DEPARTMENT OF HUMAN SERVICES

Minnesota Department of Human Services Health Care Administration

Request for Proposals for a Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through Track 1 of the Integrated Health Partnerships (IHP) Demonstration.

Date of Publication in State Register: *August 24, 2020*

Minnesota's Commitment to Diversity and Inclusion:

It is State of Minnesota policy to ensure equity, diversity and inclusion in making competitive grant awards. See Executive Order 19.01.

The Policy on Rating Criteria for Competitive Grant Review establishes the expectation that grant programs intentionally identify how the grant serves diverse populations, especially populations experiencing inequities and/or disparities. See OGM Policy 08-02.

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1. INTRODUCTION

1.1 Objective of RFP

The Minnesota Department of Human Services, through its Healthcare Research & Quality Division in the Health Care Administration (STATE), is seeking Proposals from qualified Responders to perform the tasks and services set forth in this RFP. The term of any resulting contract is anticipated to be for three years, from January 1, 2021 until December 31, 2023. STATE may extend the contract up to a total of five (5) years.

The goal of the Integrated Health Partnerships (IHP) program is to improve the quality and value of the care provided to the citizens served by Minnesota's public health care programs. This Request for Proposal (RFP) solicits a response from organizations interested in participating in the Integrated Health Partnership program.

The Integrated Health Partnerships program allows provider organizations to voluntarily contract with the Minnesota Department of Human Services (DHS) to care for Minnesota Health Care Programs (MHCP) recipients in both fee-for-service (FFS) and managed care under a payment model that holds these organizations accountable for the total cost of care and quality of services provided to this population. Within this structure, DHS seeks to expand the IHP program in different geographic regions of the state and across different models of care delivery that will integrate health care with chemical and mental health services, safety net providers, and social service agencies. The projects will include clear incentives for quality of care and targeted savings, and will result in increased competition in the marketplace through direct contracting with providers.

1.2 Proposal due date

Letters of Intent must be submitted by **4:00 p.m. Central Time on September 21, 2020**. Letters must be submitted via email to Mathew Spaan, Manager of Care Delivery and Payment Reform, at Mathew.Spaan@state.mn.us. The Letter of Intent does not obligate the STATE to enter into negotiations with the responder and does not serve as a substitute for the proposal. The Letter of Intent does not obligate the responder to complete the proposal process. Responders that do not submit a Letter of Intent by September 21, 2020 at 4:00 p.m. Central Time will not be considered for the IHP program in 2021. A template for submission can be found in Appendix A-1: Letter of Intent Template.

Complete proposals must be submitted by **4:00 p.m. Central Time on September 28, 2020**. This Request for Proposal (RFP) does not obligate the STATE to award a contract or complete the project, and the STATE reserves the right to cancel the solicitation if it is considered to be in its best interest. All costs incurred in responding to this RFP will be borne by Responder. Details of proposal submission can be found in Section 3. Proposal Requirements, Section 4. RFP Process, and Appendix A: Integrated Health Partnerships Application Template.

1.3 Background

The IHP program has allowed the Minnesota Department of Human Services (DHS) to engage in alternative payment arrangements directly with provider organizations that serve an attributed population, which may include an agreed-upon total cost of care and risk/gain sharing payment

arrangement. Quality of care and patient experience are measured and incorporated into the IHP payment models alongside cost of care. DHS is interested in advancing this accountable care model to continue to improve the quality of and reduce the cost of care provided to individuals in the state's public programs, such as Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare.

The IHP program was designed to reduce the Total Cost of Care (TCOC) for Medicaid patients while maintaining or improving the quality of care. The first IHP RFP was issued in late 2011 following input from many providers, health plans, consumers, community agencies and professional associations. Trailblazing IHPs signed contracts for their first performance year starting in 2013, and new participants have been added each subsequent year.

Combined, Minnesota's now twenty-six (26) IHPs provide care to over 428 Thousand Minnesotans enrolled in MHCPs, and have achieved an estimated savings of nearly 400 million dollars. A portion of these savings are used by provider systems to achieve the Triple Aim of health care (reduce the cost of care, improve health outcomes, and improve patient experience), through strategies such as expanding use of care coordinators, extending available hours for primary care clinics, and developing partnerships with community supports that impact the health of members. Additional background on the current IHP program can be located at DHS's Integrated Health Partnerships (IHP) Overview webpage.

1.4 Statutory Authority

Under the authority of Minnesota Statutes, section 256B.0755, the State is soliciting proposals for Responders to participate in alternative payment arrangements for health care services on a statewide basis as an IHP. The proposed IHP will serve the population of non-dually eligible adults and children in Medical Assistance and MinnesotaCare enrolled under both fee for service and managed care programs.

2. SCOPE OF WORK AND GENERAL APPROACH

2.1 Scope of Work

The purpose of the IHP program is to provide opportunities for providers and other organizations to develop innovative forms of care delivery through payment arrangements that reduce the cost of care, improve health outcomes, and improve patient experience. The demonstration will be conducted over a three-year contract cycle with annual performance periods. The demonstration will be conducted statewide and is not limited to providers or MHCP beneficiaries in a specified geographic area. This RFP provides the detail of how an IHP can meet the objectives of the program.

IHPs will not administer the MHCP benefit set or pay claims under the demonstration or be required to contract for additional services outside of the services delivered by the IHP.

Nothing in the contract agreement will release providers included in the IHP from the responsibility to meet all MHCP fee-for-service and/or managed care organization (MCO) requirements including, but not limited to enrollment, reporting, claims submission, and quality measures.

2.2 Overview

This RFP provides background information and describes the services desired by STATE. It describes the requirements for this procurement and specifies the contractual conditions required by the STATE. Although this RFP establishes the basis for Responder Proposals, the detailed obligations and additional measures of performance will be defined in the final negotiated contract. Responders must be in agreement with Section 10. Required Contract Terms and Conditions.

2.3 Core Principles of Model

The goal of the IHP program is to allow providers to participate in value-based payment arrangements, and to continue to work towards achieving the Triple Aim of health care for patients in the state of Minnesota. Core principles of the program are:

- Recognition that "value-based" payment arrangements for health care consist of cost, utilization and quality components.
- Promoting IHP sustainability and innovation through population-based payments paid on a quarterly basis for IHP-attributed patients which will encourage IHP responsibility for patient care coordination, quality of care provided, and Total Cost of Care.
- Addressing non-medical health factors by incentivizing community partnerships between medical and non-medical providers; both recognizing the additional risk and investment required to establish and incorporate non-medical community partnerships into the health system, and rewarding non-medical providers appropriately for contribution to patient and population health.
- Claims-based attribution with an emphasis on primary care but that is flexible based on services provided and coordinated by the IHP.
- Actuarially sound benchmarks, cost estimations, and payment mechanisms, for the benefit of the payer as well as the provider participating in the value-based payment arrangement.
- Ability to act upon, share, and strengthen health care data and technology in a timely and accurate way.
- Alignment with other federal, national, and state-based value-based payment arrangements and/or existing initiatives to the extent possible.
- If you would like a copy of the sample contract, please email Mathew Spaan at Mathew.Spaan@state.mn.us and request one.

3. PROPOSAL REQUIREMENTS

3.1 Overview

Proposals must conform to all instructions, conditions, and requirements included in this RFP. Responders are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the Proposal is at the Responder's risk and may, at the discretion of the STATE, result in disqualification of the Proposal for nonresponsiveness. Responders may withdraw their application at any time prior to contract execution with the State. Acceptable Proposals must offer all services identified in Section 2, Scope of Work and General Approach, agree to the contract conditions specified throughout the RFP, meet the requirements in Section 5, Responder Eligibility and

Participation Requirements, and include all of the items referenced in the Required Statements and Applicable Forms sections. Responder must also agree to the terms and conditions in the attached sample contract unless specifically making an exception pursuant to the Exceptions to Sample Contract and RFP Terms in Section 3.3(b) of this RFP.

3.2 Proposal Contents

Responses to this RFP must consist of all of the following components. Each of these components must be separate from the others and identified with labeled tabs.

Proposal Components

1. Table of Contents
2. Application (Required questions and information can be found in Appendix A: Integrated Health Partnerships Application Template
3. Application Supplementary Materials
    a. Provide Roster
    b. Organizational Chart with TINs
    c. Sample Agreement with IHP Participants
    d. List of Participating Clinics
    e. Equity Measures
    f. Other Application Requirements, As Necessary
4. Required Statements and Forms
5. Optional – Additional Materials (Any additional information thought to be relevant, but not applicable to the prescribed format, may be included in the optional appendix of your Proposal.)

3.3 Detail of Proposal Components

The following will be considered minimum requirements of the Proposal. The emphasis should be on completeness and clarity of content.

1. **Table of Contents:** List each section and the accompanying page number.
2. **Application:** This component of the Proposal should demonstrate the Responder's understanding of the applicant IHP's eligibility to participate in the IHP program, eligibility for Track 1, organizational structure, experience and familiarity with value-based payments and risk-sharing arrangements, clinical care model, quality measurement, population health and disparities, and community partnerships.

3.4 Required Statements and Forms

Complete the correlating forms found in **eDocs**[1] by searching for the form numbers referenced below, or by pasting the form file path name found in the footnotes below to your browser, and submitting the completed forms in the "Required Statements and Forms" section of your Proposal. You must use the

[1] http://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp

current forms found in eDocs. Failure to submit a Required Statement or to use the most current forms found in eDocs is at the Responder's risk and may, at the discretion of STATE, result in disqualification of the Proposal for nonresponsiveness.

a. Responder Information and Declarations (Responder Information/Declarations Form DHS-7020-ENG**)**[2]**:** Complete the "Responder Information and Declarations" form available at the above link and submit it with the Proposal. If you are required to submit additional information as a result of the declarations, include the additional information as part of this form. Responder may fail the Required Statements Review in the event that Responder does not affirmatively warrant to any of the warranties in the Responder Information and Declarations. Additionally, STATE reserves the right to fail a Responder in the event the Responder does not make a necessary disclosure in the Responder Information and Declarations or makes a disclosure which evidences a conflict of interest.

b. Exceptions to Sample Contract and RFP Terms (Exceptions to Terms and Conditions Form DHS-7019-ENG**)**[3]**:** The contents of this RFP and the Proposal(s) of the successful Responder(s) may become part of the final contract if a contract is awarded. A Responder who objects to any condition of this RFP or STATE's sample contract terms and conditions (attached as **Appendix A**) must note the objection(s) on the "Exceptions to Sample Contract and RFP Terms and Conditions" form available at the above link and submit it with its Proposal. Much of the language reflected in the sample contract is required by statute. Only those exceptions indicated in your response to the RFP will be available for discussion or negotiation.

Responders are cautioned that claiming either of the following may result in its Proposal being considered nonresponsive and receiving no further consideration:

1. Exceptions to the terms of the standard STATE contract that give the Responder a material advantage over other Responders;
2. Exceptions to all or substantially all boilerplate contract provisions.

c. Affidavit of Noncollusion (Affidavit of Noncollusion Form- DHS-7021**)**[4]**:** Each Responder must complete an "Affidavit of Noncollusion" form available at the above link and submit it with its Proposal.

d. Disclosure of Funding Form (Disclosure of Funding Form- DHS-7018-ENG**)**[5]:
In order to comply with federal law, Responder is required to fill out the "Disclosure of Funding" form available at the above link and submit it with its Proposal. The form requires Responders to provide their Data Universal Numbering System (DUNS) number, which is the nine-digit number

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[2] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7020-ENG
[3] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7019-ENG
[4] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7021-ENG
[5] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7018-ENG

established and assigned by Dun and Bradstreet, Inc. (D&B) to uniquely identify business entities. If a Responder does not already have a DUNS number, a number may be obtained from the D&B by telephone (currently 866-705-5711) or online (currently at http://fedgov.dnb.com/webform). Responders must have a DUNS number before their Proposal is submitted.

e. Human Rights Compliance:

i. Workforce Certificate Information. (State of Minnesota Workforce Certificate Information-DHS-7016-ENG)[6]: (*Applies if a resulting contract will be in excess of $100,000*). Responder is required to complete the "Workforce Certificate Information" document available at the above link and submit it with its Proposal.

As required by Minnesota Rules, part 5000.3600, Subp. 9, "[i]t is hereby agreed between the parties that Minn. Stat. § 363A.36 and Minnesota Rules, parts 5000.3400 - 5000.3600 are incorporated into any contract between these parties based upon this specification or any modification of it. A copy of Minn. Stat. § 363A.36 and Minnesota Rules, parts 5000.3400 - 5000.3600 are available upon request from the contracting agency."

ii. Equal Pay Certificate. (Equal Pay Certificate Compliance – DHS -7075-ENG)[7]**:** (*Applies if a resulting contract will be in excess of $500,000*). Pursuant to Minn. Stat. § 363A.44, Responder must complete and submit the form available at the above link with its Proposal if the resulting contract with all amendments will be in excess of $500,000 and Responder has had 40 or more full-time employees in Minnesota or its principal place of business in a single day during the prior 12 months. It is the Responder's sole responsibility to provide the information requested and when necessary to obtain an Equal Pay Certificate from the Minnesota Department of Human Rights prior to contract execution. This section does not apply to a contract to provide goods and services to individuals under chapters 43A, 62A, 62C, 62D, 62E, 256B, 256I, 256L, and 268A, with a business that has a license, certification, registration, provider agreement, or provider enrollment contract that is prerequisite to providing those goods and services.

Please contact MDHR with questions at: 651-539-1095 (metro), 1-800-657-3704 (toll free), 711 or 1-800-627-3529 (MN Relay) or email at compliance.MDHR@state.mn.us. Responder must apply for an equal pay certificate by paying a $150 filing fee and submitting an equal pay compliance statement to the Minnesota Department of Human Rights ("MDHR"). MDHR's Equal Pay Certificate instructions and Application Form can be obtained at this link.[8]

It is Responder's sole responsibility to submit this statement to MDHR and – if required – apply for an equal pay certification before the due date of this Proposal and obtain the

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[6] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7016-ENG

[7] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7075-ENG

[8] https://mn.gov/mdhr/certificates/apply-renew/equal-pay-certificate/equalpay-app-form.jsp

certification prior to the execution of any resulting contract.

If a contract is awarded to a business that does not have an equal pay certificate as required by Minnesota Statutes, section 363A.44, or is not in compliance with the laws identified within section 363A.44, MDHR may void the contract on behalf of the state, and the contract may be abridged or terminated by the STATE upon notice that the MDHR has suspended or revoked the certificate of the business.

f. Certification Regarding Lobbying (Certificate Regarding Lobbying Form- DHS-7017-ENG)[9]**:** (*Applies if a resulting contract will be in excess of $100,000*). If federal money will be used or may potentially be used to pay for all or part of the work under the contract, Responder must complete the "Certification Regarding Lobbying" form available at the above link and submit it with its Proposal.

g. Documentation to Establish Financial Stability (Documentation to Establish Financial Stability-DHS-7896-ENG)[10]**:** It is the policy of the State of Minnesota to make grants to organizations that are sufficiently financially stable to carry out the purpose of the grant. The information collected under this section will be used in STATE's determination of the award of the contract. Responder must complete the "Documentation to Establish Financial Stability" form and submit the form along with the financial statements required with its Proposal.

4. RFP PROCESS

4.1 Timeline

This timeline outlines the tentative RFP process for the 2021 IHP Contract:

ACTIVITY	DATE
RFP Publication	August 17, 2020
Individual 30 minute meetings (Optional)	August 24 – September 4, 2020
All RFP Questions Received	September 4, 2020
RFP Questions Answered and Posted on DHS Website	Anticipated September 9, 2020
Letter of Intent Due Date	September 21, 2020
Proposal Responses Due	September 28, 2020
RFP Review Completed	Anticipated October 2, 2020
Notice of Intent to Contract	Anticipated October 5, 2020
Individual IHP Contract Negotiations Begin	Anticipated October 12, 2020
Performance period begins	January 1, 2021

[9] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7017-ENG
[10] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7896-ENG

4.2 Communications

DHS may release periodic updates on the RFP as necessary. Communication will occur on the IHP Website. Updates to the RFP will also be posted on the DHS RFP webpage.

- Link to the IHP Website: www.dhs.state.mn.us/IHP

4.3 Responders' Questions

Responders' questions regarding this RFP must be submitted via email to IHP.Admin.DHS@state.mn.us prior to 4:00 p.m. Central Time on September 4, 2020.

Other personnel are NOT authorized to discuss this RFP with Responders before the Proposal submission deadline. Questions sent via email to any other email address will not be accepted or answered. Questions may also be asked via conference call or during webinar meetings. STATE will not be held responsible for oral responses to Responders.

Questions will be de-identified, addressed in writing and distributed to all identified prospective Responders. Every attempt will be made to provide answers timely, no later than September 14, 2020.

4.4 Optional Individual Question and Answer Sessions

All potential provider responders may request one optional 30-minute Question and Answer (Q&A) session from August 24 – September 4, 2020 via conference call. The optional Q&A sessions will serve as an opportunity for Responders to ask specific questions of State staff concerning the project. A Q&A session is not mandatory. DHS staff will record all questions and answers provided in the individual sessions and post them to the DHS website. To schedule a Q&A session for your provider organization, please contact Mathew Spaan at Mathew.Spaan@state.mn.us before or by August 28, 2020. Oral responses provided at the conference will be non-binding. Written responses to questions asked at the Q&A session(s) will be sent to all identified known responders after the conference.

4.5 Letter of Intent

Letters of intent must be submitted by 4:00 pm Central Time on September 21, 2020. Letters may be submitted via email to Mathew Spaan, Manager of Care Delivery and Payment Reform, at Mathew.Spaan@state.mn.us. The Letter of Intent does not obligate the STATE to enter into negotiations with the responder, and does not serve as a substitute for the proposal. The Letter of Intent does not obligate the applicant to complete the proposal process. Responders that do not submit a letter of intent by September 21, 2020 will not be considered for the IHP program in 2021. A template for submission can be found in Appendix A-1: Letter of Intent Template.

4.6 Proposal Submission

Proposals must be submitted via e-mail and received by 4:00 p.m. Central Time on September 28, 2020 to be considered. Late Proposals will not be considered. Faxed or physically mailed Proposals will not be accepted.

Responders submitting via email must ensure that the forms in Section 3.4, Required Statements, meet legal signature requirements. STATE will accept e-signatures that have been authenticated by a third-party digital software, such as DocuSign and Adobe Sign, when it includes the date and time of the signature, an authentication code, and is attributable to the person intending to sign the document. Handwritten signatures on faxed or scanned documents are e-signatures and are acceptable for all purposes.

For Required Statements requiring a notary: pursuant to Minnesota Statutes, section 325L.17, the STATE will temporarily accept documents with e-signatures that have been notarized by a remote online notary public. Remote online notarization must be performed by a remote online notary public currently registered with the Minnesota Secretary of State and pursuant to the procedures set forth in Minnesota Statutes, section 358.645, subdivision 7.

The main body of the Proposal pages must be numbered and submitted in 12-point font, single spaced. The size and/or style of graphics, tabs, attachments, margin notes/highlights, etc. are not restricted by this RFP and their use and style are at the Responder's discretion.

The proposal and all correspondence related to this RFP must be delivered via e-mail to:

Mathew Spaan at Mathew.Spaan@state.mn.us. Please also cc: IHP.Admin.DHS@state.mn.us on your correspondence.

It is solely the responsibility of each Responder to assure that its Proposal is delivered to the specific e-mail address, in the specific format, and prior to the deadline for submission. **Failure to abide by these instructions for submitting Proposals may result in the disqualification of any non-complying Proposal.**

5. RESPONDER ELIGIBILITY AND PARTICIPATION REQUIREMENTS

5.1 System Requirements

To be considered eligible to participate as an IHP for the purposes of responding to this RFP, a successful Responder must meet the following criteria:

1. Must provide or coordinate the full scope of health care services, as evidenced by provision of coordinated care, and/or prior/current participation in an outcomes-based contract with CMS or Medicaid. Accepted forms of evidence of provision of coordinated care include but are not limited to:
    a. Health Care Home (HCH) Certification
    b. NCQA PCMH Recognition
    c. Current/past participation in IHP demonstration as an IHP
    d. Additional evidence or documentation of ability to provide or coordinate full scope of health care services (See Appendix B-1: Example IHP Health System Characteristics)

2. All providers included in the IHP demonstration payment model must be enrolled MHCP providers.
3. Demonstrate, through the care delivery model, how the IHP will affect the total cost of care of its MHCP beneficiaries regardless of whether the services are delivered by the IHP. MHCP beneficiaries included in the demonstration are non-dually eligible Medical Assistance and MinnesotaCare enrollees attributed to the IHP for the performance period. (See Appendix B-2: Eligible and Excluded Populations)
4. Demonstrate established processes to monitor and ensure the quality of care provided. Participate in quality measurement activities as required by the State and engage in quality improvement activities.
5. Demonstrate the capacity to receive data from DHS via secure electronic processes and use it to identify opportunities for patient engagement and to stratify its population to determine the care model strategies needed to improve outcomes.
6. Demonstrate and/or describe efforts related to addressing social determinants of health and the particular risk factors present in the applicant's Medicaid patient population.

5.2 Legal Entity, Governance Structure, Leadership

An IHP is made up of a network of providers, and may include an organizing entity and agreement of shared governance. This may include but is not limited to a non-profit, a county or group of counties, and other group types. The IHP as a network must meet or demonstrate ability to meet the requirements in Section 5.1., System Requirements, above. All IHP payments must be provided to and/or received from an MHCP enrolled provider. The IHP organizing entity must obtain agreement from participating providers, clinics, and/or health systems in the IHP program prior to the beginning of the contract period in January 1, 2021.

5.3 Social Determinants of Health and Community Engagement

DHS is committed to advancing equity, reducing disparities in DHS program outcomes, and improving access to human services for communities experiencing inequities. DHS's Equity Policy requires that DHS utilize a Health in All Policies (HiAP) approach, a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

It is important that IHPs are thoughtful about the context that creates and affects the health of individuals as well as communities, which is also known as the social determinants of health. DHS recognizes that health systems may not be the best equipped to address the social determinants that affect health, healthcare costs, and patient experience. The IHP program is an opportunity for responders and participants to innovate and advance efforts such as community partnerships, screening, referral, and care coordination for social needs, and other strategies that may already be underway.

IHPs will be required to propose an intervention to address social determinants of health, and will be held accountable for agreed upon health equity measures related to the proposed intervention. More information on how the health equity measures affect payment, see Section 7.2. Quality and the Population-Based Payment.

Broadly, responders to this proposal must demonstrate how formal and informal partnerships with community-based organizations, social service agencies, counties, public health resources, etc., are included in the care delivery model. The responder must also demonstrate how the IHP will engage and coordinate with other providers, counties, and organizations, including county-based purchasing plans that provide services to the IHP's patients on issues related to local population health, including applicable local needs, priorities, and public health goals.

Responders should describe how local providers, counties, organizations, county-based purchasing plans, and other relevant purchasers were consulted in developing the application to participate in the demonstration project. The Health Equity Intervention, documented in Appendix E, will include the target population, proposed solution, detailed intervention, historical background, and proposed equity measures.

The responder must also demonstrate how the IHP will meaningfully engage patients and families as partners in the care they receive, as well as in organizational quality improvement activities and leadership roles.

5.4 Interaction With Other IHP-related RFPs and Procurements

Unlike in prior years, this current IHP RFP is limited to the Track 1 non-risk bearing model. DHS will not be releasing a IHP Track 2 model RFP for contracts beginning in 2021. IHP RFPs released in future years may include both Track 1 and Track 2 model options.

Applicants to the IHP 2.0 program will not be precluded from future application to any IHP-related RFPs or procurements.

6. MODEL DESIGN ELEMENTS

6.1 Overview of Model

IHP 2.0 model generally includes both a Track 1 non-risk bearing option and a Track 2 risk bearing option. **However, due to the unique complications and unpredictability of costs and utilization created by the COVID-19 pandemic, this current RFP will only include the Track 1 option.** Future years' IHP RFPs may include both Track 1 and Track 2 options. Details for the Track 1 IHP model follow. For further information on the Track 2 option included in prior IHP RFPs, contact DHS at IHP.Admin.DHS@state.mn.us.

All IHPs that meet the requirements and are accepted into the IHP program will be eligible for a quarterly population-based payment (PBP) for the purposes of care coordination that corresponds with its ability to manage an individual's total cost of care. The Track 1 IHP is intended for small, independent

provider systems; specialty health care groups that coordinate care for specific groups of individuals or a specific major portion of services (including primary care); or a range of other health care providers subject to consideration by DHS.

Additional requirements for participation in the Track 1 IHP program model can be found in Section 6.4, Payment Models, Mechanisms, Risk, and Section 7, Quality.

In order to encourage efficient, effective care coordination and to ensure no duplication of billing or services, **the PBP will take the place of any current Health Care Home or in-reach service payments currently being received by the IHP for an IHP attributed member**.

Additionally, an IHP will not receive the PBP for any patients that are also receiving Behavioral Health Home (BHH), Health Care Home (HCH), or Hospital In-reach Service Coordination (IRSC) services.

6.2 Beneficiary Eligibility and Attribution

Attribution will be determined using a retrospective model using a 24-month look back process. Attribution will be determined by an IHP's billing and/or treating provider roster, using one of the following two methods.

- **All-In Roster:** IHPs that select this option will be required to submit a full list of their billing NPIs to be included in the IHP prior to the start of each contract year. A quarterly attestation process will determine accuracy and completion. This is the preferred roster option for IHP attribution, as it more accurately captures the full set of providers billing to a given clinic NPI, and there is no need to update the roster on a quarterly basis unless clinic NPIs are changing.
- **Billing and Treating Provider Roster:** IHPs that select this option will be required to submit a full list of the billing and treating provider NPIs to be included in the IHP prior to the start of each quarter. This list must be kept accurate and updated on a quarterly basis.

Submission instructions can be found in Appendix A: Integrated Health Partnerships Application Template. A list of the eligible and excluded populations for attribution to IHP can be found in Appendix B-2: Eligible and Excluded Populations.

Attribution Methodology

The following describes the general process for attributing individuals to an IHP, although certain segments of the population may be carved out of the attributed population depending on the purpose for which attribution is being run, as described below. Further details are provided in Appendix C: Attribution Methodology.

Attribution is run on a monthly basis. Attribution will be done using a hierarchical process that incentivizes active outreach and retention of patients by the IHP under the following general methodology:

1. Patients actively enrolled in care coordination through a certified Health Care Home (HCH) or Behavioral Health Home (BHH), submitting a monthly care coordination claim.
2. Patients that cannot be attributed based on HCH or BHH enrollment may be attributed to the IHP based on the number of Evaluation and Management (E&M) visits (i.e., encounters) with a provider who specializes in primary care.
3. Patients that cannot be attributed through primary care visits may be attributed to the IHP based on their E&M visits with non-primary care (specialty) providers.

If a patient was not enrolled with a HCH or BHH and did not have any E&M claims within the relevant twelve (12) month period and therefore were not attributed to an IHP, then the attribution process described above will be repeated using claims occurring within an additional twelve (12) month period, for a total of twenty-four (24) months. Patients will be attributed to one IHP at a time.

Because the results of the attribution method will impact the size of the population included in each IHP's demonstration payment model, the State and Responder will define contract terms based on subsequent analysis of which patients are actually attributable.

Population-Based Payment (PBP)

As mentioned above, MHCP beneficiaries will be attributed on a monthly basis by DHS to an IHP using retrospective claims data for the purposes of determining the per-member amount and risk adjustment level of quarterly population-based payments (PBPs). For purposes of the PBP, individuals who are receiving care coordination payments through programs such as Behavioral Health Homes (BHHs) will be excluded from the population used to determine the magnitude of the quarterly PBP. However, these individuals will be included in Step 1 of the process for attribution that is reported to IHPs on a monthly basis and for the calculation of an IHP's Total Cost of Care.

Base and Performance Period

MHCP beneficiaries will be attributed by DHS to an IHP using retrospective claims data for the purposes of determining the Total Cost of Care (TCOC) Target and actual Performance TCOC, according to the general methodology laid out above (see Attribution Methodology).

The attribution for performance measurement is calculated on an annual, calendar year basis. An IHP's target (Base Period TCOC) is based on a review of the attributed population and claims experience for the twelve months preceding contract initiation and includes additional members that could be attributed during the additional 12 months of "look back" history. Performance Period TCOC is based on the same criteria as the Base Period TCOC, but on the attributed population for the relevant calendar year.

6.3 Definition of Total Cost of Care (TCOC)

Services Included in Total Cost of Care

All Medicaid covered services will be included in the Total Cost of Care (TCOC), with a few exceptions such as Long-Term Care, Foster Care, and IEP. All of the attributed patients' care as provided in the total cost of care definition will be attributed to the IHP, regardless of whether the IHP delivered the services.

For a detailed breakdown of services included in TCOC, see Sample Contract Appendix 2 – Category of Service Table.

Calculation of Total Cost of Care: Specifications and Measurements

The risk-adjusted Total Cost of Care (TCOC) target will be calculated by DHS for all MHCP recipients in both fee-for-service and managed care attributed to the IHP for the performance period, based on the stated services included in the Total Cost of Care.

While Track 1 IHPs are not subject to shared losses or shared savings, Total Cost of Care is calculated for Track 1 IHPs in order to provide illustrative performance results.

To assure that a participating IHP does not have the measurement of their performance inappropriately impacted by changes in the risk status of the membership, DHS will perform risk adjustment on the attributed populations in the base period and performance period and adjust the Target TCOC (the "Adj. Target TCOC") to reflect the changes in risk. To further refine the measurement process and reduce the potential variability inherent in any risk score methodology, DHS has developed the following specifications and requirements:

1. **Population Size:** Responders that apply to participate as a Track 1 IHP do not have a minimum population size; however, ability to enter into a Track 1 arrangement depends on the responder's overall population risk and cost profile. The prospective number of attributed patients is determined by the roster of providers which is submitted along with the RFP Application (Appendix A: Integrated Health Partnerships Application Template).

2. **Claim cap level:** To reduce the potential variability of the risk assessment, DHS will develop the risk scores and total cost of care per member per month (PMPM) by removing the claim costs for individual members that fall above specific thresholds. This claims cap will not exceed $200,000. Because of the greater impact of large claimants on the results for smaller populations, DHS will determine the claims cap for a given Responder's attributed population during contract development. For Track 1 IHPs, DHS will use either a $50,000 or $100,000 claims cap threshold, which will be identified based on the IHP's population size.

3. **Minimum Performance Threshold:** For Track 2 IHPs, DHS has established a two percent (2%) minimum performance threshold that must be met prior to the distribution of any shared savings or losses payments between the State (including its contracted MCOs, as applicable) and the IHP. Specifically, the Performance TCOC must be above 102% or below 98% of the Adjusted Target TCOC in the Integrated IHP for shared savings and losses payments to occur. Once the

performance target is met, shared savings or shared losses payments are calculated back to the first dollar, i.e., any amount above or below the TCOC target.

4. **Shared Savings and Shared Losses Payment Distribution:** IHPs participating in Track 2 will enter into reciprocal upside and downside risk arrangements with DHS, within risk corridors proposed by the IHP and finalized during contract discussions. Savings and/or losses incurred will be shared at a rate of 50% by the IHP and 50% by DHS. Modifications to these risk arrangements can be made possible through demonstration of Accountable Care Partnership arrangements.

A summary of the above requirements for the different tracks can be found in Table 2 below.

Table 1: Total Cost of Care Specifications and Requirements by IHP Track

Model Type	Population Size	Claims Cap	Shared Savings Model
Track 1	No minimum	Maximum of $100,000	n/a
Track 2	Minimum of 2,000 attributed patients	Maximum of $200,000	Reciprocal upside and downside risk with 50% share of savings in each risk corridor. Arrangement can be modified according to demonstrated Accountable Care Partnerships

6.4 Payment Models, Mechanisms, Risk

Payment in Track 1

Population-Based Payment

Track 1 IHPs will receive an aggregate monthly PBP, which is paid quarterly, for their respective attributed population (attribution is as described in Section 6.2 above). The PBP encourages accountability for the total cost of care of attributed patients, resource utilization, and quality of health care services provided. The total amount paid to each IHP will be based on the number of attributed members and an average base rate for each individual attributed to the IHP. The base rate will vary by the medical and social complexity of each IHP's attributed population. Each quarter, the amount of the PBP will be adjusted to reflect changes to the population attributed to the IHP. An IHP's ability to continue participating in the IHP program and receive the PBP will be contingent on cooperation with and performance on quality measures as laid out in Section 7, Quality.

6.5 Interaction with MCOs

The IHP demonstration will be implemented consistently at the delivery system level and for MHCP beneficiaries currently enrolled in either fee-for-service and managed care. DHS will implement and execute the IHP payment model, quality measures and methodology, patient attribution for both MHCP enrollees in fee-for-service and in MCOs under contract with the State to provide services to non-dually

eligible Medical Assistance and MinnesotaCare enrollees. The MCOs will participate as a payer in the IHP payment process via their contract requirement with the State.

The State's managed care organization (MCO) contract has been modified to require cooperation with the IHP contracts. The current MCO contracts are posted on the State's public web page at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp.

MHCP beneficiaries will be attributed to an IHP regardless of whether they are enrolled in fee-for-service or in an MCO. All attributed patients will be calculated together at the IHP level for the purposes of the population-based payment, the Total Cost of Care and the payment model. DHS will calculate the total population-based payments, the total cost of care targets and performance across both fee-for-service and managed care using retrospective claims and encounter data. DHS will also calculate relevant claims-based quality measures using data applicable to each measure at the IHP level across both fee-for-service and managed care.

MCOs (licensed health plans or County-Based Purchasing Organizations) may not participate as principal Responders in the IHP demonstration.

7. QUALITY

7.1 Overview

A core principle of the IHP model is that payment for health care is tied to the quality of the care provided. As explained in Section 6.2. of the RFP, Track 1 IHPs are eligible to receive the population-based payment (PBP). The population-based payment is tied to various quality, health equity, and utilization metrics. IHPs will be evaluated on quality, health equity, and utilization measures to determine eligibility to continue participation in the IHP program after the conclusion of each three-year cycle.

7.2 Quality and the Population-Based Payment

Eligibility to receive the population-based payment is tied to an IHP's ability to evaluate, intervene, and improve the health of its attributed patients. The IHP will work with DHS to agree on quality, health equity, and utilization measures to evaluate the effectiveness of efforts by the IHP to improve health outcomes of its attributed population.

By the second year of the contract cycle, the IHP will be expected to demonstrate that it is exchanging admission, discharge, transfer or CCD messages with providers outside their system by either using DHS's encounter alerting service or via other existing health information exchange activity.

During contract discussions, the IHP attributed population will be examined to determine its predominant health disparities using DHS data as well as information provided by the IHP. The IHP will be required to propose an intervention and health equity measures tied to this intervention that are

intended to reduce health disparities among the IHP's population. A template to propose an intervention is included in Appendix E: Health Equity Measures.

The IHP will be annually evaluated across a set of agreed upon measures – clinical, utilization, and equity measures. A lack of improvement or an insufficient quality performance could result in modifications or discontinuation of the population-based payment after the conclusion of an IHP's three-year contract cycle.

8. DATA SHARING AND REPORTS

8.1 IHP Data Portal and MN-Its Mailbox

DHS will make utilization and risk information for its attributed population available to IHP providers via DHS' IHP and MN-ITs data portals. The data will be populated by a monthly set of risk adjustment (Johns Hopkins Adjusted Clinical Groups [ACG®]) output in the DHS data warehouse, and will include both fee-for-service and MCO encounter claim data. Data will be as timely as possible given standard claims lag, and will be available via risk adjustment software output or standardized reports.

Key variables available to delivery systems will be primarily from ACG® output, and will include population-level data (such as the total cost of care and rates of inpatient and emergency department utilization) and patient-level data (such as medical and pharmacy utilization histories, predictive risk information, and indices of care coordination).

The data in the portals will be provided in raw exportable form for IHP use, but will also be provided in easily digestible reports and visual graphics. Examples can be found in Appendix F: IHP Reports and Data. A few examples of the features and reports provided through the DHS IHP Provider Portal are:

- Performance Dashboard
- Total Cost of Care Summary (Breakdowns by Category of Service, inside system vs. outside system, included versus excluded services, by member program, etc.)
- Care Coordination Reports (Care Management Reports, Chronic Condition Profile, Provider Roster Gaps, and Attribution Change Analysis)
- Utilization Reports (Inpatient and ED Trends by Clinic, Pharmacy Utilization and Spend)
- Quality Reports (HEDIS Measures, Summary of Quality and Patient Experience Measures)

IHPs must designate, during time of application for IHP, who within their organization will be the primary administrator for the IHP Data Portal and MN-ITs Mailbox.

A link to the full IHP Report Reference documentation can be found here: IHP Report Reference Documentation

8.2 Learning Opportunities

IHPs are invited to participate in Quarterly Data Users Group Meetings with DHS via WebEx. DHS may present on data or other program related topics, answer questions, and facilitate data and program

related discussions amongst IHPs. Data Users Group meetings are an opportunity for IHPs to communicate and collaborate with DHS and one another.

IHPs are also invited to participate in the annual IHP Learning Day. The IHP Learning Day is an in-person forum to discuss key issues, potential strategies, and future opportunities for IHPs. Although the IHP Learning Day is typically an in-person opportunity, it will not be taking place in-person during to the COVID-19 pandemic. IHPs may also be invited to other learning activities related to health care delivery and payment reform.

9. PROPOSAL EVALUATION AND SELECTION

9.1 Overview of Evaluation Methodology

1. The IHP program is a non-competitive, flexible program that allows for multiple types and sizes of health systems and groups of providers to participate in order to achieve the Triple Aim of Health care for Minnesota's MHCP beneficiaries. The evaluation methodology below is mostly used to discuss a Responder's suitability for the model, clarify questions about the Responder's ability to participate in the IHP, and to consider additional material or discussions necessitated in order to partner with the health system.

2. All responsive Proposals received by the deadline will be evaluated by STATE. Proposals will be evaluated on "best value" as specified below. The evaluation will be conducted in three phases:

a. *Phase I* Required Statements Review

b. *Phase II* Evaluation of Proposal Requirements

c. *Phase III* Selection of the Successful Responder(s)

3. During the evaluation process, all information concerning the Proposals submitted, except for the name of the Responder(s), will remain non-public and will not be disclosed to anyone whose official duties do not require such knowledge.

4. Nonselection of any Proposals will mean that either another Proposal(s) was determined to be more advantageous to STATE or that STATE exercised the right to reject any or all Proposals. At its discretion, STATE may perform an audit of the reasonableness of any Proposal.

9.2 Evaluation Team

1. An evaluation team will be selected to evaluate Responder Proposals.

2. STATE and professional staff, other than the evaluation team, may also assist in the evaluation process. This assistance could include, but is not limited to, the initial mandatory requirements review, contacting of references, or answering technical questions from evaluators.

3. STATE reserves the right to alter the composition of the evaluation team and their specific responsibilities.

9.3 Evaluation Phases

At any time during the evaluation phases, STATE may, at STATE's discretion, contact any Responder to (1) provide clarification of their Proposal, (2) have each Responder provide an oral presentation of their Proposal, or (3) obtain the opportunity to interview the proposed key personnel. Reference checks may also be made at this time. However, there is no guarantee that STATE will look for information or clarification outside of the submitted written Proposal. Therefore, it is important that the Responder ensure that all sections of the Proposal have been completed to avoid the possibility of failing an evaluation phase or having their score reduced for lack of information.

1. *Phase I*: Required Statements and Forms Review

The Required Statements will be evaluated on a pass or fail basis. Responders must "pass" each of the requirements identified in Section 3.4 to move to Phase II.

2. *Phase II*: Evaluation of Technical Requirements of Proposals

a. Points have been assigned as follows to each of the component areas described in Section 3.2 of this RFP:

Proposal Components	Possible Points
1. Cover Sheet	**5**
2. Background Information and Organizational Structure	**15**
3. Leadership and Management	**15**
4. Financial Plan and Experience with Risk Sharing	**15**
5. Clinical Care Model	**20**
6. Quality Measurement	**15**
8. Community Partnerships and Social Determinants of Health	**15**
Total:	**100 points**

b. The evaluation team will review the components of each responsive Proposal submitted. Each component will be evaluated on the Responder's understanding and the quality and completeness of the Responder's approach and solution to the problems or issues presented.

c. After reviewing the Proposals, the members of the evaluation team will rate each Proposal component according to the following scale:

Proposal Component Rating	Point Factor
Excellent	1.000
Very Good	0.875
Good	0.750
Satisfactory	0.625
Poor	0.500
Unacceptable	0.000

Upon determining which of the above Ratings best describes the component being rated, the total possible points available for the component from paragraph a will be multiplied by the corresponding point factor.

EXAMPLE: A "very good" rating (0.875) of a Proposed Work Plan worth a maximum of 40 points would receive a score of 35 (40 x 0.875 = 35).

All component scores will then be added together to create a Proposal's total score.

A minimum score of 40 will be required for Responders to be considered for acceptance into the program. A score greater than 40 does not guarantee participation in the program. Scoring will generally be used to determine the adequacy and completeness of an IHP's proposal, but as stated above, the IHP model is flexible and supportive of emerging and/or innovative models for inclusion in the program.

3. *Phase III*: Selection of the Successful Responder(s)

a. Only the Proposals found to be responsive under Phases I and II will be considered in Phase III.

b. The evaluation team will review the scoring in making its recommendations of the successful Responder(s).

c. STATE may submit a list of detailed comments, questions, and concerns to one or more Responders after the initial evaluation. STATE may require said response to be written, oral, or both. STATE will only use written responses for evaluation purposes. The total scores for those Responders selected to submit additional information may be revised as a result of the new information.

d. The evaluation team will make its recommendation based on the above-described evaluation process. The successful Responder(s), if any, will be selected approximately one week after the Proposal submission due date.

9.4 Contract Negotiations and Unsuccessful Responder Notice

If a Responder(s) is selected, STATE will notify the successful Responder(s) in writing of their selection and STATE's desire to enter into contract negotiations. Until STATE successfully completes negotiations

with the selected Responder(s), all submitted Proposals remain eligible for selection by STATE. Data created or maintained by the STATE as part of the evaluation process (except trade secret data as defined and classified in Minn. Stat. § 13.37) will be public data when contract negotiations have been successfully completed. If the STATE determines that it is unlikely that a Responder will be selected for contract negotiations, the STATE may, as a courtesy, notify the Responder that it has not been selected for contract negotiations.

In the event contract negotiations are unsuccessful with the selected Responder(s), the evaluation team may proceed with the next highest scorer.

After STATE and chosen Responder(s) have successfully negotiated a contract, STATE will notify the unsuccessful Responders in writing that their Proposals have not been accepted. All public information within Proposals will then be available for Responders to review, upon request.

10.REQUIRED CONTRACT TERMS AND CONDITIONS

A. Requirements. All Responders must be willing to comply with all state and federal legal requirements regarding the performance of the grant contract. **The full requirements are set forth throughout this RFP and are contained in the attached sample grant contract in the Appendix. The attached sample grant contract should be reviewed for the terms and conditions that will likely govern any resulting contract from this RFP.** Please note that the attached sample contract includes language covering both the Track 1 and Track 2 IHP model options; this current IHP RFP opportunity is limited to Track 1 IHP model applicants only. Although this RFP establishes the basis for Responder Proposals, the detailed obligations and additional measures of performance will be defined in the final negotiated contract.

B. Governing Law/Venue. This RFP and any subsequent contract must be governed by the laws of State of Minnesota. Any and all legal proceedings arising from this RFP or any resulting contract in which STATE is made a party must be brought in the State of Minnesota, District Court of Ramsey County. The venue of any federal action or proceeding arising here from in which STATE is a party must be the United States District Court for the State of Minnesota in Ramsey County.

C. Preparation Costs. STATE is not liable for any cost incurred by Responders in the preparation and production of a Proposal. Any work performed prior to the issuance of a fully executed grant contact will be done only to the extent the Responder voluntarily assumes risk of non-payment.

D. Contingency Fees Prohibited. Pursuant to Minn. Stat. § 10A.06, no person may act as or employ a lobbyist for compensation that is dependent upon the result or outcome of any legislation or administrative action.

E. Accessibility Standards. Any information systems, tools, information content, and/or work products, including the response to this solicitation/contract, applications, web sites, video, learning modules, webinars, presentations, etc., whether commercial off-the-shelf (COTS) or custom, purchased or developed, must comply with the Minnesota IT Accessibility Standards effective September 1, 2010, as

updated on June 14, 2018. This standard requires in part, compliance with the Web Content Accessibility Guidelines (WCAG) 2.0 (Level AA) and Section 508 Subparts A-D.

Information technology deliverables and services offered must comply with the MN.IT Services Accessibility Standards.[11] (The relevant requirements are contained under the "Standards" tab at the link above.) Information technology deliverables or services that do not meet the required number of standards or the specific standards required may be rejected and may not receive further consideration.

F. Insurance Requirements

1. Responder shall not commence work under the grant contract until they have obtained all the insurance described below and the State of Minnesota has approved such insurance. All policies and certificates shall provide that the policies shall remain in force and effect throughout the term of the grant contract.
2. Responder is required to maintain and furnish satisfactory evidence of the following insurance policies:
    a. Workers' Compensation Insurance: Except as provided below, Responder must provide Workers' Compensation insurance for all its employees and, in case any work is subcontracted, Responder will require the subcontractor to provide Workers' Compensation insurance in accordance with the statutory requirements of the State of Minnesota, including Coverage B, Employer's Liability. Insurance minimum amounts are as follows:

    $100,000 – Bodily Injury by Disease per employee
    $500,000 – Bodily Injury by Disease aggregate
    $100,000 – Bodily Injury by Accident

    If Minnesota Statute, section 176.041 exempts Responder from Workers' Compensation insurance or if the Responder has no employees in the State of Minnesota, Responder must provide a written statement, signed by an authorized representative, indicating the qualifying exemption that excludes Responder from the Minnesota Workers' Compensation requirements.

    If during the course of the grant contract the Responder becomes eligible for Workers' Compensation, the Responder must comply with the Workers' Compensation Insurance requirements herein and provide the State of Minnesota with a certificate of insurance

    b. Commercial General Liability: Responder is required to maintain insurance protecting it from claims for damages for bodily injury, including sickness or disease, death, and for care and loss of services as well as from claims for property damage, including loss of

[11] https://mn.gov/mnit/about-mnit/accessibility/

use which may arise from operations under the grant contract whether the operations are by the Responder or by a subcontractor or by anyone directly or indirectly employed by the Responder under the grant contract. Insurance minimum amounts are as follows:

$2,000,000 – per occurrence
$2,000,000 – annual aggregate
$2,000,000 – annual aggregate – Products/Completed Operations

The following coverages shall be included:

Premises and Operations Bodily Injury and Property Damage
Personal and Advertising Injury
Blanket Contractual Liability
Products and Completed Operations Liability
Other; if applicable. Please list_____.
State of Minnesota named as an Additional Insured, to the extent permitted by law.

c. Commercial Automobile Liability: Responder is required to maintain insurance protecting the Responder from claims for damages for bodily injury as well as from claims for property damage resulting from ownership, operation, maintenance or use of all owned, hired, and non-owned autos which may arise from operations under this grant contract, and in case any work is subcontracted the Responder will require the subcontractor to provide Commercial Automobile Liability. Insurance minimum amounts are as follows:

$2,000,000 – per occurrence Combined Single limit for Bodily Injury and Property Damage

In addition, the following coverages should be included:

Owned, Hired, and Non-owned Automobile

d. Professional/Technical, Errors and Omissions, and/or Miscellaneous Liability Insurance

This policy will provide coverage for all claims the Responder may become legally obligated to pay resulting from any actual or alleged negligent act, error, or omission related to Responder's professional services required under the grant contract.

Responder is required to carry the following minimum amounts:

$2,000,000 – per claim or event
$2,000,000 – annual aggregate

Any deductible will be the sole responsibility of the Responder and may not exceed $50,000 without the written approval of the State. If the Responder desires authority from the State to have a deductible in a higher amount, the Responder shall so request in writing, specifying the amount of the desired deductible and providing financial documentation by submitting the most current audited financial statements so that the State can ascertain the ability of the Responder to cover the deductible from its own resources.

The retroactive or prior acts date of such coverage shall not be after the effective date of this grant contract and Responder shall maintain such insurance for a period of at least three (3) years, following completion of the work. If Responder discontinues such insurance, then extended reporting period coverage must be purchased to fulfill this requirement.

e. Blanket Employee Theft/Employee Dishonesty Insurance.

Responder is required to obtain a blanket employee theft/employee dishonesty policy in at least the total amount of the first year's grant award as either an addendum on its property insurance policy, or if it is not feasible to include it as an addendum to a property insurance policy, as a stand-alone employee theft/employee dishonesty policy. The State will be named as both a joint payee and a certificate holder on the property insurance policy addendum or on the stand-alone employee theft/employee dishonesty policy, whichever is applicable. Only in cases in which the first year's grant award exceeds the available employee theft/employee dishonesty coverage may Responders provide blanket employee theft/employee dishonesty insurance in an amount equal to either 25% of the yearly grant amount, or the first quarterly advance amount, whichever is greater. Upon execution of a grant contract, the Responder must furnish the State with a certificate of employee theft/employee dishonesty insurance. This requirement does not apply to grant contracts with the University of Minnesota, counties, school districts or reservations.

f. Additional Insurance Conditions:
    i. Responder's policy(ies) shall be primary insurance to any other valid and collectible insurance available to the State of Minnesota with respect to any claim arising out of Responder's performance under this grant contract;
    ii. If Responder receives a cancellation notice from an insurance carrier affording coverage herein, Responder agrees to notify the State of Minnesota within five (5) business days with a copy of the cancellation notice, unless Responder's policy(ies) contain a provision that coverage afforded under the policy(ies) will not be cancelled without at least thirty (30) days advance written notice to the State of Minnesota;

iii. Responder is responsible for payment of grant contract related insurance premiums and deductibles;
iv. If Responder is self-insured, a Certificate of Self-Insurance must be attached;
v. Include legal defense fees in addition to its liability policy limits, with the exception of II.G.2.d. above; and
vi. Obtain insurance policies from an insurance company having an "AM BEST" rating of A- (minus); Financial Size Category (FSC) VII or better and must be authorized to do business in the State of Minnesota; and
vii. An Umbrella or Excess Liability insurance policy may be used to supplement the Responder's policy limits to satisfy the full policy limits required by the grant contract.

3. The State reserves the right to immediately terminate the grant contract if the Responder is not in compliance with the insurance requirements and retains all rights to pursue any legal remedies against the Responder. All insurance policies must be open to inspection by the State, and copies of policies must be submitted to the State's authorized representative upon written request.

4. The successful Responder is required to submit Certificates of Insurance acceptable to the State of Minnesota as evidence of insurance coverage requirements prior to commencing work under the grant contract.

11. STATE'S AUTHORITY

1. STATE may:

A. Reject any and all Proposals received in response to this RFP;

B. Disqualify any Responder whose conduct or Proposal fails to conform to the requirements of this RFP;

C. Have unlimited rights to duplicate all materials submitted for purposes of RFP evaluation, and duplicate all public information in response to data requests regarding the Proposal;

D. Select for contract or for negotiations a Proposal which best represents "best value" as defined in Minnesota Statutes, section 16C.02, subdivision 4 and in this RFP document;

E. Consider a late modification of a Proposal if the Proposal itself was submitted on time and if the modifications were requested by STATE, and the modifications make the terms of the Proposal more favorable to STATE, and accept such Proposal as modified;

F. At its sole discretion, reserve the right to waive any non-material deviations from the requirements and procedures of this RFP;

G. Negotiate as to any aspect of the Proposal with any Responder and negotiate with more than one Responder at the same time, including asking for Responders' "Best and Final" offers;

H. Extend the grant contract, in increments determined by STATE, not to exceed a total contract term of five years;

I. Cancel the RFP at any time and for any reason with no cost or penalty to STATE; and

J. STATE will not be liable for any errors in the RFP or other responses related to the RFP.

2. If federal funds are used in funding a contract that results from this RFP, in accord with 45 C.F.R. § 92.34, for Works and Documents created and paid for under the contract, the U.S. Department of Health and Human Services will have a royalty free, non-exclusive, perpetual and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the Works or Documents created and paid for under a resulting contract for federal government purposes.

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12.GLOSSARY OF ACRONYMS

BHH – Behavioral Health Home
CCBHC – Certified Community Behavioral Health Clinic
DHS – Department of Human Services
IHP – Integrated Health Partnerships
E&M – Evaluation & Management
EAS – Encounter Alert System
EMR – Electronic Medical Record
FFS – Fee-for-Service
HCH – Health Care Home
HIE – Health Information Exchange
MCO – Managed Care Organization
MHCP – Minnesota Health Care Program
MPIP – Medicaid Promoting Interoperability Program
NCQA – National Committee for Quality Assurance
PBP – Population-Based Payment
PCMH – Patient Centered Medical Home
PMPM – Per-Member-Per-Month
RFP – Request for Proposals
TCOC – Total Cost of Care

Remainder of the page intentionally left blank. (Appendices follow)

13.APPENDICES

Appendix A: Integrated Health Partnerships Application Template
- Appendix A-1: Letter of Intent Template
- Appendix A-2: IHP Roster Submission Process
- Appendix A-3: Sample Roster Template

Appendix B-1: Example Health System Characteristics
Appendix B-2: Eligible and Excluded Populations
Appendix C: Attribution Methodology
Appendix D: Payment Mechanism Methodology
Appendix E: Health Equity Measures Template
Appendix F: IHP Reports and Data
Appendix G: Sample IHP Contract
Appendix H: Sample Population Health Report

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