liability Co.

☐ For Profit Corporation ☐ Non-Profit Corporation X County ☐ State ☐ Other ________________

IV. Ownership, Control and Management Information

A. Please provide the following information for each **Managing Employee**, and **Person with an Ownership or Control Interest** in you as a Provider, or in any Subcontractor in which you as a Provider have direct or indirect ownership of 5% or more. For entities with ownership or control interest, include primary business address, every business location, and P.O. Box address. All fields must be completed. The date of birth and social security number (SSN) are required if a *person's* name is provided, and the federal employer identification (FEIN) number is required if an *entity's* name is provided.

No.	Full Legal Name	Address	Date of Birth	SSN or FEIN	% Ownership Interest, if applicable
1	No Ownership – County Government				
2					
3					

B. If any Person with an Ownership or Control Interest listed in subsection IV(A) is related to another Person with an Ownership or Control Interest listed in subsection IV(A) as a spouse, parent, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name	SSN	Name of Person Related To	Related Person's SSN	Relationship
1					
2					
3					

C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in an organization other than that indicated in subsection IV(A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	SSN or FEIN	Name of Other Organization	% Ownership Interest
1					
2					
3					

V. Excluded Individuals or Entities

A. Are there any employees, Persons with an Ownership or Control Interest in you as a Provider, or any of your Managing Employees or Agents who are or have ever:

- Been excluded from participation in Medicare or any of the State health care programs?

☐ Yes X No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs?

☐ Yes X No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (that is, federal fraud and abuse law civil monetary penalty provisions)?

☐ Yes X No

B. Do you as a Provider have any agreements for the provision of items or services related to Medica's obligations under its contracts with the Minnesota Department of Human Services (DHS) or the Centers for Medicare and Medicaid Services (CMS) with an individual or entity who: (i) has been excluded from participation in Medicare or any of the State health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or other state or jurisdiction since the inception of those programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

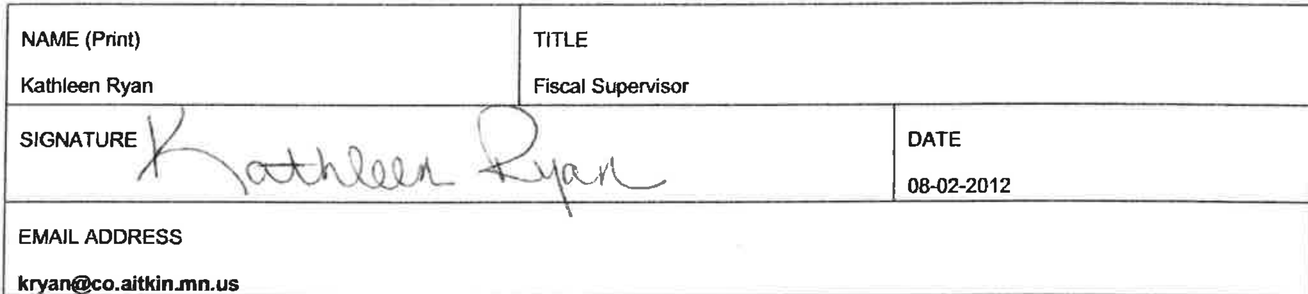
☐ Yes X No

If you answered "Yes" to any of the above questions, list the name and social security number (SSN) or federal employer identification number (FEIN) of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in, or exclusion from participation in, Medicare, Medicaid, or other federally funded government health care programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN	Reason
1			
2			
3			
4			

VI. Certification

I am authorized to bind the entity named in this document and I certify that the above information is true and correct. I will notify Medica of any changes to this information.



NAME (Print)	TITLE	
Kathleen Ryan	Fiscal Supervisor	
SIGNATURE Kathleen Ryan		DATE 08-02-2012
EMAIL ADDRESS kryan@co.aitkin.mn.us		

Return a completed, signed disclosure form to Medica as follows:

Email a scanned copy of the signed form to: providercertifications@medica.com. You may also mail the form to: Medica Health Plans, Mail Route CP250, P.O. Box 9310, Minneapolis, MN 55440-9310; or Fax the form to: 952-992-8666. If you have any questions, please call 952-992-8638, or send an email to the above email address.

VII. DEFINITIONS

For the purpose of this disclosure, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider.

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

3. **Person with an Ownership or Control Interest** means a person or corporation that:
   A) has an ownership interest, directly or indirectly, totaling 5% or more in the Provider;
   B) has a combination of direct and indirect ownership interests equal to 5% or more in the Provider;
   C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least 5% of the value of the property or assets of the Provider;
   D) is an officer or director of a Provider organized as a corporation (this includes senior officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies); or
   E) is a partner in a Provider organized as a partnership, including without limitation limited liability partnerships.

4. **Provider** means an individual or entity that: A) is engaged in the delivery of health care services and is legally authorized to do so by the state in which the individual or entity delivers services; and B) has entered into an agreement with Medica to provide health care services to Medica members, including members enrolled through Medica's contracts with DHS or CMS. For purposes of this disclosure, "Provider" also means a vendor providing non-health services through an agreement with Medica to members enrolled through Medica's government program contracts with DHS or CMS, provided those services are significant and material to Medica's obligations under the respective government program contract.

5. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted (or a person with an employment, consulting or other arrangement with the Provider) for the provision of items and services that are significant and material to the Provider's contract with Medica and Medica's obligations under its contracts with DHS or CMS.

Julie Lueck

From: Julie Lueck [jllueck@co.aitkin.mn.us]
Sent: Thursday, August 02, 2012 3:52 PM
To: Molly.Sikorski@medica.com
Cc: Tom Burke
Subject: FW: Medica forms -8-2-12
Attachments: 3562_001.pdf

August 2, 2012

Molly:

With reference to your e-mail (copied below) I am attaching the documents that I faxed to Medica back on June 6th, 2012, which should provide the needed documentation for the Attestation of Compliance Training.

Would you please send us a Disclosure of Ownership Form at your earliest convenience.

Thanks – Julie Lueck at Aitkin County Health & Human Services

Dear Contracted Vendor:

We are in need of your assistance; we are trying to complete our Contracted Vendor files. We have found that we are missing some important information regarding your contract with Medica. Please send us the missing information by August 15, 2012.

We are missing your Disclosure of Ownership Form and Attestation of Compliance Training.

If you have any questions, please call me at 952-992-8638.

Regards,

Trent Kramer
Medica Government Programs
Contracts Supervisor

Julie Lueck

From: Sikorski, Molly [Molly.Sikorski@medica.com]
Sent: Thursday, August 02, 2012 3:03 PM
To: tburke@co.aitkin.mn.us; Jllueck@co.aitkin.mn.us
Subject: Missing Information email 2012.doc

August 2, 2012

Dear Contracted Vendor:

We are in need of your assistance; we are trying to complete our Contracted Vendor files. We have found that we are missing some important information regarding your contract with Medica. Please send us the missing information by August 15, 2012.

We are missing your Disclosure of Ownership Form and Attestation of Compliance Training.

If you have any questions, please call me at 952-992-8638.

Regards,

Trent Kramer
Medica Government Programs
Contracts Supervisor

TK/ms

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Aitkin County Health & Human Services

204 First St. NW
AITKIN, MINNESOTA 56431
PHONE 1-800-328-3744 or 1-218-927-7200 - FAX # 927-7210

IF ANY PROBLEMS OCCUR WITH THIS TRANSMISSION
OR IF YOU HAVE ANY QUESTIONS, PLEASE CALL (218) 927-7200

NUMBER OF PAGES SENT (including this cover page): **4**
DATE OF TRANSMISSION: **June 6, 2012**

TO: NAME/TITLE:

COMPANY: **Medica Health Plans**

ADDRESS: **Mail Route CP250**

401 Carlson Parkway

Minneapolis, SMN 55440-9310

FAX #: **952-992-8666**

MESSAGE: Attached please find your Compliance Training & Standards of Conduct Attestation Form completed by Kathleen Ryan, Fiscal Supervisor, along with a copy of the Aitkin County Health & Human Services staff training sign-off sheet for annual training completed for 2012.

If you have any questions, please feel free to contact Ms. Ryan at 218-927-7200.

FROM: NAME/TITLE: Julie Lueck, OSSS

COMPANY: Aitkin County Health & Human Services

FAX OPERATOR'S NAME: Julie Lueck

OUR FAX NUMBER: 218-927-7210

IF YOU DO NOT RECEIVE ALLPAGES, PLEASE CALL BACK AS SOON AS POSSIBLE! THANK YOU!!

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MEDICA®

Compliance Training and Standards of Conduct Attestation

By signing below, I attest that my organization:

(i) Agrees to comply, and all employees, board members and downstream entities have read and agreed to comply, with all written compliance policies and procedures and standards of conduct made available by Medica, or comparable policies and procedures and standards of conduct of its own that meet CMS requirements;

(ii) is in compliance with annual Fraud, Waste and Abuse, Compliance, and specialized training requirements in accordance with guidelines set by CMS;

(iii) has required its downstream entities to comply with annual Fraud, Waste and Abuse, Compliance, and specialized training requirements in accordance with guidelines set by CMS

I am authorized to bind the entity and I attest that the above information is true and correct. I will notify Medica of any changes to this information.

See List Attached
Print name of organization representative

Aitkin County Health & Human Services
Organization (legal entity name)

Representative's title

Signature

See Attached
Date signed

Please return this form to Medica by e-mail to providercertifications@medica.com; fax to 952-992-8666; or by U.S. Mail to: Medica Health Plans, Mail Route CP250, 401 Carlson Parkway, Minneapolis, MN 55440-9310. If you have any questions, please call 1-800-458-5512, or send an email to the above email address.

May 2012

STAFF TRAINING SIGN-OFF - 2012

Staff Member Name	Training Day – May 23, 2012 Completed Training Review Staff Signature	HIPAA – Date Completed	HIPAA Score	Sexual Harassment Date Completed	Fraud, Waste & Abuse Medicare/Medicaid
ALDERSON, Alisha	[signature]	3-22-12	17	6-1-12	5-23-12
ARNOLD, Jane	[signature]	5-22-12	17	3-8-12	5-23-12
BENNETT, Cynthia	[signature]				5-23-12
BURKE, Tom	[signature]			5-4-12	5-23-12
CARLSON, Kathy	[signature]	5-22-12	16	5-17-12	5-23-12
CEBELINSKI, Susan	[signature]	5-14-12	16	5-14-12	5-23-12
CHENEVERT, Lori	[signature]	5-18-12	16	2-9-12	5-23-12
CHRISTENSEN, Leslie	[signature]	5-3-12	19	4-9-12	5-23-12
DOBSON, Barb	[signature]	5-9-12	18	3-6-12	5-23-12
DURGIN, Stacey	[signature]			5-31-12	5-23-12
EASTMAN, Diane	[signature]	4-30-12	16	4-30-12	5-23-12
EIBES-ROLLINS, Carol	[signature]	5-2-12	16	5-2-12	5-23-12
FAIRCHILD, Janice	[signature]	1-27-12	19	1-25-12	5-23-12
FLIER, Amanda	[signature]	3-28-12	16	3-22-12	5-23-12
FLOWERS, Debby	[signature]	5-7-12	18	2-17-12	5-23-12
FOSS, Eileen	[signature]	5-7-12	19	4-6-12	5-23-12
GANZ, Bonnie	[signature]	5-16-12	16	5-16-12	5-23-12
HATFIELD, Janet	[signature]	5-2-12	17	5-15-12	5-23-12
HENDRICKSON, Julia	[signature]	3-20-12	18	3-20-12	5-23-12
HILL, Jeannine	[signature]	5-4-12	20	2-15-12	5-23-12
HRUZA, Sue Anne	[signature]	4-3-12	18	3-6-12	5-23-12
JENSEN, Deb	[signature]	5-2-12	16	4-19-12	5-23-12
JEZIERSKI, Deanna	[signature]	5-2-12	17	5-2-12	5-23-12
KARNOWSKI, Pam	[signature]	5-4-12	18	3-13-12	5-23-12
KELSEY, Kathy	[signature]	4-13-12	20	4-13-12	5-23-12
LAIRD, Nikky	[signature]	5-17-12	17	2-2-12	5-23-12
LAMKE, DeAnn	[signature]	1-22-12	19	3-21-12	5-23-12
LARSON, Naomi	[signature]	5-22-12	20	3-29-12	5-23-12
LUECK, Julie	[signature]	3-1-12	17	2-14-12	5-23-12
MATH, Sara	[signature]	4-13-12	21	4-13-12	5-23-12
MELZ, Erin	[signature]	1-24-12	20	1-24-12	5-23-12
METSA, Brenda	[signature]	4-17-12	16	3-1-12	5-23-12
MOEN, Jon	[signature]	4-30-12	19	4-17-12	5-23-12
NELSON, Linda	[signature]	2-8-12	18	2-23-12	5-23-12
NISKANEN, Joan	[signature]	5-21-12	18	5-18-12	5-23-12
PERSON, Rebecca	[signature]	5-1-12	15	2-7-12	5-23-12

Staff Member Name	Training Day – May 23, 2012 Completed Training Review Staff Signature	HIPAA – Date Completed	HIPAA Score	Sexual Harassment Date Completed	Fraud, Waste & Abuse Medicare/Medicaid
PETERSEN, Mona	[signature]	5-16-12	19	5-15-12	5-23-12
PEYSAR, Lois	[signature]	5-10-12	20	2-23-12	5-23-12
PHILIPP, Jody	[signature]	5-2-12	15	3-2-12	5-23-12
RUBIO, Prudence	[signature]	5-11-12	15	2-1-12	5-23-12
RYAN, Kathleen	[signature]	5-1-12	18	2-10-12	5-23-12
SARFF, Marlene	[signature]	5-22-12	18	5-22-12	5-23-12
SCHNEIDER, Nancy	[signature]	3-26-12	20	3-26-12	5-23-12
SCHULTZ, Jessica	[signature]	5-8-12	18	3-1-12	5-23-12
STICH, Reina	[signature]	5-17-12	17	6-5-12	5-23-12
SUNDERMEYER, Ruth	[signature]			2-16-12	5-23-12
SWENSON, Beth	[signature]	5-10-12	18	2-8-12	5-23-12
TANGE, Sue	[signature]	4-30-12	20	1-23-12	5-23-12
TOHM, Kaycie	[signature]	5-22-12	17	5-11-12	5-23-12
TROTTER, Emily	[signature]	4-30-12	20	5-17-12	5-23-12
TUPER, Debra	[signature]	5-22-12	19	5-22-12	5-23-12
WEST, Jan	[signature]	4-2-12	17	3-1-12	5-23-12
ZAHN, Rae	[signature]	5-7-12	19	4-24-12	5-23-12

H:\Lists\staff\2012\staff-training-list-SIGN-OFF-5-23-12.doc