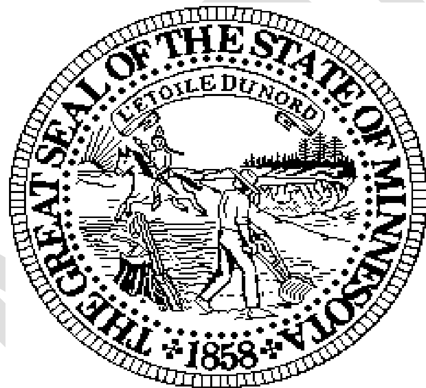
MINNESOTA
DEPARTMENT OF HUMAN SERVICES

INTEGRATED HEALTH PARTNERSHIPS CONTRACT



With

<IHP NAME>

January 1, 2024

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Contract Data – this page is not part of the contract

Field's content	Name of the field	***Type over the colored text to fill in this contract's data here:***
Name of this IHP	Data name IHP	<IHP Name>
Year of this contract	Data start year	2024
Starting date of this contract	Data start date	January 1, 2024
Ending date of this contract	Data end date	December 31, 2026
IHP contact person name	Data IHP contact	<Insert Name>
DHS contact person name	Data DHS contact	Mathew Spaan
Contract number	Data contract number	<Insert Number>
Next year from the start year	Data Next Year	2024
Two years from the start year	Data Next2 Year	2025
Last year from the start year	Data Prev Year	2023
Two years ago from start year	Data Prev2 year	2022
Base Period	Data base period	2023
Performance period 1	Data Perf period 1	2024
Performance period 2	Data Perf period 2	2025
Performance period 3	Data Perf period 3	2026
Signer from DHS	Data signer	Julie Marquardt
Signer from DHS title	Data signer title	Acting Assistant Commissioner, State Medicaid Director

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STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

INTEGRATED HEALTH PARTNERSHIPS CONTRACT

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STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
INTEGRATED HEALTH PARTNERSHIPS CONTRACT
For <IHP NAME>

This Contract, and all amendments and supplements to the contract (“CONTRACT”), is between the State of Minnesota, acting through its Department of Human Services, Health Care Administration (“STATE”) and Click here to enter Grantee Name, an independent IHP, not an employee of the State of Minnesota, located at Click here to enter physical street address, city, state, zip code (“IHP”).

RECITALS

1. The STATE, pursuant to Minnesota Statutes, § 256.01, subd. 2 (a) (6) and § 256B.0755, has authority to enter into contracts for an Integrated Health Partnerships payment model that will represent a wide variety of geographic locations, patient populations, providers, and care coordination models, and will encourage formal and informal partnerships among health care delivery systems, counties, and non-profit agencies that provide services such as social services, public health, mental health, community-based projects, and continuing care; and

2. STATE has received approval from the Centers for Medicare and Medicaid Services (CMS) for Integrated Care Models for Health Care Delivery Systems State Plan Amendment; and

3. STATE is in need of contractors for the delivery of health care services as described in Minnesota Statutes, § 256B.0755, and

4. STATE, in accordance with Minnesota Statutes, section 13.46, is permitted to share information with IHP; and

5. IHP has established a mechanism of shared governance as described in Minnesota Statutes,

§ 256B.0755, subd. 1 (d); and

6. IHP represents that it is duly qualified and willing to perform the services set forth in this CONTRACT to the satisfaction of the STATE.

THEREFORE, the parties agree as follows:

Section 1. CONTRACT TERM AND SURVIVAL OF TERMS

1.1 Effective date: This Contract shall be effective on January 1, 2024, or the date that the STATE obtains all required signatures under Minnesota Statutes, §16B.98, subdivision 5, whichever is later.

1.2 Expiration date. This CONTRACT is valid through December 31, 2026**,** or until all obligations set forth in this CONTRACT have been satisfactorily fulfilled, whichever occurs first.

1.3 No performance before notification by STATE. IHP may not begin work under this CONTRACT, nor will any payments or reimbursements be made, until all required signatures have been obtained per Minn. Stat. § 16B.98, subd. 7, and IHP is notified to begin work by STATE's Authorized Representative.

1.4 Survival of terms. All provisions of this Contract that, by their nature and content, should survive the termination of this Contract in order to achieve the fundamental purposes of this Contract shall survive and continue to bind the Parties. IHP’s continuing obligations, after said period, include but are not limited to the following provisions: Section 9, Information Privacy and Security; Section 10,

Intellectual Property Rights, Section 12.1 Governing Law, Jurisdiction and Venue, Section 12.8 Indemnification (with regard to acts or omissions that occurred during the term of the Contract or in connection with continuing Contract obligations post termination), and Section 12.9 State Audits.

1.5 Time is of the essence. IHP will perform its duties within the time limits established in CONTRACT unless it receives written approval from STATE. In performance of CONTRACT, time is of the essence.

Section 2. ACRONYMS, ABBREVIATIONS AND DEFINITIONS.

The following terms as used in this Contract and its Appendices shall be construed and interpreted as follows:

2.1 Adjusted Clinical Groups (ACG) means the data obtained from claims and encounters as derived from the Johns Hopkins Adjusted Clinical Groups (ACG®).

2.2 All-In Roster means a comprehensive list of billing NPIs for their participating locations. DHS will use this list, in conjunction with claims data, to build and maintain a provider Roster.

2.3 Attributed Population means the Patients included in the Total Cost of Care calculations for which the IHP is accountable.

2.4 Attribution means the process, described in Section 13.3, of determining which Patients are assigned to a particular IHP.

2.5 Billing/Treating Provider Roster means a specific subset of treating providers who bill at participating locations, including the individual treating or servicing providers' NPIs and organizational level billing NPIs. DHS will use this list, in conjunction with claims data, to build and maintain a provider Roster.

2.6 Child and Teen Checkups (C&TC) is the name for Minnesota's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. C&TC are covered services for children from birth through twenty (20) years who are enrolled in Medical Assistance (MA).

2.7 Claims Run-out means the period of time between the date a service is rendered and the date the claims or encounter data record is considered complete.

2.8 Contract means this Contract, its terms and conditions, appendices, documents incorporated by reference under the terms of this Contract, and any future modifying agreements made pursuant to Section 12.4 of this Contract.

2.9 Day means calendar day unless otherwise specified (for example, business day). If due dates for reporting requirements fall on the weekend or on a holiday, the report will be due to the STATE on the following business day.

2.10 Equity Score Card means the document that provides a numerical score and feedback on the IHP's annual Population Health Report.

2.11 Fee–For-Service (FFS) means the Minnesota Health Care Programs payment method whereby a health care provider is paid directly by DHS for each service rendered.

2.12 Final Payment (Applicable to Track 2 only) means an adjustment to the Interim Payment that occurs after the conclusion of a Performance Period based on complete data. A percentage of the Final Payment shall be affected by IHP performance on quality and patient experience measures.

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2.13 Health Home means a provider organization certified by the Minnesota Department of Health (MDH) as a Health Care Home (HCH) pursuant to Minnesota Statutes, § 256B.0751, or a Behavioral Health Home certified by the Minnesota Department of Human Services (DHS) pursuant to Minnesota Statutes, § 256B.0757.

2.14 IHP Entity means an Integrated Health Partnership that is able to coordinate or deliver the full scope of primary care services and directly deliver or demonstrate the ability to coordinate with additional non-primary care providers. The IHP Entity may be a separate legal entity able to bind providers to the terms of this Contract to deliver services. The IHP Entity that is a Party to this Contract is further described in Section 14.

2.15 IHP Fiscal Agent means the agent or entity acting as the fiscal agent for the IHP Entity that makes, distributes or receives Population-Based Payments, Interim Payments and Final Payments.

2.16 IHP Participant means a constituent part of an IHP as a health care delivery system, and includes but is not limited to clinic location(s), hospitals, physician and other provider group(s) or outpatient service locations. Each IHP Participant shall be included in the Shared Governance mechanism required by Minnesota Statutes, § 256B.0755, subd. 1(d). A list of the IHP Participants and a description of the shared governance system is included in Section 14.

2.17 Integrated Health Partnership (IHP) means a health care delivery system described in Minnesota Statutes, § 256B.0755, subd. 1(d).

2.18 Interim Payment (Applicable to Track 2 only) means the payment of the Shared Savings amount that occurs after the conclusion of a Performance Period based on the most complete data available at that time. The Interim Payments shall not be affected by IHP performance on quality and patient experience measures.

2.19 Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract with the STATE pursuant to the Minnesota PMAP program in Minnesota Statutes, § 256B.69 and the MinnesotaCare program in Minnesota Statutes, Chapter 256L.

2.20 MinnesotaCare means the program authorized in Minnesota Statutes, Chapter 256L.

2.21 Minnesota Health Care Programs (MHCP) means Minnesota's Medical Assistance and MinnesotaCare programs including FFS and managed care programs.

2.22 Minnesota Health Care Programs Provider Agreement means the form DHS-4138 agreement, as amended, between the STATE and a provider allowing the provider to serve MHCP recipients.

2.23 National Provider Identifier (NPI) means, in the context of this Contract, the 10-digit numeric identifier that is used on claim forms submitted to payers by individual and organizational health care providers, which DHS uses for the purposes of identifying an IHP's attributable population.

2.24 Party means the STATE or IHP and Parties means both the STATE and IHP.

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2.25 Patient or Attributed Patient means, for purposes of this Contract, either a recipient in the MHCP FFS program or an MCO enrollee who is included in the IHP's Attributed Population.

2.26 Performance Period means a period of time for the purposes of calculating the Total Cost of Care for services provided to the IHP Attributed Patients.

2.27 Population-Based Payment (PBP) means a payment that supports care coordination services for all individuals served by integrated health partnerships pursuant to Minnesota Statutes, § 256B.0755, subd. 4(d), as described in Section 15.

2.28 Population Health Report means the report completed by the IHP on their Equity Intervention and described in Sections 4.5.2 and 8.1.1.

2.29 Prepaid Medical Assistance Program (PMAP) means the Medicaid program authorized under Minnesota Statutes, § 256B.69 and Minnesota Rules, Parts 9500.1450 through 9500.1464.

2.30 Primary Care Provider means a health care provider whose principal specialty is among those listed as primary care or PCP in Appendix 1, Provider Taxonomy, which is attached and incorporated into this CONTRACT.

2.31 Quality Measurement Period means a specific reporting period based upon dates of service, discharge dates, or visit dates for which a particular quality or patient experience measure is calculated to determine scoring and impact on Shared Savings.

2.32 Roster means a list of the IHP Participants and Primary Care and Specialty Providers the IHP provides to the STATE at least fourteen (14) days before the first day of each quarter according to specifications provided by the STATE.

2.33 Shared Governance means a mechanism of IHP governance pursuant to Minnesota Statutes, § 256B.0755, subd. 1(d).

2.34 Shared Losses means the amount by which the observed Performance Period Total Cost of Care is in excess of the adjusted Total Cost of Care target for the Performance Period after the IHP Entity exceeds the performance threshold as described in Section 16.

2.35 Shared Savings means the amount by which the observed Performance Period Total Cost of Care is below the adjusted Total Cost of Care target for the Performance Period after the IHP Entity exceeds the performance threshold as described in Section 16.

2.36 Specialty Provider means a provider whose principal specialty is other than those listed as primary care according to Appendix 1, Provider Taxonomy.

2.37 Total Cost of Care (TCOC) means, in the context of this Contract, the cost of services as specified in Section 16, using the list of core services in Appendix 2, Included Services – Category of Service Table, which is attached and incorporated into this CONTRACT.

Section 3. IHP REQUIREMENTS.

IHP represents and warrants that it meets the requirements of Minnesota law, in that:

SAMPLE

3.1 Legal Entity.

IHP warrants it is a recognized legal entity formed under applicable state, federal, or tribal law and authorized to conduct business in the State of Minnesota. Its charter, articles, and/or bylaws allow it to:

3.1.1 Establish reporting, and ensure IHP Participants' compliance with reporting of health care quality measures in Section 17 and Section 18 (Applicable to Track 2 only), as applicable; and

3.1.2 Fulfill other IHP functions as defined herein.

3.2 Governance.

IHP warrants that IHP and its Participants have a mechanism of Shared Governance in accordance with Minnesota Statutes, § 256B.0755, subd. 1(d), which is described in Section 14.5. In addition:

3.2.1 The IHP must make available a copy of this Contract to each IHP Participant, and other individuals and entities involved in IHP governance.

3.2.2 The IHP governing body must have a conflict-of-interest policy that applies to members of the governing body, IHP management and their agents who exercise operational or managerial control over the IHP. The conflict-of-interest policy must:

3.2.3 Require the disclosure of relevant financial interests;

3.2.4 Provide a procedure to determine whether a conflict of interest exists and set forth a process to address conflict; and

3.2.5 Address remedial action for any person or entity that fails to comply with the policy.

3.3 Legal Authority.

IHP warrants that it possesses the legal authority to enter into this Contract and that it has taken all actions required by its articles, by-laws, resolutions, operating agreements and/or applicable laws to exercise that authority, and to authorize its undersigned signatories to execute this Contract, or any part thereof, and to bind IHP and IHP Participants to its terms.

3.4 Documentation of Legal Entity and Fiscal Soundness.

Upon request, IHP must provide copies to the STATE of all relevant documents effectuating the IHP's formation and operation relevant to the IHP program, including but not limited to its articles, by-laws, resolutions, operating agreements, partnership agreements, joint venture agreements, management and consulting agreements, asset purchase agreements, financial statements and records, and resumes and other documentation for leaders of the IHP.

3.5 Reporting.

On an annual basis, the IHP must submit to the STATE its most recent certified financial audit, IRS Form 990, or most recent board-reviewed financial statements of its IHP Participants by December 1.

3.6 Assurance of Ability to Make Final Payments. (Applicable to Track 2 only)

IHP must have the ability to make a Final Payment of Shared Losses for which it may be liable. The STATE may request documentation that the IHP is capable of making a Final Payment of Shared Losses, if it is expected that a Shared Losses payment may exceed the amount that DHS FFS program would pay the IHP Fiscal Agent for 120 days' services. Documentation of a repayment mechanism may include reinsurance, escrowed funds, surety bonds, a line of credit the STATE can draw upon, or another payment mechanism that will ensure its ability to repay the STATE.

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3.7 Taxpayer Identification Number.

IHP will designate a single Taxpayer Identification Number (TIN) of the IHP Fiscal Agent to receive any Population-Based Payments or Interim or Final Payments.

3.8 Provider Rosters.

IHP agrees that its IHP Participants and providers will remain as listed on the most recent Roster reported to the STATE:

3.8.1 IHP may modify IHP Participant National Provider Identifiers (NPIs), locations, clinics, specialties, groups of providers, or add individual Primary Care Providers or Specialty Providers to its Roster by submitting an updated Billing/Treating Roster or All-In Roster at least fourteen (14) days prior to the beginning of each calendar quarter. IHP may only add non-Participant locations, clinics, specialties, regional health systems, or groups of providers only by amending Section 14.3 as applicable, pursuant to Section 12.4. All Roster changes are effective the quarter following notification of the change. It is the IHP's responsibility to maintain the accuracy of the Roster, and any new Roster must be certified as described in Section 4.9.5.

3.8.2 Any changes to processes for maintaining provider Rosters and corresponding impacts to Attribution will be discussed with the IHP, and at least ninety (90) days' notice will be provided to the IHP.

3.8.3 Any changes to the provider Roster or in the way claims are submitted for providers on the Roster or by individual IHP Participants that result in a significant change in the population attributed to the IHP may result in discussions of the impacted terms of contract including but not limited to payment.

3.8.4 An IHP must designate its Roster as an All-In or Billing/Treating Roster in Section 14.4.

3.8.4.1 All-In Rosters must include clinic level billing NPIs for all IHP Participants. DHS will use the most recently submitted All-In Roster for an IHP, unless the IHP submits an updated Roster. Roster updates must be submitted to DHS no later than fourteen (14) days before the beginning of each quarter.

3.8.4.2 Billing/Treating Rosters must include all relevant IHP Participant billing NPIs and individual treating provider NPIs and indicate whether a provider serves as a Primary Care Provider ("PCP") or Specialty Provider ("SPE") in its organization. If neither a PCP / SPE designation nor a primary taxonomy code is included on the Roster, the primary taxonomy code for that provider from the National Plan and Provider Enumeration System (NPPES) file will be used to categorize the provider according to the information contained in the weblink in Appendix 1. A provider taxonomy not listed in this appendix will be considered a Specialty Provider, unless the IHP has otherwise designated the provider as a "PCP" on their Roster. Mapping Definitions from the NUCC Database Download can be found in Appendix 1, Provider Taxonomy, on the DHS website. DHS will use the most recently submitted All-In Roster for an IHP, unless the IHP submits an updated Roster. Roster updates must be submitted to DHS no later than fourteen (14) days before the beginning of each quarter.

3.8.5 The IHP Roster effective in the final quarter of each Performance Period will be utilized for calculation of the Performance Period's Total Cost of Care Financial Settlement, as described in Section 16 (Total cost of Care – Financial Settlement Information).

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3.8.6 (Applicable to Track 2 only) The IHP Participant list effective in the final quarter of each Performance Period will be utilized for the purpose of awarding points for Quality Measures included in Section 18 (Total Cost of Care – Quality Measures), where applicable. The IHP will review and attest to the accuracy of relevant measurement IDs included in the IHP Participant list no later than the final business day of March following the close of each Performance Period.

3.9 Statutory Eligibility.

IHP warrants that it is eligible to participate in the IHP program consistent with Minnesota Statutes, § 256B.0755, in that it and/or its Participants has or will:

3.9.1 Establish processes to monitor and ensure the quality of care provided;

3.9.2 Provide or coordinate the full scope of primary care, and adopt methods of care delivery so that the full scope of primary care is provided and care is coordinated across the spectrum of services provided;

3.9.3 Contract and/or coordinate with necessary providers and clinics for the delivery of care; and contract or form partnerships with community-based organizations and public health resources;

3.9.4 Develop and use processes to engage Patients and their families meaningfully in the care they receive;

3.9.5 Have the capability to use data provided by the STATE to identify opportunities for Patient engagement and to stratify its population to determine the care model strategies needed to improve outcomes;

3.9.6 Provide consistent implementation of its care delivery model regardless of whether a Patient is enrolled in FFS or managed care in accordance with Minnesota Statutes, § 256B.0755, subd. 1(c); and

3.9.7 Utilize the population-based payment to support care coordination services for all individuals served by the IHP, while meeting cost and quality metrics under the program to maintain eligibility.

3.10 Insurance and Insurance Risk Management.

IHP shall not begin work under the CONTRACT until it has obtained all the insurance described below and STATE has approved such insurance. IHP shall maintain the insurance in force and effect throughout the term of the contract. IHP is required to maintain and furnish satisfactory evidence of the following insurance policies.

3.10.1 Worker's Compensation. The IHP certifies that it is in compliance with Minn. Stat. § 176.181, subd. 2, pertaining to workers' compensation insurance coverage. The IHP's employees and agents will not be considered employees of the STATE. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees or agents and any claims made by any third party as a consequence of any act or omission on the part of these employees or agents are in no way the STATE's obligation or responsibility. Minimum insurance limits are as follows:

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

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If Minn. Stat. § 176.041 exempts IHP from Workers' Compensation insurance mandates, including if IHP has no employees in the State of Minnesota, IHP must provide a written statement, signed by an authorized representative, indicating the qualifying exemption that excludes IHP from the Minnesota Workers' Compensation requirements.
IHP's employees and agents will not be considered employees of STATE. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees or agents and any claims made by any third party as a consequence of any act or omission on the part of these employees or agents are in no way STATE's obligation or responsibility.

3.10.2 General Commercial Liability Insurance. IHP agrees that it will at all times during the term of the contract keep in force a commercial general liability insurance policy with the following minimum insurance limits:

- $2,000,000 per occurrence
- $2,000,000 annual aggregate

Such insurance will protect 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 use which may arise from operations under the contract whether the operations are by IHP or by a subcontractor or by anyone directly or indirectly employed by IHP under the contract. STATE will be named as both an additional insured and a certificate holder on the general commercial liability policy.

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Section 4. DUTIES.

4.1 Participation in Program.

IHP and the STATE agree to participate in the program described in Minnesota Statutes, § 256B.0755.

4.2 Provider Enrollment.

All IHP Participants and their providers must be enrolled in MHCP and comply with the provisions of the MHCP Provider Agreement, as amended.

4.3 Population-Based Payment

IHP understands and agrees that the IHP program requires calculation of a quarterly population-based payment (PBP) based upon the Attribution of Patients to the IHP. The Attribution model is described in Section 13. The population-based payment calculation is described in Section 15, based on current Roster submission by IHP.

4.4 Shared Savings or Losses. (Applicable to Track 2 only)

IHP understands and agrees that the IHP program requires calculation of Shared Savings or Shared Losses based upon the Attribution of Patients to the IHP. The Attribution model is described in Section 13. The Shared Savings and Shared Losses calculation is described in Section 16.

4.5 Provision of Data.

To the extent authorized by Minnesota law, the Parties agree to provide data as follows:

4.5.1 Data from IHP. IHP and/or its Participants agrees to provide necessary data in the form of claims and/or encounters, as required by its MHCP Provider Agreement with DHS or its

contract with any MCO that participates in the Minnesota Health Care Programs, using standard data formats as required by state and federal law and/or the relevant contract.

4.5.1.1 Claims and/or encounters must be submitted within the timeframes required by the relevant provider agreement or contract.

4.5.1.2 Quality and patient experience data must be submitted consistent with the data collection and submission requirements for measures in Section 17 and Section 18 (Applicable to Track 2 only).

4.5.1.3 In the event the STATE identifies trends or patterns suggesting improper claim submission, discriminatory marketing activities, selective recruitment, or avoidance of at-risk patients, IHP agrees to submit additional documentation as required by the STATE for further investigation.

4.5.1.4 Upon request, the IHP shall provide status updates, data, or reports to the STATE associated with the IHP program to assist the STATE in meeting CMS monitoring and reporting obligations related to the status and progress of the IHP's care delivery transformation. This includes: participation in IHP learning collaboratives, tracking the progress of the IHP's analysis of utilization and ACG output data provided by the STATE as well as the IHP's clinical data, and updates on the progress of expansion and formation of relationships and coordination with community partners.

4.5.2 Population Health Report. Annually, the IHP shall demonstrate how the IHP's population health initiatives operate to improve service and address population health issues relevant to the IHP attributed population.

4.5.2.1 The STATE will make the Population Health report template available to IHPs by March 31 of the contract year.

4.5.2.2 The Population Health report shall be completed and submitted in accordance with Section 8.1.1 and Section 14.8.

4.5.3 Child and Teen Checkups Outreach Report. Annually, the IHP shall demonstrate the Child and Teen Checkups outreach activities.

4.5.3.1 The STATE will make the initial Child and Teen Checkups Outreach Report template available to IHPs by March 31, 2024, and subsequent templates will be made available to IHPs prior to the start of each remaining contract year.

4.5.3.2 The initial Child and Teen Checkups Outreach Report shall be completed and submitted by March 1, 2025, and subsequent reports will be due to DHS by March 1 following each remaining contract year.

4.6 Data from STATE.

STATE agrees to provide the following data in a secure format:

4.6.1 Clinical Data. The STATE will provide clinical data, enrollment data, ACG risk adjustment output and claims-level data outlined below for the IHP's Attributed Population monthly throughout the term of this Contract, unless otherwise mutually agreed by the Parties in writing. Data will be derived from the STATE data warehouse, and will include both FFS claim data and MCO encounter data in a form and format determined by the STATE. The STATE will provide IHP with at least ninety (90) days' notice of changes in the data format, unless otherwise mutually agreed by the Parties.

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4.6.1.1 Data for a rolling twelve (12) month period will be provided on a monthly basis no later than the final business day of each month, unless otherwise mutually agreed in writing by the Parties. The ACG risk adjustment output will have a three (3) month lag for Claims Run-out; claims-level data will not have a lag for Claims Run-out.

4.6.1.2 Data will include patient claim-level data (which must be protected according to Section 9) including name and date of birth; procedure codes and diagnosis codes, inpatient and emergency department utilization; medical and pharmacy utilization; predictive risk information including an individual risk score; and indices of care coordination for the defined Attributed Population. All lines of claims for chemical and alcohol dependency treatment programs as governed by 42 USC § 290dd-2 and 42 CFR § 2.1 to § 2.67 will be excluded.

4.6.2 Quarterly Total Cost of Care Data Package. The STATE will provide lists of Patients with name and date of birth who are attributed to the IHP, their Total Cost of Care, and risk score according to the methodology described in Section 13.6, applied to the eligible populations described in Sections 13.1 and 13.2 and based on the Information Sets described in Section 16. For the second, third, and fourth quarters of each Performance Period, the STATE will provide these data packages forty-five (45) days after the end of each quarter. For the first quarter of each Performance Period, the data package will be the Interim Settlement calculation and related materials and will be provided according to the timing described in Section 5.4.2.

4.6.3 Annual payment-to-charge ratio or equivalent cost factor, as determined by the STATE. The STATE will provide a payment-to-charge ratio or equivalent cost factor annually to the IHP and no later than forty-five (45) days after the beginning of the Performance Period.

4.6.4 IHP may reconcile its patients to its Attributed Population list.

4.6.4.1 In the event that IHP believes an Attributed Population list contains errors, IHP must provide notice and supporting data to the STATE, according to error report specifications provided by the STATE, no later than sixty (60) days after receiving the Attributed Population list associated with the settlement or Population-Based Payment calculation.

4.6.4.2 The STATE will review the possible error(s) and at least thirty (30) days before the Final Payment calculation will provide a written response of whether it will make changes based upon this review. The determination that results from the STATE's review shall be final. Any adjustment to the IHP Attributed Population based on the STATE's review will be included in the IHP's Final Payment calculation or to the Population-Based Payment reconciliation taking place following the close of the Performance Period.

4.6.5 The STATE shall not provide provider- or episode-specific cost of care for any code or encounter, pursuant to Minnesota Statutes, § 256B.69, subd. 9c.

4.7 Data Problems.

The Parties will work together to anticipate and mitigate problems that may affect the data in Section 4.5.

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4.8 Data Analysis.

4.8.1 The STATE shall perform necessary data analysis to calculate the Attribution, population-based payments, and settlement methods described in Sections 13.3 through 13.11, Section 15, and Section 16, respectively.

4.8.2 The IHP may subcontract with a vendor. In the event of such a subcontract, the subcontractor must agree to provide to the IHP any necessary reports and data that the IHP requires to continue its IHP participation if the subcontract is terminated. A clause outlining such arrangement shall be included in the subcontract.

4.9 Required Reports and Notices.

4.9.1 IHP shall provide the initial Roster of its NPIs or Primary Care and Specialty Providers to the STATE at least fourteen (14) days before the beginning of the Performance Period.

4.9.2 IHP shall notify the STATE of a change in its Authorized Representative, pursuant to the timeframes in Section 7.2.

4.9.3 IHP shall notify the STATE within ten (10) days of the following events:

4.9.3.1 Material change in fiscal soundness that may impair the ability of IHP to perform its obligations under this Contract.

4.9.3.2 Upon being served with any legal action filed with a court or administrative agency, related to this Contract or which may materially affect the IHP's ability to perform its obligations hereunder.

4.9.4 IHP shall notify the STATE of errors in its Attributed Population list consistent with the timeframes in Section 4.6.4 above.

4.9.5 Report Certification. As a condition for receiving payment and upon request, IHP shall certify its data and reports that are utilized by the STATE for purposes including, but not limited to payment calculations and provider Rosters.

4.9.5.1 Data or reports which must be certified are:

4.9.5.1.1 Rosters pursuant to Section 3.8;

4.9.5.1.2 Alternative quality reporting (only for IHPs who have alternative quality reporting in Section 17 and Section 18.)

4.9.5.1.3 Other data or reports requested by the STATE with notice that a certification is required; and

4.9.5.1.4 Errors in its Attributed Population list pursuant to Section 4.6.4.

4.9.5.2 The certification must be submitted by an officer of the IHP or an individual who has been delegated the authority to sign for the IHP chief executive officer or chief financial officer. The certification shall accompany the data or report. The certification must identify each submission, the date it was submitted, and attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the data or report.

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4.10 Patient Protection and Patient-Centeredness.

4.10.1 IHP shall comply with Medicaid marketing requirements:

4.10.1.1 The IHP, its agents and marketing representatives, may not offer or grant any reward, favor or compensation as an inducement to a MHCP recipient to receive services from the IHP or an IHP Participant.

4.10.1.2 The IHP, acting indirectly through publications and other marketing activity, or through mass media advertising (including the Internet), may inform MHCP recipients of the availability of IHP-related services through the IHP, the location and hours of service and other IHP characteristics, subject to all restrictions in this section. IHP shall provide the STATE with a timely advance copy of such materials.

4.10.1.3 Patients attributed to the IHP are free to choose any qualified provider, and services will not result in restrictions in a MHCP recipient's choice of or access to medically necessary services and benefits.

4.10.1.4 IHP and its Participants must not discriminate among Patients on the basis of health or social status and must not engage in activities designed to result in selective recruitment and attribution of Patients with more favorable health or social status.

4.10.2 IHP and its Participants shall have processes in place to accomplish the following:

4.10.2.1 Promote patient engagement;

4.10.2.2 Develop infrastructure for IHP Participants to internally report on quality and cost metrics that enables the IHP to monitor performance and use these results to improve care over time; and

4.10.2.3 Coordinate care across and among providers.

4.11 Promoting Health and Wellness Activities – Child and Teen Checkups (C&TC) Outreach

4.11.1 IHP is responsible for Child and Teen Checkups (C&TC) outreach to children birth through age 20 covered by Medical Assistance (MA) who are attributed to IHP.

4.11.2 IHP and its Participants shall have processes in place to conduct C&TC outreach activities for eligible members who are attributed to the IHP.

4.11.3 Eligible members are attributed individuals age birth through 20 years and enrolled in Medical Assistance (MA).

4.11.4 C&TC outreach must include:

4.11.4.1 The IHP must inform families and children of the child's eligibility for the C&TC program. IHPs must outreach to children and families at least once each calendar year.

4.11.4.2 The IHP must inform eligible attributed families and children about the C&TC program.

4.11.4.3 Child and Teen Checkups outreach must include information explaining:

4.11.4.3.1 the benefits of preventive health care,

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4.11.4.3.2 the patient care services available under the Child and Teen Checkups program, including age-related screenings according to the MN DHS periodicity schedule,

4.11.4.3.3 the Child and Teen Checkups patient care services and age-related screenings are available at no cost, and

4.11.4.3.4 that transportation, interpreter, and scheduling assistance is available and instructions on how to access the assistance.

4.11.4.4 The IHP must provide effective means to inform eligible families and children who need additional assistance because of disabilities or home language needs.

4.11.4.4.1 The IHP must provide reasonable assistance to eligible attributed children and their parents or guardians to effectively use health services and resources, by providing reasonable assistance to enable access to health services and resources. This includes assistance with any follow-up or referral from the Child and Teen Checkups age-related screening. IHPs must also be aware of and follow the consent laws related to minors, including which services or circumstances may not require parental or guardian consent.

4.11.4.4.2 The IHP must ensure they are utilizing effective methods to identify social needs and are able to provide referrals to services as appropriate. This may include but is not limited through outreach activities, clinic intake, well-child visits, and/or fulfillment of health equity interventions.

4.11.4.4.3 The IHP is responsible for ensuring that their providers are aware of the Child and Teen Checkups program and the importance of complete well-child visits. DHS shall communicate any programmatic or administrative changes to the Child and Teen Checkups program to IHPs and IHPs shall use reasonable efforts to remain up to date on the same.

4.11.5 Child and Teen Checkups (C&TC) Outreach Documentation.

4.11.4.1 IHPs must maintain documentation of the specific mode or manner of outreach to individual children and their families or guardians.

4.11.4.2 IHPs must maintain documentation of individual family responses to Child and Teen Checkups program participation. Where possible, documentation must indicate an eligible member or family (a) accepted, (b) declined, or (c) gave an undecided response or failed to respond to an outreach.

4.11.6 Data from DHS. DHS will provide data to IHPs in support of this work that must be utilized by IHPs. The data will include a list of attributed individuals eligible for Child and Teen Checkups outreach.

Section 5. PAYMENT.

5.1 Claims Payments and IHP Program Payments. Services shall be paid as follows:

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5.1.1 IHP Participants will receive reimbursement for health care services according to and under its contract(s) with the Department of Human Services FFS program, or the relevant MCO in which the Patient is enrolled; and

5.1.2 The Population-Based Payment will be calculated and distributed by the STATE pursuant to the method in Section 4.3.

5.1.3 The Child and Teen Checkups Outreach Payment will be calculated and distributed by the STATE pursuant to the method in Section 5.2.

5.1.4 (Applicable to Track 2 only) Shared Savings or Shared Losses will be calculated and distributed by the STATE pursuant to the method in Section 4.4. Final Payment of Shared Savings is reducible by the score calculated for quality and patient experience determined by Section 18.

5.2 Terms of Payment for Child and Teen Checkups (C&TC) Outreach

5.2.1 Terms of Payment for Child and Teen Checkups outreach will be calculated and paid on a quarterly basis.

5.2.1.1 IHP will receive $1.00 per eligible attributed member per month for Child and Teen Checkups outreach.

5.2.1.2 The Child and Teen Checkups outreach payments will be calculated by the STATE and reported to the IHP no later than the first forty-five (45) days of every quarter.

5.2.1.3 STATE shall reserve the right to delay the payment in the interest of ensuring accurate calculation of the Child and Teen Checkups outreach payments. In the event of a delay, STATE shall notify the IHP no later than twenty (20) days after the first business day of every quarter.

5.2.1.4 The Child and Teen Checkups outreach payment shall be paid to the IHP on the next available FFS payment warrant after each notice in Section 5.2.1.2 above.

5.2.2 C&TC Payment Recoupment. IHP may reimburse STATE upon demand or STATE may deduct from future payments under this CONTRACT or future CONTRACTS any amounts paid by STATE for C&TC Outreach services, as described in Section 4.11, which have been inaccurately reported or are found to be unsubstantiated.

5.3 Terms of Payment for Population-Based Payments

5.3.1 Terms of Payment for Population-Based Payments will be calculated and paid on a quarterly basis.

5.3.1.1 The population-based payments will be calculated by the STATE and reported to the IHP no later than thirty (30) days after the last business day of every quarter, as described in Section 15.

5.3.1.2 STATE shall reserve the right to delay the payment in the interest of ensuring accurate calculation of the population-based payment. In the event of a delay, STATE shall notify the IHP at no later than twenty (20) days after the last business day of every quarter.

5.3.1.3 The population-based payment shall be paid to the IHP on the next available FFS payment warrant after each notice in Section 5.3.1.1 above.

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5.3.1.4 Claims run-out. The population-based payment shall be reconciled at least annually following the end of every fourth quarter, and the population-based payment will be adjusted by the appropriate amount given information received for other care coordination claims considered for calculation of the population-based payment.

5.4 Terms of Payment for Shared Savings and Shared Losses. (Applicable to Track 2 only)

5.4.1 Terms of Payment for Shared Savings and Shared Losses. Shared Savings and Shared Losses will be calculated, and paid according the timeframes in Section 5.4.2 and 5.4.3 below.

5.4.2 Interim Payment.

5.4.2.1 Shared Savings and Shared Losses interim settlements will be calculated by the STATE and reported to the IHP and applicable MCOs no later than the last business day of the sixth (6th) month following the close of the Performance Period, as described in Section 16. The receipt of data necessary to complete the Interim Payment calculation is a condition precedent to the Interim Payment.

5.4.2.2 Shared Savings Interim Payments owed by the STATE to the IHP based upon FFS shall be paid by the STATE to the IHP on the next available FFS payment warrant after the notice in Section 5.4.2.1 above.

5.4.2.3 The STATE will direct applicable MCOs to make Shared Savings Interim Payments to the IHP within thirty (30) days of the date that the STATE informs the MCOs of the amount owed.

5.4.3 Final Payment.

5.4.3.1 Final Payments of Shared Savings and Shared Losses will be calculated by the STATE and reported to the IHP and applicable MCOs no later than the last business day of the eighteenth (18th) month following the close of the Performance Period, as described in Section 16. The receipt of data necessary to complete the Final Payment calculation is a condition precedent to the Final Payment.

5.4.3.2 Final Payment of Shared Savings owed by the STATE to the IHP based upon FFS shall be paid by the STATE to the IHP on the next available DHS FFS payment after the notice in Section 5.4.2.1 above.

5.4.3.3 The STATE will direct applicable MCOs to make Final Payments of Shared Savings to the IHP within thirty (30) days of the date that the STATE informs the MCOs of the amount owed.

5.4.3.4 Final Shared Losses, as calculated by the STATE, shall be paid by the IHP to the STATE or applicable MCO no later than one hundred and twenty (120) days after the calculation in Section 5.4.2.1 above is completed and the IHP is notified. The STATE may, at its option, offset any Shared Losses obligation by withholding payment from current payment warrants on a schedule to be agreed upon between the Parties.

5.5 Certain Laws not Applicable to Payments. (Applicable to Track 2 only)

The Parties agree that Population-Based Payments, Interim, and Final payments are not claims payments subject to the prompt pay laws in Minnesota Statutes, § 62Q.75. The vendor payment timelines in Minnesota Statutes, § 16A.124 apply to these payments only after calculation pursuant to this section.

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5.6 Services Performed.

All services provided by IHP pursuant to this Contract shall be performed to the satisfaction of the STATE, as determined at its sole discretion, and in accord with all applicable federal, state, and local laws, ordinances, rules and regulations including business registration requirements of the Office of the Secretary of State.

5.7 Interest.

Neither Party shall pay interest on any amounts due hereunder.

5.8 Payment, Claim, or Encounter Submission Errors.

In the event of a payment, claim, or encounter submission error identified by either Party:

5.8.1 From DHS FFS system: If either Party determines that there has been a material error in its payment to or from the other Party that resulted in overpayment or underpayment due to reasons that do not include the agreed-upon methodology in the Appendices, or Fraud or Abuse by the IHP, its Participating Entities or an Attributed Patient; then the STATE or IHP may make a claim under this section within sixty (60) days from the discovery of the error.

5.8.2 From an MCO payment error: If either Party determines that there has been a material error in payment that resulted in overpayment or underpayment, which error is due to changes in or errors in claims or encounters processing by an MCO, the procedure in Section 5.8.1 shall be followed except that the timeframe for initial notice shall be extended to ninety (90) days.

5.8.3 From an IHP or IHP Participant: If either Party determines that there has been a material error in payment to or from the other Party that resulted in overpayment, underpayment, or inability to determine attribution due to reasons that do not include the agreed-upon methodology in the Appendices, or Fraud or Abuse by the IHP, its Participant Entities or an Attributed Patient; then the STATE or IHP may make a claim under this section within sixty (60) days from the discovery of the error.

5.8.4 The IHP must have filed a timely and Patient-Specific appeal of Attribution under Section 4.6.4 in order to assert any claims regarding Attribution.

5.8.5 The Party receiving the claim above shall acknowledge in writing or e-mail the receipt of the claim.

5.8.6 Neither Party shall assert any claim for or seek the payment of or make any adjustment for any erroneous payment of claims as defined in 42 CFR 447.45 (b) made pursuant to this Contract more than one year after the date such payment was actually received by the receiving Party.

5.9 Unusual and Extreme Circumstances. (Applicable to Track 2 only)

The STATE will eliminate shared losses for any month(s) where at least 20% of the IHP’s attributed population resides in a county or counties that are impacted by an extreme and uncontrollable circumstance (for example, the COVID-19 pandemic). The state will use the determination of an extreme and uncontrollable circumstance by the HHS Secretary for the Center for Medicare and Medicaid’s (CMS) Quality Payment Program, including the identification of affected geographic areas and applicable time periods, for purposes of determining the applicability of the extreme and uncontrollable circumstances policies with respect to the IHP program. The STATE will utilize beneficiaries’ addresses

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from the STATE's data warehouse to determine if at least 20% of the IHPs population resides in an impacted county or counties. When at least 20% of the IHP's attributed population resides in a county or counties that are impacted by a declared extreme and uncontrollable circumstance, then the state would reduce shared losses by an amount determined by multiplying the shared losses by the percentage of the total months in the performance year affected by the extreme and uncontrollable circumstance, and the percentage of the Integrated Health Partnership's (IHP) attributed beneficiaries who reside in an area affected by the extreme and uncontrollable circumstance.

Section 6. TERM AND TERMINATION; DISPUTE RESOLUTION.

6.1 Termination.

6.1.1 Termination by the Department of Administration for cause or convenience. In accord with Minn. Stat. § 16B.04, subd. 2, the Commissioner of Administration has independent authority to cancel this CONTRACT with or without cause, upon thirty (30) days written notice to the STATE and the IHP. The thirty (30) day notice may be waived, in writing, by the party receiving notice. In the event of such a cancellation, IHP shall be entitled to payment, determined on a pro rata basis, for work or services satisfactorily performed.

6.1.2 Termination by STATE.

6.1.2.1 Without Cause. This Contract may be terminated by the STATE at any time, with or without cause, upon ninety (90) days written notice to IHP.

6.1.2.1.1 In the event of such a termination prior to the end of the three-year performance period, IHP shall be entitled to retain or receive any population-based payments and Child and Teen Checkups outreach payments, as applicable, through the effective date of termination for work or services satisfactorily performed. These payments will be prorated as appropriate.

6.1.2.1.2 (Applicable to Track 2 only) In the event of such a termination, IHP shall be entitled to payment, determined on a pro rata basis, of Shared Savings through the effective date of termination for work or services satisfactorily performed, but IHP will not be required to make payment for Shared Losses, if any, through the effective date of termination.

6.1.2.2 For Cause. The STATE has the right to suspend or terminate this Contract in writing immediately when the STATE deems:

6.1.2.2.1

6.1.2.2.2 The health or welfare of Patients is endangered;

6.1.2.2.3 When the STATE has reasonable cause to believe that the IHP has breached a material term of the Contract; or

6.1.2.2.4 When IHP non-compliance with the terms of the Contract may jeopardize federal financial participation in the STATE's Medicaid program.

6.1.2.3 Insufficient Funds. STATE may immediately terminate this CONTRACT if it does not obtain funding from the Minnesota Legislature, or other funding source; or if funding cannot be continued at a level sufficient to allow for the payment of the services covered here. Termination will be by written notice to IHP. STATE is not obligated to pay for any services that are provided after the effective date of termination. IHP will

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be entitled to or obligated to payment of Shared Savings or Shared Losses, determined on a pro rata basis up to the date of termination. STATE will not be assessed any penalty if the CONTRACT is terminated because of the decision of the Minnesota Legislature, or other funding source, not to appropriate funds. STATE must provide IHP notice of the lack of funding within a reasonable time of STATE's receiving that notice.

6.1.2.4 Breach**.** Notwithstanding any other provision of this Contract, upon STATE's knowledge of a curable material breach of the Contract by IHP, STATE shall provide IHP written notice of the breach and thirty (30) days to cure the breach from the date it receives the notice, unless a longer period is mutually agreed upon if the breach can be cured. In urgent situations, as determined by the STATE, the STATE may establish a shorter time period to cure the breach. If IHP does not cure the breach within the time allowed, IHP will be in default of this Contract and STATE may terminate the Contract immediately. If IHP has breached a material term of this Contract and cure is not possible, STATE may immediately terminate this Contract.

The STATE may terminate this Contract in the event the IHP:

6.1.2.4.1 Becomes insolvent, is dissolved or liquidated;

6.1.2.4.2 Files or has filed against it a petition in bankruptcy and, in the case of an involuntary petition, such petition is not dismissed within thirty (30) days;

6.1.2.4.3 Makes a general assignment for the benefit of its creditors;

6.1.2.4.4 IHP or any of its Participants, Primary Care Providers, Specialty Providers or principals is in violation of Section 0 below, unless the IHP has promptly provided termination notice to and taken steps to disaffiliate itself from any such Participant, Primary Care Provider, Specialty Provider or principal; or

6.1.2.4.5 Ceases conducting business in the ordinary course.

6.1.3 **Pre-termination Action by STATE.** The STATE may, but is not required to, take one or more of the following actions if the STATE concludes termination of the Contract is warranted: Request a Corrective Action Plan (CAP) for the IHP, or place the IHP on a special monitoring plan.

6.1.3 Conviction relating to a state grant. In accordance with Minn. Stat. § 16B.991, this CONTRACT will immediately be terminated if the recipient is convicted of a criminal offense relating to a state grant agreement.

6.2 Termination by IHP.

IHP may terminate this Contract under the following circumstances:

6.2.1 With Cause; Loss of an IHP Participant. IHP must notify the STATE under Section 4.9 above in the event that one or more of its constituent IHP Participants will no longer be available to treat Patients under this Contract. In the event that this departing IHP Participant provides care for more than fifty percent (50%) of the IHP's most recent quarter Attributed Population, the IHP may provide written notice of termination and follow the termination procedures outlined in Section 6.3.

6.2.1.1 In the event of such a termination prior to the end of the third-year performance period, IHP shall be entitled to retain or receive any population-based payments and Child and Teen Checkup outreach payments, as applicable, received up through the

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effective date of termination for work or services satisfactorily performed. These payments will be prorated as appropriate.

6.2.1.2 Breach. Notwithstanding any other provision of this Contract, upon IHP's knowledge of a curable material breach of the Contract by STATE, IHP shall provide STATE written notice of the breach and thirty (30) days to cure the breach from the date it receives the notice of breach, unless a longer period is mutually agreed upon if the breach can be cured. If STATE does not cure the breach within the time allowed, STATE will be in default of this Contract and IHP may terminate the Contract immediately.

6.2.1.3 The IHP will be entitled to pro rata payment of Shared Savings up to the effective date of the termination.

6.2.2 Without Cause. Upon ninety (90) days' written notice to the STATE.

6.2.2.1 IHP shall be entitled to retain or receive any population-based payments and Child and Teen Checkup outreach payments, as applicable, received up until the effective date of termination for work or services satisfactorily performed. These payments will be prorated as appropriate.

6.2.2.2 (Applicable to Track 2 only) The IHP will be entitled or obligated to pro rata payment of Shared Savings or Shared Losses up to the effective date of the termination.

6.3 Termination Procedures.

Upon termination of this Contract and continuing until Final Payment is complete, the IHP shall, upon request of the STATE, provide information to the STATE that may be necessary to end data collection and determine payments owed. IHP shall cooperate with a mutually agreed-upon termination plan.

6.4 Dispute Resolution.

In the event of a dispute between the STATE and IHP, the Parties will work together in good faith to resolve any disputes about their business relationship.

6.4.1 If the Parties are unable to resolve the dispute within thirty (30) days following the date one party sent written notice of the dispute to the other party, the Parties may submit the dispute to non-binding mediation before a single mediator prior to commencing any other forms of dispute resolution. The mediator shall accept both written and oral argument as requested, and make its recommendation within fifteen (15) days of receiving the request for recommendation unless the Parties mutually agree to a longer time period. The Commissioner of Human Services shall resolve all disputes after taking into account the recommendations of the mediator and within three (3) business days after receiving the recommendation of the mediator. The cost of mediation shall be shared equally between the Parties, and each party shall be responsible for its own expenses, including attorney's fees. Whether or not the Parties elect to submit the dispute to non-binding mediation, nothing in this paragraph shall bar either party from enforcing its rights under this Contract in any legal forum.

6.4.2 IHP may not dispute the methodologies in the Appendices

Section 7. AUTHORIZED REPRESENTATIVE AND RESPONSIBLE AUTHORITY.

7.1 STATE.

The STATE's authorized representative for the purposes of administration of this CONTRACT is Mathew Spaan, or his successor. Phone 651-431-2495 and Email mathew.spaan@state.mn.us. This

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representative shall have final authority for acceptance of IHP's services and final review to determine that such services are satisfactory. If the STATE's authorized representative changes at any time during this Contract, the STATE will provide notice to the IHP.

7.2 IHP.

The IHP's authorized representative(s), or their successor(s), are:

IHP Authorized Representative Name	IHP Authorized Representative Email Address	IHP Authorized Representative Phone Number

If IHP's authorized representative(s) changes at any time during this Contract, IHP will use best efforts to notify the STATE in writing within three (3) business days.

7.3 Information Privacy and Security. (If applicable) IHP's responsible authority, or their successor, for the purposes of complying with data privacy and security for this CONTRACT is:

IHP Information Privacy and Security Contact Name	IHP Information Privacy and Security Contact Address	IHP Information Privacy and Security Contact Phone Number

Section 8. QUALITY ASSESSMENT, ACCOUNTABILITY, AND POPULATION HEALTH

The STATE and IHP agree that the following standardized set of quality measures will be used as described in Sections 17 and 18 (Applicable to Track 2 only).

8.1 Quality Assessment and Population-Based Payment

8.1.1 Population Health Report

The IHP shall provide the STATE with an annual report containing a written evaluation of health equity measures in the form of Section 4.5.2, Population Health Report. This evaluation must review the impact and effectiveness of the IHP's equity measures including IHP's performance on agreed upon goals and health outcomes.

8.1.1.1 The evaluation shall include a work plan that details the IHP's proposed quality assurance and performance improvement activities related to the equity measures for the following year. The work plan will be used to update equity measures for the next Contract Year.

8.1.1.2 If the IHP chooses to substantively amend, modify or update its evaluation or work plan at any time during the year, it shall provide STATE with material amendments, modifications or updates in a timely manner.

8.1.1.3 This annual evaluation and work plan report shall follow the guidelines specified by the state and shall be submitted to the state on or before February 15th following the close of the performance period for each Contract Year.

SAMPLE

8.1.2 Clinical quality and utilization measures.

For the clinical quality and utilization measures, the STATE will use the Healthcare Effectiveness Data and Information Set (HEDIS) measure specifications and reporting requirements, including all updates and modifications, as published for each respective measure described in Section 17.1.

8.1.3 The STATE may change the measures in response to changes promulgated by any measurement organization identified in Section 17.1 as applicable, and as the IHP program evolves.

8.1.4 The STATE will not notify IHP regarding updates and modifications that originate from organizations used as a source of measures when the organization publishes its measure specifications.

8.2 Quality Assessment and Total Cost of Care Model (Applicable to Track 2 only)

The STATE and IHP agree that the following standardized set of quality measures will be used as described in Section 18.

8.2.1 Source of Measure Specifications and Reporting Requirements.

The STATE will use measure specifications and reporting requirements, including all updates and modifications, as published for each respective measure described in Section 18.

8.2.2 Changes in Measures.

The STATE may change the measures in response to changes promulgated by any measurement organization identified in Section 18 as applicable, and as the IHP evolves.

8.2.2.1 The STATE will not notify IHP regarding updates and modifications that originate from organizations used as a source of measures when the organization publishes its measure specifications.

8.2.2.2 The STATE will only add to or delete from the list of measures listed in Section 18, as applicable prior to a Performance Period, and will provide notice to IHP of the proposed new measure in advance to the extent possible.

8.2.3 Quality and Total Cost of Care Model Appeals.

The IHP must notify the STATE in writing of any appeal for errors in calculation within fourteen (14) days of receipt of the calculated score in question. The STATE will respond to the notice within fourteen (14) days, and the parties will jointly plan resolution of the appeal.

8.2.3.1 The IHP will make a best effort to describe its data and calculation in writing in order for the STATE to research and resolve the appeal; the STATE's resolution will be final.

8.2.3.2 The IHP may not appeal the choice of measures nor the method of calculation of the measures in the executed contract.

Section 9. INFORMATION PRIVACY AND SECURITY.

9.1 Part of the Welfare System.

For purposes of executing its responsibilities and to the extent set forth in this Contract, the IHP will be considered part of the welfare system, as defined in Minnesota Statutes, § 13.46, subd. (1).

SAMPLE

9.2 Information Privacy and Security.

Information privacy and security shall be governed by the "Data Sharing Agreement and Business Associate Agreement Terms and Conditions" which is attached and incorporated into this CONTRACT as **Appendix 3**, except that the parties further agree to comply with any agreed-upon amendments to the Data Sharing Agreement and Business Associate Agreement.

IHP and STATE must comply with the Minnesota Government Data Practices Act (MGDPA), the Minnesota Health Records Act, the Health Insurance Portability Accountability Act (HIPAA), and all other Applicable Safeguards as they apply to all data provided by STATE under the Contract, and as they apply to all data created, collected, received, stored, Used, maintained, or disseminated by IHP under the Contract. The civil remedies of Minn. Stat. § 13.08, "Civil Remedies," apply to IHP and STATE. Additionally, the remedies of HIPAA apply to the release of data governed by HIPAA.

Section 10. INTELLECTUAL PROPERTY RIGHTS.

10.1 Definitions. "Works" means all inventions, improvements, discoveries (whether or not patentable or copyrightable), databases, computer programs, reports, notes, studies, photographs, negatives, designs, drawings, specifications, materials, tapes, and disks conceived, reduced to practice, created or originated by IHP, its employees, agents, and subcontractors, either individually or jointly with others in the performance of the CONTRACT. Works includes "Documents." "Documents" are the originals of any data bases, computer programs, reports, notes, studies, photographs, negatives, designs, drawings, specifications, materials, tapes, disks, or other materials, whether in tangible or electronic forms, prepared by IHP, its employees, agents, or subcontractors, in the performance of this CONTRACT.

10.2 Use of Works and Documents.

IHP owns any Works or Documents developed by the IHP in the performance of this Agreement. The STATE and the U.S. Department of Health and Human Services will have royalty free, non-exclusive, perpetual and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the Works or Documents for government purposes. If using STATE data for publication, IHP must cite the data, or make clear by referencing that STATE is the source.

Section 11. COMPLIANCE WITH STATE AND FEDERAL LAWS.

11.1 General.

IHP, its Participants and other individuals or entities performing functions related to IHP's activities shall comply with all applicable state and federal laws and regulations in the performance of its obligations under this Contract. Any revisions to applicable provisions of federal or state law and implementing regulations, and policy issuances and instructions, except as otherwise specified in this Contract, apply as of their effective date. If any terms of this Contract are determined to be inconsistent with rule or law, the applicable rule or law provision shall govern.

11.2 Compliance with Federal Laws.

Notwithstanding any applicable waivers of fraud and abuse laws, the IHP shall comply with all applicable federal laws in the performance of its obligations under this Contract including, but not limited to:

SAMPLE

11.2.1 Federal Criminal Law;

11.2.2 The False Claims Act (31 USC 3729 et seq.);

11.2.3 The anti-kickback statute (42 USC 1320a-7b (b);

11.2.4 The civil monetary penalties law (42 USC 1320a-7a); and

11.2.5 The physician self-referral law (42 USC 1395nn).

11.2.6 Affirmative Action And Non-Discrimination as referenced in Section 11.2 below

11.3 Affirmative Action and Non-Discrimination.

11.3.1 Affirmative Action requirements for IHPs with more than 40 full-time employees and a contract in excess of $100,000.

If IHP has had more than 40 full-time employees within the State of Minnesota on a single working day during the previous twelve months preceding the date IHP submitted its request for proposal response to the STATE, it must have an affirmative action plan, approved by the Commissioner of Human Rights of the State of Minnesota, for the employment of qualified minority persons, women and persons with disabilities. See Minnesota Statutes § 363A.36. If IHP has had more than 40 full-time employees on a single working day during the previous twelve months in the state in which it has its primary place of business, then IHP must either: 1) have a current Minnesota certificate of compliance issued by the Minnesota Commissioner of Human Rights; or 2) certify that it is in compliance with federal Affirmative Action requirements.

11.3.2 Affirmative Action and Non-Discrimination requirements for all IHPs.

11.3.2.1 The IHP agrees not to discriminate against any employee or applicant for employment because of race, color, creed, religion, national origin, sex, marital status, status in regard to public assistance, membership or activity in a local commission, disability, sexual orientation, or age in regard to any position for which the employee or applicant for employment is qualified. Minnesota Statutes, § 363A.02. IHP agrees to take affirmative steps to employ, advance in employment, upgrade, train, and recruit minority persons, women, and persons with disabilities.

11.3.2.2 The IHP must not discriminate against any employee or applicant for employment because of physical or mental disability in regard to any position for which the employee or applicant for employment is qualified. The IHP agrees to take affirmative action to employ, advance in employment, and otherwise treat qualified disabled persons without discrimination based upon their physical or mental disability in all employment practices such as the following: employment, upgrading, demotion or transfer, recruitment, advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship, consistent with Minn. Rule 5000.3550.

11.3.2.3 IHP agrees to comply with the rules and relevant orders of the Minnesota Department of Human Rights issued pursuant to the Minnesota Human Rights Act.

SAMPLE

11.3.2.4 Notification to employees and other affected parties. The IHP agrees to post in conspicuous places, available to employees and applicants for employment, notices in a form to be prescribed by the commissioner of the Minnesota Department of Human Rights. Such notices will state the rights of applicants and employees, and IHP's obligation under the law to take affirmative action to employ and advance in employment qualified minority persons, women, and persons with disabilities.

11.3.2.5 The IHP will notify each labor union or representative of workers with which it has a collective bargaining agreement or other contract understanding, that the IHP is bound by the terms of Minnesota Statutes, § 363A.36 of the Minnesota Human Rights Act and is committed to take affirmative action to employ and advance in employment minority persons, women, and persons with physical and mental disabilities.

11.3.3 Compliance with Department of Human Rights Statutes. In the event of IHP's noncompliance with the provisions of this clause, actions for noncompliance may be taken in accordance with Minnesota Statutes § 363A.36, and the rules and relevant orders issued pursuant to the Minnesota Human Rights Act.

11.4 Workers' Compensation.

The IHP certifies that it is in compliance with Minnesota Statutes, § 176.181, subdivision 2, pertaining to workers' compensation insurance coverage. The IHP's employees and agents will not be considered employees of the STATE. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees or agents and any claims made by any third party as a consequence of any act or omission on the part of these employees or agents are in no way the STATE'S obligation or responsibility.

11.5 Voter Registration Requirement. (If applicable)

IHP certifies that it will comply with Minn. Stat. § 201.162 by providing voter registration services for its employees and for the public served by IHP. Voter Registration materials can be found at the Secretary of State's website.[1]

11.6 Federal Audit Requirements.

IHP certifies it will comply with 2 C.F.R § 200.501 et seq., as applicable. To the extent federal funds are used for this CONTRACT, IHP acknowledges that IHP and STATE shall comply with the requirements of 2 C.F.R. § 200.331. Non-Federal entities expending $750,000 or more of federal funding in a fiscal year must obtain a single or program-specific audit conducted for that year in accordance with 2 C.F.R. § 200.501. Failure to comply with these requirements could result in forfeiture of federal funds.

11.7 Debarment by STATE, its departments, commissions, agencies or political subdivisions.

IHP certifies that neither it nor its principles are presently debarred or suspended by the State of Minnesota, or any of its departments, commissions, agencies, or political subdivisions. IHP's certification is a material representation upon which the CONTRACT award was based. IHP shall provide immediate written notice to STATE's authorized representative if at any time it learns that this certification was erroneous when submitted or becomes erroneous by reason of changed circumstances.

[1] https://www.sos.state.mn.us/elections-voting/get-involved/voter-outreach-materials/

SAMPLE

11.7.1 Debarment by STATE, its Departments, Commissions, Agencies or Political Subdivisions. By signing this Contract, IHP certifies that neither it nor its IHP Participants, Primary Care Providers or principals is presently debarred or suspended by the STATE, any of its departments, commissions, agencies, or political subdivisions. This certification is a material representation upon which this Contract award was based. IHP shall provide immediate written notice to the STATE'S authorized representative if at any time it learns that this certification was erroneous when submitted or becomes erroneous by reason of changed circumstances.

11.7.2 Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion. Federal money will be used or may potentially be used to pay for all or part of the work under the contract, therefore IHP certifies that it is in compliance with federal requirements on debarment, suspension, ineligibility and voluntary exclusion specified in the solicitation document implementing Executive Order 12549. IHP's certification is a material representation upon which this Contract award was based.

11.8 Ownership and Control; Exclusions of Individuals and Entities.

To the extent the IHP is not otherwise providing the following information to the STATE, the IHP as applicable shall:

11.8.1 Make full disclosure of ownership and control information as required by 42 CFR §§ 455.100 through 455.106, and upon request, full disclosure of business transactions, as is required by 42 CFR § 455.105;

11.8.2 Make full disclosure of persons convicted of program crimes as required by 42 CFR § 455.106; and

11.8.3 Ensure that IHP, all of its owners, managers, employees and subcontractors are not excluded from participation in Medicare, Medicaid or other federal health care programs. IHP must immediately report any exclusion information discovered to the STATE.

Section 12. OTHER PROVISIONS.

12.1 Governing Law, Jurisdiction and Venue.

This Contract, and amendments and supplements thereto, shall be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this Contract, or breach of the Contract, shall be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.

12.2. Clerical Errors and Non-Waiver.

12.2.1 Clerical error. Notwithstanding Section 12.4, STATE reserves the right to unilaterally fix clerical errors contained in the Contract without executing an amendment. IHP will be informed of errors that have been fixed pursuant to this paragraph.

12.2.2 Non-waiver. If either Party fails to enforce any provision of this Contract, that failure does not waive the provision or the Party's right to enforce it.

12.3 Assignment.

IHP shall neither assign nor transfer any rights or obligations under this Contract without the prior written consent of the STATE.

SAMPLE

12.4 Amendments.

Any amendments to this Contract shall be in writing and shall be executed by the same Parties who executed the original contract, or their successors in office.

12.5 Entire Agreement.

a. If any provision of this Contract is held to be invalid or unenforceable in any respect, the validity and enforceability of the remaining terms and provisions of this Contract shall not in any way be affected or impaired. The parties will attempt in good faith to agree upon a valid and enforceable provision that is a reasonable substitute and will incorporate the substitute provision in this Contract according to Section 12.4.

b. This Contract contains all negotiations and agreements between STATE and IHP. No other understanding regarding this Contract, whether written or oral may be used to bind either party.

12.6 Drafting party.

The parties agree that each party has individually had an opportunity to review with a legal representative, negotiate and draft this Contract, and that, in the event of a dispute, the Contract shall not be construed against either party.

12.7 Subcontractors.

IHP, as an awardee organization, is legally and financially responsible for all aspects of this award that are subcontracted, including funds provided to sub-recipients and subcontractors, in accordance with 45 C.F.R. §§ 75.351-75.352. IHP shall ensure that the material obligations, borne by the IHP in this Contract, apply as between IHP and subrecipients, in all subcontracts, to the same extent that the material obligations apply as between the STATE and IHP.

12.8 Indemnification.

In the performance of this Contract by IHP, or IHP's agents or employees, the IHP must indemnify, save, and hold harmless the STATE, its agents, and employees, from any claims or causes of action, including attorney's fees incurred by the STATE, to the extent caused by IHP's:

12.8.1 Intentional, willful, or negligent acts or omissions;

12.8.2 Actions that give rise to strict liability; or

12.8.3 Breach of contract or warranty.

The indemnification obligations of this clause do not apply in the event the claim or cause of action is the result of the STATE'S sole negligence. This clause will not be construed to bar any legal remedies the IHP may have for the STATE'S failure to fulfill its obligation under this Contract.

12.9 STATE Audits.

Under Minn. Stat. § 16B.98, subd. 8, the books, records, documents, and accounting procedures and practices of the IHP or other party that are relevant to the Contract are subject to examination by STATE and either the legislative auditor or the state auditor, as appropriate, for a minimum of six years from the Contract end date, receipt and approval of all final reports, or the required period of time to satisfy all state and program retention requirements, whichever is later.

SAMPLE

12.10 Right to Review before Publication.

12.10.1 Each Party agrees to provide to the other Party a prepublication copy of materials listed below that identifiably mention the IHP and the project, except for materials produced by DHS or its subcontractors that identify multiple IHPs or describe the IHP program or results in summary form. Each Party agrees to provide comments, if any, within ten (10) days of receipt of the materials. IHP shall not state or imply that the STATE endorses the IHP's products or services.

12.10.2 Each Party shall provide to the other Party copies of any formal presentation by the Party or its subcontractors, including reports, statistical or analytical materials, papers, articles, or professional publications, based on information obtained through the administration of this IHP Contract.

12.11 No Religious-Based Counseling.

IHP agrees that no religious-based counseling shall take place under the auspices of this Contract.

12.12 Nondiscrimination

IHP will not discriminate against any person on the basis of the person's race, color, creed, religion, national origin, sex, marital status, gender identity, disability, public assistance status, sexual orientation, age, familial status, membership or activity in a local commission, or status as a member of the uniformed services. IHP must refrain from such discrimination as a matter of its contract with STATE. "Person" includes, without limitation, a STATE employee, IHP's employee, a program participant, and a member of the public. "Discriminate" means, without limitation, to fail or refuse to hire, discharge, or otherwise discriminate against any person with respect to the compensation, terms, conditions, or privileges of employment, or; exclude from participation in, deny the benefits of, or subject to discrimination under any IHP program or activity.

IHP will ensure that all of its employees and agents comply with Minnesota Management and Budget Policy #1329 (Sexual Harassment Prohibited) and #1436 (Harassment and Discrimination Prohibited).

12.13 Payment to Subcontractors.

As required by Minnesota Statutes, §16A.1245, the IHP must pay all subcontractors, less any retainage, within ten (10) days of the IHP's receipt of payment from the STATE for undisputed services provided by the subcontractor(s) and must pay interest at the rate of one and one-half percent per month or any part of a month to the subcontractor(s) on any undisputed amount not paid on time to the subcontractor(s). For the purposes of this clause, subcontractor does not include IHP Participants or providers.

12.14 Execution in Counterparts.

Each party agrees that this Contract may be executed in two or more counterparts, all of which shall be considered one and the same agreement, and which shall become effective if and when both counterparts have been signed and dated by each of the Parties. It is understood that both Parties need not sign the same counterpart.

12.15 Data Disclosure.

Consistent with Minn. Stat. §§ 270B.09, 270C.65, subd. 3, and 270C.66, and other applicable law, IHP understands that disclosure of its social security number, federal employer tax identification number, and/or Minnesota tax identification number, already provided to the STATE, may be provided to federal and state tax agencies and state personnel involved in the payment of state obligations. These

SAMPLE

identification numbers may be used in the enforcement of federal and state tax laws which could result in action requiring IHP to file state tax returns and pay delinquent state tax liabilities, if any.

12.16. Grants Management Policies.

IHP must comply with required Grants Management Policies and procedures as specified in Minn. Stat. § 16B.97, subd. 4(a)(1). Compliance under this paragraph includes, but is not limited to, participating in monitoring and financial reconciliation as required by the Office of Grants Management (OGM) Policy 08-10.

12.17 Conflict of interest.

IHP certifies that it does not have any conflicts of interest related to this Contract, as defined by OGM Policy 08-01. IHP shall immediately notify STATE if a conflict of interest arises.

SAMPLE

Section 13. Eligible and Excluded Populations, Patient Attribution Method

This document further describes the populations who are included or excluded from Attribution and Total Cost of Care.

13.1 Eligible Populations.

The following persons who are recipients of Medical Assistance and MinnesotaCare are eligible for Attribution to the IHP:

13.1.1 Medical Assistance Enrollees: Including pregnant women, children under 21, adults without children, and state-funded Medical Assistance.

13.1.2 MinnesotaCare Enrollees: Including children under 21, and adults without children. Individuals must belong to an eligible group under Minnesota Statutes, Chapter 256L, meet income criteria, satisfy all other eligibility requirements, and pay a premium to the State.

13.1.3 Recipients receiving Medical Assistance due to blindness or disability as determined by the U.S. Social Security Administration or the State Medical Review Team who are not dually eligible for Medicare.

13.2 Excluded Populations from Attribution.

The following persons are excluded from Attribution to the IHP:

13.2.1 Recipients receiving Medical Assistance who are dually eligible for Medicare.

13.2.2 Recipients receiving Medical Assistance under the Refugee Assistance Program pursuant to 8 U.S.C. 1522(e).

13.2.3 Individuals who are Qualified Medicare Beneficiaries (QMB), as defined in Section 1905(p) of the Social Security Act, 42 U.S.C. 1396d (p), who are not otherwise receiving Medical Assistance.

13.2.4 Individuals who are Service Limited Medicare Beneficiaries (SLMB), as defined in Section 1905(p) of the Social Security Act, 42 U.S.C. 1396a(a)(10)(E)(iii) and 1396d(p), and who are not otherwise receiving Medical Assistance.

13.2.5 Non-citizen recipients who only receive emergency Medical Assistance under Minnesota Statutes, Section 256B.06, subd. 4.

13.2.6 Recipients receiving Medical Assistance on a medical spend down basis.

13.2.7 Medical Assistance recipients with cost-effective employer-sponsored private health care coverage, or who are enrolled in a non-Medicare individual health plan determined to be cost-effective according to Minnesota Statutes, Section 256B.69, subd. 4, (b) (9).

13.2.8 Medical Assistance recipients with private health care coverage through a Health Maintenance Organization (HMO) licensed under Minnesota Statutes, Chapter 62D.

13.2.9 MinnesotaCare recipients who are enrolled in the Healthy Minnesota Contribution Program.

13.2.10 The STATE may exclude recipients enrolled in Minnesota Senior Care Plus (MSC+), other than those in Section 13.1.3 above.

13.2.11 Recipients for whom DHS receives incomplete claims data due to third-party liability coverage.

SAMPLE

13.2.12 Recipients who are enrolled in the Minnesota Sex Offender Program (MSOP).

13.3 Patient Attribution Method.

This section describes the STATE's method of how a recipient in the MHCP FFS program or a managed care organization enrollee is assigned to the IHP's Attributed Population as an Attributed Patient. This section also details the provider taxonomy that should be utilized by the IHP when providing the STATE with a provider roster for the purposes of determining attribution.

13.4 Definitions.

For the purposes of this Section:

13.4.1 "E&M" refers to Evaluation and Management coding.

13.4.2 "HCPCS" refers to the HCFA Common Procedural Coding System.

13.4.3 "Non-IHP provider" means a provider not included in a Roster submitted by an IHP.

13.5 Patients.

Patients must have had at least one visit or encounter with a Roster provider during the Performance Period and such visit must have been paid to a billing entity on the Roster to be eligible for Attribution. Certain populations are categorically excluded from the IHP model (for example, persons with dual eligibility), and are removed from the pool of MHCP Recipients who can be attributed (see Sections 13.1 and 13.2 "Eligible and Excluded Populations"). Patients who have less than six (6) months of continuous enrollment in qualifying programs or less than nine (9) total months of enrollment in qualifying programs during the Performance Period are excluded from Attribution. Throughout the course of the Performance Period, a Patient's attribution status (either among IHPs or to no IHP) may change as the Patient's utilization pattern changes.

13.6 Attribution Steps.

Once the exclusion process is completed to determine the base population eligible for Attribution, the Attribution process counts qualifying visits for each MHCP Recipient across providers on all the IHP Rosters and compares the total claim counts at each IHP to those at non-IHP providers. In performing the comparisons, there are four steps evaluated in the following order:

- Health Home (Health Care Home or Behavioral Health Home) claims;
- E&M procedures by a Primary Care Provider; and
- E&M procedures by a Specialty Provider; and
- Tie Breaking Step.

As the algorithm progresses, a MHCP recipient is either definitively assigned to an IHP and not evaluated in subsequent steps, determined to be not attributable to any IHP for the period, or passed to the next step in the Attribution decision process.

13.7 STEP 1. If Health Home Claim Code(s) are Present:

13.7.1 Patients with Health Home (HCH or BHH) care coordination claims (HCPCS Code S0280 and/or S0281) are attributed to the IHP using the treating and billing provider as follows:

13.7.2 Patients with care coordination codes at only one IHP are attributed to the IHP.

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13.7.3 Patients with care coordination codes at more than one IHP or at non-IHP provider(s) are attributed to the IHP or non-IHP provider(s) that submitted the greater number of care coordination claims.

13.7.4 Patients with an equal number of care coordination codes are attributed to the IHP or the non-IHP provider having the most recent date of service care coordination claim.

13.7.5 Patients with no HCH codes are assessed by the decision criteria in Step 2.

13.8 STEP 2. If Attribution from Health Home Claims Has Not Occurred, but Qualifying Visit(s) to a Primary Care Provider are Present:

13.8.1 Patients with the following E&M codes paid to an IHP billing provider and performed by an IHP Roster provider with a primary care specialty (as defined in the Provider Taxonomy): 99201 through 99215, 99304 through 99350, 99381 through 99387, 99391 through 99397, 99441 through 99443, G0402, G0438, and G0439 are attributed to the IHP as described in Sections 13.8.2 through 13.8.6 below.

13.8.1.1 Codes for attribution may be changed as determined by the STATE. STATE will notify IHPs in writing of any changes.

13.8.2 Patients with Primary Care Provider E&M codes at only one IHP are attributed to the IHP.

13.8.3 Patients with more Primary Care Provider E&M codes than at any other IHP or non-IHP provider(s) are attributed to the IHP that submitted the greater number of E&M codes by that IHP's Primary Care Providers.

13.8.4 Patients with an equal number of Primary Care Provider E&M codes at more than one IHP or non-IHP provider are assessed by the decision criteria as described in Step 4.

13.8.5 Patients with a greater number of E&M codes at an individual non-IHP provider(s) than at any IHP are not attributed to any IHP.

13.8.6 Patients with no Primary Care Provider E&M codes at any IHP are assessed by the decision criteria in Step 3.

13.9 STEP 3. If Attribution From HCH Claims or Qualifying Visits to Primary Care Providers Has Not Occurred, but Qualifying Visits to Other Specialty Providers are Present:

13.9.1 Patients with the following E&M codes performed by a Specialty Provider and paid to a billing provider from the IHP Roster: 99201 through 99215, 99304 through 99350, 99381 through 99387, 99391 through 99397, 99441 through 99443, G0402, G0438, and G0439 are attributed to the IHP as described in Sections 13.9.2 through 13.9.5 below.

13.9.1.1 Codes for attribution may be changed as determined by the STATE. STATE will notify IHPs in writing of any changes.

13.9.2 Patients with Specialty Provider E&M codes at only one IHP are attributed to the IHP.

13.9.3 Patients with Specialty Provider E&M codes at more than one IHP are attributed to the IHP that submitted the greater number of E&M codes by that IHP's Specialty providers.

13.9.4 Patients with an equal number of Specialty Provider E&M codes at more than one IHP are not attributed to any IHP.

13.9.5 Patients with a greater number of E&M codes at an individual non-IHP provider(s) than at any IHP Specialty Providers are not attributed to any IHP.

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13.10 STEP 4. Tie Breaking:

13.10.1 Patients with an equal number of E&M codes at more than one IHP Primary Care Providers, and having no E&M codes at IHP Specialty Providers are attributed to the IHP with the most recent date of service E&M claim.

13.10.2 Patients with an equal number of E&M codes at more than one IHP Primary Care Provider and having a greater number of E&M codes at one of those IHP Specialty Providers are attributed to the IHP with the greater number of E&M codes at Specialty Providers.

13.10.3 Patients with an equal number of E&M codes at more than one IHP Primary Care Provider, and having an equal number of E&M codes at those IHP Specialty Providers are attributed to the IHP with the most recent Primary Care Provider date of service E&M claim.

13.10.4 Patients with an equal number of E&M codes at an IHP Primary Care Provider and a non-IHP provider are attributed to the IHP if the IHP had the most recent date of service E&M claim.

13.11 Attribution Time Periods.

The Attribution Steps described above in Section 13.6 through Section 13.10 will be based on claims in a twelve (12) month period of a Patient's claim history. If attribution does not occur and Patient did not have any applicable Health Home or E&M claims within the twelve (12) month period, then the Attribution Steps described in Section 13.6 through Section 13.10 will be repeated based on claims in an additional twelve (12) month period of a Patient's claim history for a total of twenty-four (24) months of claims history.

SAMPLE

Section 14. IHP-Specific Description and Governance

This Section further defines <IHP Name> and certain other details about the IHP as referenced in this contract.

14.1 As defined in Section 2.13 of the Contract, the IHP Entity is:

☐ Provider health system(s) whose clinics and/or hospitals are owned by or under contract for the purposes of this program.

☐ A separate legal entity.

14.2 Description of IHP

14.3 List of IHP Participants

As defined in Section 2.16, the list of IHP Participants includes the organizations and locations listed in the table below. Subsequent IHP Rosters, if submitted in a manner consistent with Section 3.8, and certified as described in Section 4.9.5, will supersede the IHP Participants listed below.

NPI	Name:	Address:	City	State	Zip

14.4 Roster Option. The IHP has selected the following Roster option:

☐ All In Roster;

☐ Billing/Treating Roster;

14.5 Description of the IHP's Shared Governance System as required under Section 3.2 of the Contract:

14.5.1 The IHP's Shared Governance System includes the following groups of providers and suppliers as listed in Minnesota Statutes, 256B.0755, subd. 1 (d).

☐ Professionals in group practice arrangements;

☐ Networks of individual practices of professionals;

☐ Partnerships or joint venture arrangements between hospitals and health care professionals;

☐ Hospitals employing professionals; or

☐ Other groups of providers of services and suppliers.

14.5.1.1 List of Members of the IHP's Governing Body

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Name:	Title:	Expertise	Patient Representative? Y/N	Consumer Advocate? Y/N

14.6 Fiscal Agent or Guaranteeing entity name and Tax ID to receive Population-Based Payments, Interim Shared Savings Payments or Final Shared Savings Payments, and to make a Final Payment of Shared Losses (as applicable) is:

Fiscal Agent or Guaranteeing entity name	Tax ID (TIN)

14.7 Insurance as required in Section 3.10 of the Contract:

☐ The IHP has in force a general commercial liability policy with a minimum amount of $2,000,000 per occurrence and $2,000,000 annual aggregate; a worker's compensation insurance policy with a minimum of $100,000 for bodily injury by disease per employee, $500,000 for bodily injury by disease aggregate, and $100,000 for bodily injury by accident, if applicable; and a network security and privacy liability insurance policy with a minimum amount of $2,000,000 per occurrence and $2,000,000 annual aggregate, or

☐ Other: Explanation: ____________________.

14.8 Accountable Care Partnerships (Applicable to Track 2 only)

As described in Section 4.5.2 of the Contract, IHP will submit a Population Health Report on February 15 following the close of the performance period for each contract year describing each of the Accountable Care Partnerships in place.

14.8.1 Accountable Care Partnership Description

SAMPLE

Section 15. IHP Payment Methodology – Population-Based Payment

IHPs will receive a Population-Based Payment (PBP) that supports care coordination related services and infrastructure for individuals served by the IHP and is risk-adjusted to reflect their combined clinical and social risk factors, pursuant to Minnesota Statutes, § 256B.0755, subd. 4(d). Individuals served by the IHP shall be constituted of the individuals collectively attributed to the IHP, according to the methodology in Section 13.3. The STATE will calculate and distribute the payment on a quarterly basis. At the end of the contract period, the IHP's ability to continue participation in the program will be subject to evaluation as described in Section 17.1, Quality Measures in Population-Based Payment.

15.1 Definitions

15.1.1 "PBP Eligible" means a patient who is IHP attribution eligible for whom the IHP is not receiving another form of care coordination payment such as Health Care Home or In-Reach,

15.1.2 "Per-Member-Per-Month" or PMPM means the calculated monthly dollar amount, assigned to an individual or groups of individuals, that the STATE considers for payment to an IHP,

15.1.3 "IHP Attribution Eligible Population" means the pool of MHCP patients considered for attribution to the IHP program according to the attribution methodology in Sections 13.3 to 13.11.

15.2 Quarterly Payment Calculation – Clinical Risk

15.2.1 The PBP Eligible Attributed Population is defined in Section 13.3, Patient Attribution Method.

15.2.2 The STATE will use the ACG® risk adjustment tool to assign PBP Eligible individuals to exclusive risk categories based on the aggregate claims experience of the PBP Eligible Attributed Population. The STATE will then assign a relative risk score to each risk category, normalized based on the IHP-attribution eligible population.

15.2.3 The relative risk categories will be arrayed in order of low to high relative risk score and arranged into percentiles. The ACG risk categories within each percentile will be assigned a PMPM based on the general methodology as shown in the table in Section 15.2.4 below.

15.2.4 **Table 1** – Population-Based Payment Calculation Table

Risk Percentile	Calculation of Average Dollar Amount of PMPM
0-6%	Members without claims or diagnoses - $1.00
6-30%	$2.00
30-80%	$2.30 plus $0.275 for each 0.1 increase in relative risk by ACG
80 – 100%*	$6.00 increasing as a logarithmic function of the relative risk by ACG
*The PBPs for the three ACG risk categories with the highest relative risk increase linearly from $17.12 to $30.17	

15.2.5 The dollar amount assigned to each relative risk category will be multiplied by the number of members in each category, and the total sum of dollars represents the monthly total clinically adjusted PMPM for the IHP.

SAMPLE

15.3 Quarterly Payment Adjustment – Social Risk

15.3.1 Definitions

15.3.1.1 "Deep Poverty" means that an individual or family's income falls below 50% of the Federal Poverty Line.

15.3.1.2 "Homelessness" means that an individual is homeless based on self-reported homelessness, an address-based method of identifying a living situation that is not meant for housing, or has a homeless shelter as an address.

15.3.1.3 "Serious and Persistent Mental Illness (SPMI)" means an individual has any of the following diagnoses: schizophrenia, borderline personality disorder, bipolar disorder, and/or major depressive disorder, and is receiving services billed to the following codes: 90804 – 90857, 740 – 760, 90882, H0018, H0019, H0031, H0034, H0035, H0040, H2011, H2012, H2017, S9484.

15.3.1.4 "Serious Mental Illness (SMI)" means an individual has any of the following diagnoses: schizophrenia, borderline personality disorder, bipolar disorder, and/or major depressive disorder.

15.3.1.5 "Substance Use Disorder (SUD)" means an individual with a diagnosis of substance abuse, substance dependence, or a substance-induced disorder.

15.3.1.6 "Child Protection Involvement (CPI)" means that the individual has been involved with child protection anytime during the analytic period.

15.3.1.7 "Adult" means an individual eighteen (18) years of age and older.

15.3.1.8 "Child" means an individual under eighteen (18) years of age.

15.3.2 The STATE will determine the social risk factors present in the attributed population of all IHPs through a combination of enrollment and claims data.

15.3.3 The STATE will apply a payment modifier that will adjust the aggregate PMPM for the relative proportion of individuals experiencing social risk factors within an IHP's population which may include Deep Poverty, Homelessness, Serious and Persistent Mental Illness, Serious Mental Illness, Substance Use Disorder, and Child Protection Involvement.

15.3.4 The STATE reserves the right to modify, adjust, add, or delete social risk factors from the payment modifier in order to more accurately represent the presence of social risk factors in an IHP's population, the cost of providing or coordinating care for individuals with social risk factors, or based on other research.

15.3.4.1 The STATE will notify the IHP at least forty-five (45) days in advance of changes to the social risk adjustment methodology and parties shall amend the terms of the contract.

15.3.5 The payment modifiers are based on the following relative risk and social risk factor criteria:

15.3.5.1 The PBP will be adjusted to reflect the relative number of attributed Adult members identified with SMI and SUD.

15.3.5.2 An adjustment will also be included for the relative number of Adult members with SMI or SUD, but are not identified as having both social risk factors. The adjustment will also be applied to reflect the relative portion of Adult members who are homeless or were previously incarcerated.

SAMPLE

15.3.5.3 The PBP will be adjusted to reflect the relative number of attributed Children who are identified as having Child Protection Involvement or parents with an SPMI social risk factor.

15.3.5.4 The PBP will also be adjusted to reflect the relative number of Infants who were identified as having parents with SUD or SMI social risk factors.

15.3.6 The dollar amount assigned to each member in Section 15.2.5 will be adjusted to reflect the estimated relative increase in risk as indicated by their social risk factor, using the risk and PBP methodology described in Section 15.2.4. Individual member monthly PBP amounts will be used to derive an average PMPM amount for an IHP's PBP.

15.4 Total Quarterly Payment Calculation

15.4.1 The average PMPM for the IHP in Section 15.3.6 will be multiplied by the total number of attributed member months each quarter to represent the quarterly total PMPM for the IHP.

15.4.2 The payment shall be made according to Section 5.2.

15.5 PBP Annual Reconciliation

15.5.1 Providers for attributed individuals may not receive both a PBP and a Behavioral Health Home (BHH), Health Care Home (HCH), or In-Reach Care Coordination (IRCC) payment. Each year, after the first Performance Period, STATE will review IHP's attributed population during the prior Performance Period for BHH, HCH, or IRCC payments to any providers during the prior Performance Period and will reconcile the first quarterly PBP to IHP as appropriate.

SAMPLE

Section 16. Total Cost of Care – Financial Calculation Information

IHP performance will be measured against a Total Cost of Care target, derived from the IHP's historical performance and adjusted for changes in population risk and expected trend. Applicable to Track 2 Only: If the performance threshold in Section 16.7 is met, all Shared Savings or Shared Losses will be shared (i.e., first dollar) based upon the agreed-upon distribution between DHS and IHP described in Section 4.4, subject to reductions determined by Section 18.

16.1 Definitions.

16.1.1 "Base Period" means the period covering dates of service beginning January 1, 2023 and ending December 31, 2023.

16.1.2 "Performance Period 1" means the period covering dates of service beginning January 1, 2024 and ending December 31, 2024.

16.1.3 "Performance Period 2" means the period covering dates of service beginning January 1, 2025 and ending December 31, 2025.

16.1.4 "Performance Period 3" means the period covering dates of service beginning January 1, 2026 and ending December 31, 20266.

16.1.5 "Caps" or "Cap" means thresholds to adjust the PMPM results for "catastrophic cases".

16.2 Total Cost of Care (TCOC) Performance Assessment Process

Because the Attributed Population will change from the Base Period to the Performance Period(s), the STATE will adjust the Total Cost of Care target for changes in the Attributed Population and illness burden (i.e., population risk score).

16.3 Base Period.

16.3.1 Base Period Attributed Population: DHS will attribute patients to an IHP using retrospective claims and MCO encounter data available to DHS consistent with Sections 13.3 through 13.11.

16.3.2 Base Period Total Cost of Care (Base TCOC):

16.3.2.1 DHS will calculate the retrospective per patient per month (PMPM) TCOC for the Base Period Attributed Population.

16.3.2.2 The Base TCOC will be based on the core services outlined in Section 16.10. The services included in the TCOC may not change except under a contract amendment.

16.3.2.3 Claim costs for an Attributed Patient that fall outside of Caps in Section 16.1.5 above will be capped to adjust the PMPM results for catastrophic cases.

16.4 Base Period Risk Score:

16.4.1.1 Based on the services included in the Base TCOC, a risk score will be developed for the Attributed Population to reflect the relative risk of the population.

16.4.1.2 DHS will use the ACG® risk adjustment tool and develop category-specific risk weights based on the aggregate claims experience of the MHCP population who are eligible for attribution. In addition to developing weights based exclusively

on the services included in the Base TCOC, the weights will be developed using the claim Caps to adjust the weights and reduce the impact of catastrophic cases.

16.4.2 Expected Trend:

16.4.2.1 DHS will develop an expected trend rate for the Total Cost of Care based on the same unit cost and utilization trend rates used to develop the annual expected cost increases for the aggregate MHCP population.

16.4.2.2 Appropriate adjustments will be made for services excluded from the Base TCOC or other factors that are applicable to the Total Cost of Care and goals of the program.

16.4.2.3 Total Cost of Care Target (TCOC Target): The TCOC Target PMPM for the Performance Period will be developed based on the Base TCOC and the expected trend.

16.5 Performance Period.

16.5.1 Performance Period Total Cost of Care (Performance TCOC):

16.5.1.1 At the end of a Performance Period, DHS will calculate the Performance Period TCOC PMPM for the Performance Period Attributed Population.

16.5.1.2 Claim costs for an Attributed Patient that fall outside of Caps in 16.9 will be capped to adjust the PMPM results for catastrophic cases.

16.5.2 Performance Period Risk Score: Based on the services included in the Total Cost of Care, a risk score will be developed for the Performance Period Attributed Population to reflect their relative risk. The risk weights will be based on the aggregate MHCP population's claims experience, based exclusively on the services included in the Total Cost of Care, and developed using the claim Caps in 16.9 to adjust the weights for catastrophic cases.

16.5.3 Adjusted Total Cost of Care Target (Adj. TCOC Target):

16.5.3.1 The Target TCOC will be adjusted based on the increase or decrease in the risk of the Attributed Populations (i.e., the change in the population risk from the Base Period to the Performance Period).

16.5.3.2 The Adjusted TCOC Target will be compared to the Performance Period TCOC for purposes of determining the performance results and the basis for any financial settlement.

16.6 Settlement Timing and Information. (Applicable to Track 2 only)

16.6.1.1 Each performance period will result in the calculation of Interim Payment and Final Payment by the STATE for purposes of integrating sufficient Claims Runout information into the final Shared Savings and Shared Losses calculation. The Interim Payment will be calculated within six (6) months from the end of the Performance Period using up to three (3) months of Claims Run-out. The Final Payment will be calculated within eighteen (18) months of the end of the Performance Period using a minimum of twelve (12) months of Claims Run-out.

SAMPLE

16.6.1.2 The Interim Payment will be calculated no later than six (6) months following the end of the Performance Period based on:

16.6.1.2.1 The final Base Period TCOC based on the claims incurred during the Base Period by the Attributed Population in the final Base Period Attributed Population.

16.6.1.2.2 The interim Performance Period TCOC based on the claims incurred during the Performance Period by the Attributed Population in the interim Performance Period Attributed Population.

16.6.1.2.3 The change in risk between the final Base Period Risk Score for the Attributed Population in the final Base Period Attributed Population and the interim Performance Period Risk Score for the Attributed Population in the interim Performance Period Attributed Population.

16.6.1.2.4 The Base Period TCOC will be adjusted for trend and the change in the Base Period Risk Score and the Performance Period Risk Score to develop the interim Adjusted Target. The interim Adjusted Target will be compared to the interim Performance Period TCOC for purposes of calculating the settlement amount.

16.6.1.3 The Final Payment will be calculated no later than eighteen (18) months following the end of the performance period based on:

16.6.1.3.1 The final Base Period TCOC is based on the claims incurred during the Base Period by the Attributed Population in the final Base Period Attributed Population.

16.6.1.3.2 The final Performance Period TCOC based on the claims incurred during the Performance Period by the Attributed Population in the final Performance Period Attributed Population.

16.6.1.3.3 The change in risk between the final Base Period Risk Score for the Attributed Population in the final Base Period Attributed Population and the final Performance Period Risk Score for the Attributed Population in the final Performance Period Attributed Population.

16.6.1.3.4 The Base Period TCOC will be adjusted for trend and the change in the Base Period Risk Score and the Performance Period Risk Score to develop the Final Adjusted Target. The Final Adjusted Target will be compared to the final Performance Period TCOC for purposes of calculating the Final Payment.

16.7 Performance Thresholds. (Applicable to Track 2 only)

A two percent (2%) minimum performance threshold must be met prior to any Shared Savings or Shared Losses. The Performance TCOC must be above 102% or below 98% of the Adjusted TCOC Target for Shared Losses or Shared Savings payments to occur.

16.8 Amount and Distribution of Assumed Risk. (Applicable to Track 2 only) This section includes the amount and distribution of the Shared Savings and Shared Losses in each year of the contract.

16.8.1 IHP Shared Savings and Losses. The IHP may counter-propose the amount of Shared Savings and Shared Losses (i.e., savings achieved, meeting the two percent (2%) minimum performance threshold). IHP must provide such counter-proposal, if any, to the

SAMPLE

STATE at least one hundred and twenty (120) days before the Performance Period begins. In the absence of a counter-proposal, the table in Section 16.8.2.3 below shall govern for the subsequent Performance Period.

16.8.2 The Parties agree that the amount of Shared Savings and Shared Losses will be as follows for each Performance Period:

16.8.2.1 IHP must meet the two percent (2%) minimum performance threshold in order to receive any Shared Savings or incur payments for Shared Losses.

16.8.2.2 The savings or loss share as determined by the thresholds will be calculated prior to the addition of the PBP to the Performance Period TCOC. Any offset to shared savings or increases to shared losses resulting from the adjustment of the claim expenses for the PBP will be based on the savings share applicable to the corridor of the unadjusted savings or losses.

16.8.2.3 Risk Sharing Summary. The table below includes the risk sharing agreement for each Performance Period included in this contract.

Table 2: Risk Sharing Summary

Threshold	% of Adj. Target TCOC	IHP/DHS Distribution
1	>110%	n/a
2	102%-110%	50%/50%
3	100%-102%	50%/50%
4	98%-100%	50%/50%
5	90%-98%	50%/50%
6	<90%	n/a

16.9 Claims Cap.

The IHP has elected a claims Cap of $200,000 maximum annual claims per Patient.

16.10 Core Services, or Services Included in Total Cost of Care.

Categories of service included in Total Cost of Care are as follows.

SAMPLE

Ambulatory surgical center;

Anesthesia;

Audiology;

Chemical dependency;

Child & Teen Check-up (EPSDT);

Chiropractic;

Dental;

Federally qualified health center;

Home health (excluding personal care assistant services);

Hospice;

Inpatient hospital;

Laboratory;

Mental health;

Nurse midwife;

Nurse practitioner;

Occupational therapy;

Outpatient hospital;

Pharmacy;

Physical therapy;

Physician services;

Podiatry;

Private duty nursing

Public health nurse;

Radiology;

Rural health clinic;

Speech therapy; and

Vision

SAMPLE

Section 17. Population-Based Payment - Equity, Utilization, and Quality Measures

17.1 Quality Measures in Population-Based Payment Summary:

This document further describes the STATE's method of measuring quality for the purpose of the population-based payment.

17.1.1 Definitions. Capitalized terms in this Section take the same meaning as in the Contract.

17.1.1.1 "Baseline" means the Quality Measurement Period for the prior Performance Period (e.g., the Quality Measurement Period for Performance Period 1 are the Baseline for the Quality Measurement Periods for Performance Period 2).

17.1.1.2 "Absolute Improvement" is defined as the change in performance from Baseline to follow-up.

17.1.1.3 "Relative Improvement" is defined as Absolute Improvement divided by the Baseline measurement.

17.1.1.4 "NCQA" means National Committee for Quality Assurance.

17.1.1.5 "HEDIS" means Healthcare Effectiveness Data and Information Set.

17.1.1.6 "MNCM" means Minnesota Community Measurement.

17.1.1.7 "AHRQ" means the Agency for Healthcare Research and Quality.

17.1.2 Measures: For the Performance Periods, the following measures will be used:

Measure Category	Contract ID	Measure Name	Measure Specification Organization	Method of Data Collection	Rate Used in Calculations	Population Data Required
Equity*	E01	Example Equity Program and Measures below	IHP	Results submitted to DHS by the IHP	Target Population	Target Population
Utilization Measure	M01	Plan All-Cause Readmissions (PCR)**	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
	M02	Ambulatory Care – Emergency Dept. Visits (AMB)**	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
Clinical Quality	M03	Prevention Quality Indicator: Chronic Composite (PQI 92)**	AHRQ	MN DHS claims and encounter data	IHP-specific	Total Attributed Population

Measure Category	Contract ID	Measure Name	Measure Specification Organization	Method of Data Collection	Rate Used in Calculations	Population Data Required
	M04	Asthma Medication Ratio (AMR)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
	M05	Optimal Diabetes Care (ODC)	MNCM	DHS shall obtain the measure results***	Medicaid-specific	Total Population
Care for Children and Adolescents	M06	Well-Child Visits in the First 30 Months of Life: First 15 Months (W30)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
	M07	Well-Child Visits in the First 30 Months of Life: 15 Months – 30 Months (W30)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
	M08	Child and Adolescent Well-Care Visits (WCV): Children	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
	M09	Child and Adolescent Well-Care Visits (WCV): Adolescents	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
	M10	Childhood Immunization Status Combo (CIS)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
	M11	Immunization for Adolescents (IMA)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
	M12	Oral Evaluation, Dental Services (OED): Children	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population

*See Section 17.4 for the description of each equity measure.

**A lower rate is better for this measure. This is reflected in the scoring methodology in Section 17.3.

*** IHP must submit the required measures consistent with state and federal requirements associated with these measures. DHS will then obtain measure results.

SAMPLE

17.1.3 Effect on the population-based payment. Eligibility to continue participation in the population-based payment will be determined based on IHP's performance on measures in Section 17.1.2. Each Performance Period, DHS will calculate IHP's population-based quality score using methodology described below in Sections 17.2 and 17.3. In order to remain eligible for the population-based payment, IHP's population-based quality score demonstrate utility of the intervention for the targeted population based on the measures defined in Section 17.1.2. The population-based quality score will be calculated for all Performance Periods. The IHP will have to maintain measure performance in order to continue participation after the conclusion of the contract. The score will not have an effect on the amount of the population-based payment.

17.2 Calculation of Measures for the Population-Based Payment.

17.2.1 Quality Measurement Periods. Applicable dates of service, visit dates, or discharge dates for the three Performance Periods of the program are described below for each quality measure.

Applicable Dates of Service (DOS), Visits Dates, or Discharge Dates

	Quality Measurement Periods		
Measure Category	**Performance Period 1 (2024)**	**Performance Period 2 (2025)**	**Performance Period 3 (2026)**
Equity	January – December **2024**	January – December **2025**	January– December **2026**
Utilization	January – December **2024**	January – December **2025**	January – December **2026**
Clinical Quality	January – December **2024**	January – December **2025**	January – December **2026**
Care for Children and Adolescents (Applicable to Track 1 only)	January – December **2024**	January – December **2025**	January – December **2026**

17.3 Cumulative Calculation Methods.

17.3.1 Awarding Points for Utilization and Clinical Quality Measures.

17.3.1.1 For measures in this Section, if a measure is retired by the Measure Specification Organization (e.g., NCQA, AHRQ, etc.) or otherwise no longer available for measure calculation, the State and the IHP will mutually agree in writing on an alternative measure(s) for inclusion in the measure category. If no alternative measure(s) is selected, the measure will be removed and no achievement or improvement points will be available for this measure. If a measure is revised and combined with another measure by the Measure Specification Organization, but the measure remains the same, the State will notify the IHP in writing of the change and use the revised measure for awarding achievement and improvement points.

17.3.1.2 The IHP rate for each measure listed in Section 17.1.2 shall be assessed for both achievement and improvement and the score for each measure will be the greater of the achievement or improvement score as defined below.

SAMPLE

17.3.1.3 Awarding of points for measures DHS will calculate using administrative claims and encounter data.

17.3.1.3.1 Achievement for measures M01 through M04 and M06 through M12. Each measure shall be assessed against the State Medicaid Aggregate Rate that will function as a benchmark. For each measure that exceeds (or is below, as appropriate) the benchmark by more than eight percent (8%), two (2) points shall be awarded. For each measure that is below the benchmark by more than four percent (4%), zero (0) points shall be awarded. For each measure that is below the benchmark by four percent (4%) or less and above the benchmark by less than eight percent (8%), between one half (0.5) and two (2) points shall be awarded according to the following ranges:

Percent (%) Difference from the Benchmark	Points Awarded
-4% -> -2%	0.5
-2% -> 0%	1.0
0% -> 2%	1.2
2% -> 4%	1.4
4% -> 6%	1.6
6% -> 8%	1.8
8% or greater	2.0

17.3.1.3.2 Improvement for measures M01 through M04 and M06 through M12. Each measure shall be assessed against a baseline rate. For each measure that has an eight percent (8%) or more relative improvement compared to the baseline rate, the IHP shall be awarded two (2) points. For each measure that has less than a three percent (3%) relative improvement compared to the baseline, the IHP shall be awarded zero (0) points. For each measure that has three percent (3%) or more and less than eight percent (8%) relative improvement compared to the baseline rate, between one (1) and two (2) points shall be awarded according to the following ranges:

Percent (%) Relative Improvement	Points Awarded
3% -< 4%	1.0
4% -< 5%	1.2
5% -< 6%	1.4
6% -< 7%	1.6
7% -< 8%	1.8
8% or greater	2.0

Example calculation: Performance Period 1 (Baseline) rate = 25%

SAMPLE

Performance Period 2 rate achieved = 28%
(28% - 25% = 3% Absolute Improvement; 3% /25% =12% Relative Improvement)
Improvement points earned for measure = 2 points

17.3.1.4 Awarding of Points for measure M05 (Optimal Diabetes Care).

17.3.1.4.1 Aggregating clinic-level results. An IHP quality measure result will be determined for each quality measure by summing the numerators and denominators of multiple clinic-level results.

17.3.1.4.2 Achievement for measure M05. Each measure with a sufficient representative sample shall be assessed against a defined minimum attainment threshold and an upper threshold for the commercial population. For each measure, the total points shall be reducible by the percent of IHP Participants not reporting the quality measure in the manner specified in section 17.1.2. For each measure that meets or exceeds the upper threshold, two (2) points shall be awarded. For each measure that is below the minimum attainment threshold, zero (0) points shall be awarded. For each measure that meets or exceeds the minimum attainment threshold and is below the upper threshold, between one (1) and two (2) points shall be awarded, according to the following ranges:

Percentile	Points Awarded
30th -< 40th	1.0
40th -< 50th	1.2
50th -< 60th	1.4
60th -< 70th	1.6
70th -< 80th	1.8
80th or greater	2.0

17.3.1.4.3 Improvement for measure M05. Each measure with a sufficient representative sample shall be assessed against a baseline rate. For each measure that has an eight percent (8%) or more relative improvement compared to the baseline rate, the IHP shall be awarded two (2) points. For each measure that has less than a three percent (3%) relative improvement compared to the baseline, the IHP shall be awarded zero (0) points. For each measure that has three percent (3%) or more and less than eight percent (8%) relative improvement compared to the baseline rate, between one (1) and two (2) points shall be awarded according to the following ranges:

Percent (%) Relative Improvement	Points Awarded
3% -< 4%	1.0
4% -< 5%	1.2
5% -< 6%	1.4

Percent (%) Relative Improvement	Points Awarded
6% -< 7%	1.6
7% -< 8%	1.8
8% or greater	2.0

17.3.2 For all Performance periods, the total points earned by the IHP in each measure category shall be summed and divided by the total points available for that category to produce a category score of the percentage of points earned versus points available for the Performance Period. The points score shall be converted to a population-based quality score, considering the weights listed below.

Measure Category (Applicable to Track 1 only)	**Weights**
Total Equity Category	40%
Total Utilization Measures Category	20%
Total Clinical Quality Category	20%
Total Care for Children and Adolescents	20%

Measure Category (Applicable to Track 2 only)	**Weights**
Total Equity Category	40%
Total Utilization Measures Category	30%
Total Clinical Quality Category	30%

17.4 Equity Measures Description

17.4.1 Program Overview

17.4.1.1 Target population:

17.4.1.2 Explanation of the issue this intervention is designed to fix:

17.4.1.3 Proposed solution:

SAMPLE

17.4.1.4 Intervention:

17.4.1.5 Background:

17.4.2 Equity Measures.

17.4.2.1 Pursuant to Section 8.1.1, Population Health Report, of this contract, the IHP shall submit to the STATE an annual report containing a written evaluation of the **PROGRAM** described in Section 17.4.1 including the impact and effectiveness of the intervention as well as IHP's performance on the following equity measures.

17.4.2.2 Awarding Points for Equity Measures.

17.4.2.2.1 The IHP will be evaluated by their Population Health report(s), which is due on February 15th following the close of each year of the contract. The report will be awarded points based on the Equity Score Card, which includes qualitative and quantitative evaluation.

SAMPLE

Section 18. Total Cost of Care - Quality Measures (Applicable to Track 2 only)

18.1 Quality Measures in Shared Risk Model Summary:

This document further describes the STATE's method of measuring quality among Attributed Patients in the shared risk model.

18.1.1 Definitions. Capitalized terms in this Section take the same meaning as in the Contract.

18.1.1.1 "Baseline" means the Quality Measurement Period for the prior Performance Period (e.g., the Quality Measurement Periods for Performance Period 1 are the Baseline for the Quality Measurement Periods for Performance Period 2).

18.1.1.2 "Absolute Improvement" is defined as the change in performance from Baseline to follow-up.

18.1.1.3 "Relative Improvement" is defined as Absolute Improvement divided by the Baseline measurement.

18.1.1.4 "NCQA" means National Committee for Quality Assurance.

18.1.1.5 "HEDIS" means Healthcare Effectiveness Data and Information Set.

18.1.1.6 "MNCM" means Minnesota Community Measurement.

18.1.1.7 "AHRQ" means Agency for Healthcare Research and Quality.

18.1.1.8 "CG-CAHPS" means Clinician & Group Consumer Assessment of Healthcare Providers & Systems.

18.1.1.9 "HCAHPS" means Hospital Consumer Assessment of Healthcare Providers and Systems.

18.1.1.10 "CMS" means Centers for Medicare and Medicaid Services.

18.1.1.11 "Servicing Providers" means providers on the IHP Roster who contributed to the attribution.

18.1.2 Measures: For the Performance Periods, the following measures will be used:

18.1.2.1 Quality Core Set Measures. Measures must be submitted using the data collection mechanism identified in the following table.

Contract ID	Measure Category	Measure Name	Measure Specification Organization	Method of Data Collection	Rate Used in Calculations	Population Data Required
C01	Prevention & Screening for Adults	Colorectal Cancer Screening (CRC)	MNCM	MN DHS shall obtain the measure results*,~	Medicaid-specific	Total Population
C02		Breast Cancer Screening (BCS)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population

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Contract ID	Measure Category	Measure Name	Measure Specification Organization	Method of Data Collection	Rate Used in Calculations	Population Data Required
C03	Care for at risk populations	Asthma Medication Ratio (AMR)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
C04		Statin Therapy for Patients With Cardiovascular Disease (SPC)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
C05	Behavioral Health	Follow-up After Hospitalization for Mental Illness (FUH)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
C06		Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
C07	Patient-centered Care	CG-CAHPS Timely Appointments, Care, and Information	AHRQ	DHS Survey**	IHP-specific	Sample
C08		CG-CAHPS How Well Providers Communicate with Patients	AHRQ	DHS Survey**	IHP-specific	Sample
C09		CG-CAHPS Helpful, Respectful, and Courteous Office Staff	AHRQ	DHS Survey**	IHP-specific	Sample
C10		CG-CAHPS Providers' Use of Information to Coordinate Patient Care	AHRQ	DHS Survey**	IHP-specific	Sample
C11		CG-CAHPS Patient Rating of Provider as 9 or 10	AHRQ	DHS Survey**	IHP-specific	Sample
C12		HCAHPS Overall Hospital Rating	CMS	DHS shall obtain the measure results*	Total Population "Top Box" Rate	Sample Total Population
C13		HCAHPS recommend the Hospital as 9 or 10	CMS	DHS shall obtain the measure results*	Total Population "Top Box" Rate	Sample Total Population
C14	Quality of Outpatient Care	Prevention Quality Indicators: Overall Composite (PQI 90) ***	AHRQ	MN DHS claims and encounter data	IHP – specific	Total Attributed Population

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Contract ID	Measure Category	Measure Name	Measure Specification Organization	Method of Data Collection	Rate Used in Calculations	Population Data Required
*IHP must submit the required measures consistent with state and federal requirements associated with these measures. DHS will then obtain measure results.						
**DHS will manage the survey administration.						
***A lower rate is better for this measure.						
~ If DHS is unable to obtain data for this measure because it is no longer available on a statewide-basis, the HEDIS version of the measure will be used instead.						

18.1.2.2 Care for Children and Adolescent Measures. Measures must be submitted using the data collection mechanism identified in the following table.

Contract ID	Measure Category	Measure Name	Measure Specification Organization	Method of Data Collection	Rate Used in Calculations	Population Data Required
C15	Care for Children and Adolescents	Well-Child Visits in the First 30 Months of Life: First 15 Months (W30)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
C16		Well-Child Visits in the First 30 Months of Life: 15 Months – 30 Months (W30)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
C17		Child and Adolescent Well-Care Visits: Children (WCV)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
C18		Child and Adolescent Well-Care Visits: Adolescents (WCV)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
C19		Childhood Immunization Status Combo 10 (CIS)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
C20		Immunization for Adolescents Combo 2 (IMA)	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
C21		Oral Evaluation, Dental Services (OED): Children	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population

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18.1.2.3 Quality Improvement Measures. Measures must be submitted using the data collection mechanism identified in the following table.

Contract ID	Measure Category	Measure Name	Measure Specification Organization	Method of Data Collection	Rate Used in Calculations	Population Data Required
Q1	Quality Improvement	Example 1 - Breast Cancer Screening (BCS) *(agreed to by the state and the IHP)*	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
Q2		Example 2 - Child and Adolescent Well-Care Visits (WCV) *(agreed to by the state and the IHP)*	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population
Q3		Example 3 - Follow-up After Hospitalization for Mental Illness (30-day) (FUH) *(agreed to by the state and the IHP)*	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total Attributed Population

18.1.2.4 Closing Gaps Measures. Measures must be submitted using the data collection mechanism identified in the following table.

Contract ID	Measure Category	Measure Name	Measure Specification Organization	Method of Data Collection	Rate Used in Calculations	Population Data Required
G1	Closing gaps	Example 1 - Colorectal Cancer Screening (CRC) *(agreed to by the state and the IHP)*	MNCM	MN DHS shall obtain the measure results*	Medicaid-specific	Total Population
G2	Closing gaps	Example 2 - Optimal Diabetes Care (ODC) *(agreed to by the state and the IHP)*	MNCM	DHS shall obtain the measure results*	Medicaid- specific	Total Population
* IHP must submit the required measures consistent with state and federal requirements associated with these measures. DHS will then obtain measure results.						

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18.1.2.5 Equitable Care Measures. Measures must be submitted using the data collection mechanism identified in the following table.

Contract Reference ID	Measure Category	Measure Name	Measure Specification Organization	Method of Data Collection	Rate Used in Calculations	Population Data Required
E1	Equitable Care	Example 1 - Breast Cancer Screening (BCS) *(agreed to by the state and the IHP)*	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total attributed population stratified by race and ethnicity
E2		Example 2 - Child and Adolescent Well-Care Visits (WCV) *(agreed to by the state and the IHP)*	HEDIS, NCQA	MN DHS claims and encounter data	IHP-specific	Total attributed population stratified by race and ethnicity

18.2 Effect on Shared Savings and Shared Losses.

Quality measures will affect the IHP's portion of the Shared Savings or Shared Losses. The amount of the Final Payment that would otherwise be available pursuant to Section 5.4 of the Contract shall be modified. The measures will have a fifty percent (50%) effect on the payment (if any) of Shared Savings or Shared Losses; that is, 50% of the dollar amount saved or owed in the Total Cost of Care calculation in Section 16 of the Contract shall be reducible by the score calculated for quality in Section 18.4 below.

18.3 Calculation of Measures for Overall Quality Score.

18.3.1 Quality Measurement Periods. Applicable dates of service, visit dates, or discharge dates for each Performance Period are described below for each quality measure.

Applicable Dates of Service (DOS), Visits Dates, or Discharge Dates

	Quality Measurement Periods		
Measure*	**Performance Period 1 (2024)**	**Performance Period 2 (2025)**	**Performance Period 3 (2026)**
Colorectal Cancer Screening	January – December **2024**	January – December **2025**	January – December **2026**
Breast Cancer Screening	January – December **2024**	January – December **2025**	January – December **2026**
Asthma Medication Ratio	January – December **2024**	January – December **2025**	January – December **2026**

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	Quality Measurement Periods		
Measure*	**Performance Period 1 (2024)**	**Performance Period 2 (2025)**	**Performance Period 3 (2026)**
Statin Therapy for Patients With Cardiovascular Disease	January – December **2024**	January – December **2025**	January – December **2026**
Follow-up After Hospitalization for Mental Illness	January – December **2024**	January – December **2025**	January – December **2026**
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	January – December **2024**	January – December **2025**	January – December **2026**
CG-CAHPS**	Six consecutive months in **2023**	Six consecutive months in **2025**	Six consecutive months in **2025**
HCAHPS	January – December **2024**	January – December **2025**	January – December **2026**
Prevention Quality Indicators: Overall Composite	January – December **2024**	January – December **2025**	January – December **2026**
Well-Child Visits in the First 30 Months of Life: First 15 Months	January – December **2024**	January – December **2025**	January – December **2026**
Well-Child Visits in the First 30 Months of Life: 15 Months – 30 Months	January – December **2024**	January – December **2025**	January – December **2026**
Child and Adolescent Well-Care Visits: Children	January – December **2024**	January – December **2025**	January – December **2026**
Child and Adolescent Well-Care Visits: Adolescents	January – December **2024**	January – December **2025**	January – December **2026**
Childhood Immunization Status Combo 10	January – December **2024**	January – December **2025**	January – December **2026**
Immunization for Adolescents Combo 2	January – December **2024**	January – December **2025**	January – December **2026**
Oral Evaluation, Dental Services: Children	January – December **2024**	January – December **2025**	January – December **2026**
Optimal Diabetes Care	January – December **2024**	January – December **2025**	January – December **2026**

*If the Measure Specification Organization modifies applicable Dates of Service in their reporting guidelines, DHS will require Dates of Service that best align with the corresponding IHP performance period.

**Survey is typically performed every other year.

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18.4 Cumulative Calculation Methods.

18.4.1 For measures in this Section, if a measure specification changes in a way that would make a year-to-year comparison statistically invalid, such as a change in the clinical target value (for example, most recent HbA1c value changes from <8.0 to <7.0 for the Optimal Diabetes Care Measure from one measurement period to the next) awarding points based on improvement will not be available for that measure.

18.4.2 For measures in this Section, if a measure is revised and combined with another measure by the Measure Specification Organization (e.g., NCQA, AHRQ, etc.), but the measure remains the same, the State will notify the IHP in writing of the change and use the revised measure for awarding achievement and improvement points. If a measure is retired by the Measure Specification Organization or otherwise no longer available for measure calculation, the State and the IHP will mutually agree in writing on an alternative measure(s) to replace that measure or to remove the measure entirely from the measure category.

18.4.3 When a measure is eligible for both achievement and improvement, the IHP rate for the measure with a sufficient representative sample listed in Section 18.1 shall be assessed for both achievement and improvement and the score for the measure will be the greatest of the achievement or improvement score as defined below.

18.4.4 Awarding of Points for clinical measures in the Quality Core Set and Care for Children and Adolescents' Measures.

18.4.4.1 Achievement for measures C01 through C06 and C14 through C21. Each measure shall be assessed against the State Medicaid Aggregate Rate that will function as a benchmark. For each measure that exceeds (or is below, as appropriate) the benchmark by eight percent (8%) or more, two (2) points shall be awarded. For each measure that is below the benchmark by more than four percent (4%), zero (0) points shall be awarded. For each measure that is below the benchmark by four percent (4%) or less and above the benchmark by less than eight percent (8%), between one half (0.5) and two (2) points shall be awarded according to the following ranges:

Percent (%) Difference from the Benchmark	Points Awarded
-4% -< -2%	0.5
-2% -< 0%	1.0
0% -< 2%	1.2
2% -< 4%	1.4
4% -< 6%	1.6
6% -< 8%	1.8
8% or greater	2.0

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18.4.4.2 Improvement for measures C01 through C06 and C14 through C21.

Each measure shall be assessed against a baseline rate. For each measure that has an eight percent (8%) or more relative improvement compared to the baseline rate, the IHP shall be awarded two (2) points. For each measure that has less than a three percent (3%) relative improvement compared to the baseline, the IHP shall be awarded zero (0) points. For each measure that has three percent (3%) or more and less than eight percent (8%) relative improvement compared to the baseline rate, between one (1) and two (2) points shall be awarded according to the following ranges:

Percent (%) Relative Improvement	Points Awarded
3% -< 4%	1.0
4% -< 5%	1.2
5% -< 6%	1.4
6% -< 7%	1.6
7% -< 8%	1.8
8% or greater	2.0

Example calculation: Performance Period 1 (Baseline) rate = 25%
Performance Period 2 rate achieved = 28%
(28% - 25% = 3% Absolute Improvement; 3% /25% =12% Relative Improvement)
Improvement points earned for measure = 2 points

18.4.5 Awarding of Points for CG-CAHPS measures.

18.4.5.1 Achievement for CG-CAHPS measures C07 through C11. Each measure with a sufficient representative sample shall be assessed relative to the benchmark calculated as the total performance rate for all surveyed IHPs. For each measure that exceeds the benchmark by more than three (3) percent, two (2) points shall be awarded. For each measure that is within three (3) percent above or below (+/-3%) the benchmark, one and one-half (1.5) points shall be awarded. For each measure that is below the benchmark by more than three (3) percent, zero (0) points shall be awarded.

18.4.5.2 Improvement for CG-CAHPS measures C07 through C11. Each measure with a sufficient representative sample shall be assessed against a baseline rate. For each measure that has an eight percent (8%) or more relative improvement compared to the baseline rate, the IHP shall be awarded two (2) points. For each measure that has less than a three percent (3%) relative improvement compared to the baseline, the IHP shall be awarded zero (0) points. For each measure that has three percent (3%) or more and less than eight percent (8%) relative improvement compared to the baseline rate, between one (1) and two (2) points shall be awarded according to the following ranges:

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Percent (%) Relative Improvement	Points Awarded
3% -< 4%	1.0
4% -< 5%	1.2
5% -< 6%	1.4
6% -< 7%	1.6
7% -< 8%	1.8
8% or greater	2.0

18.4.6 Awarding of Points for HCAHPS measures C12 and C13.

18.4.6.1 Aggregating hospital-level results. An IHP quality measure result will be determined for each quality measure by summing the numerators and denominators of multiple hospital-level results.

18.4.6.2 Achievement for measures C12 and C13. Each measure with a sufficient representative sample shall be assessed against a defined minimum attainment threshold and an upper threshold. For each measure, the total points shall be reducible by the percent of IHP Participants not reporting the quality measure in the manner specified in section 18.1.2. For each measure that meets or exceeds the upper threshold, two (2) points shall be awarded. For each measure that is below the minimum attainment threshold, zero (0) points shall be awarded. For each measure that meets or exceeds the minimum attainment threshold and is below the upper threshold, between one (1) and two (2) points shall be awarded, according to the following ranges:

Percentile	Points Awarded
30th -< 40th	1.0
40th -< 50th	1.2
50th -< 60th	1.4
60th -< 70th	1.6
70th -< 80th	1.8
80th or greater	2.0

18.4.6.3 Improvement for measures C12 and C13. Each measure with a sufficient representative sample shall be assessed against a baseline rate. For each measure that has an eight percent (8%) or more relative improvement compared to the baseline rate, the IHP shall be awarded two (2) points. For each measure that has less than a three percent (3%) relative improvement compared to the baseline, the IHP shall be awarded zero (0) points. For each measure that has three percent (3%) or more and less than eight percent (8%) relative improvement compared to the baseline rate, between one (1) and two (2) points shall be awarded according to the following ranges:

Percent (%) Relative Improvement	Points Awarded
3% -< 4%	1.0
4% -< 5%	1.2

Percent (%) Relative Improvement	Points Awarded
5% -< 6%	1.4
6% -< 7%	1.6
7% -< 8%	1.8
8% or greater	2.0

18.4.7 Awarding of Points for Quality Improvement measures Q1, Q2, and Q3.

18.4.7.1 Improvement for measures Q1, Q2, and Q3. Scoring will be based solely on improvement. Each measure with a sufficient representative sample shall be assessed against a baseline rate. For each measure that has an eight percent (8%) or more relative improvement compared to the baseline rate, the IHP shall be awarded two (2) points. For each measure that has less than a one percent (1%) relative improvement compared to the baseline, the IHP shall be awarded zero (0) points. For each measure that has one percent (1%) or more and less than eight percent (8%) relative improvement compared to the baseline rate, between one fourth (0.25) and two (2) points shall be awarded according to the following ranges:

Percent (%) Relative Improvement	Points Awarded
1%-< 2%	0.25
2% -< 3%	0.5
3% -< 4%	0.75
4% -< 5%	1.0
5% -< 6%	1.25
6%-< 7%	1.5
7% -< 8%	1.75
8% or greater	2.0

Example calculation: Performance Period 1 (Baseline) rate = 25%
Performance Period 2 rate achieved = 28%
(28% - 25% = 3% Absolute Improvement; 3% /25% =12% Relative Improvement)
Improvement points earned for measure = 2 points

18.4.8 Awarding of Points for Closing Gaps measures G01 and G02.

18.4.8.1 Aggregating clinic-level results. An IHP quality measure result will be determined for each quality measure by summing the numerators and denominators of multiple clinic-level results.

18.4.8.2 Achievement for measures G01 and G02. Each measure with a sufficient representative sample shall be assessed against a defined minimum attainment threshold and an upper threshold for the commercial population. For each measure, the total

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points shall be reducible by the percent of IHP Participants not reporting the quality measure in the manner specified in section 18.1.2. For each measure that meets or exceeds the upper threshold, two (2) points shall be awarded. For each measure that is below the minimum attainment threshold, zero (0) points shall be awarded. For each measure that meets or exceeds the minimum attainment threshold and is below the upper threshold, between one (1) and two (2) points shall be awarded, according to the following ranges:

Percentile	Points Awarded
30th -< 40th	1.0
40th -< 50th	1.2
50th -< 60th	1.4
60th -< 70th	1.6
70th -< 80th	1.8
80th or greater	2.0

18.4.8.3 Improvement for measures G01 and G02. Each measure with a sufficient representative sample shall be assessed against a baseline rate. For each measure that has an eight percent (8%) or more relative improvement compared to the baseline rate, the IHP shall be awarded two (2) points. For each measure that has less than a three percent (3%) relative improvement compared to the baseline, the IHP shall be awarded zero (0) points. For each measure that has three percent (3%) or more and less than eight percent (8%) relative improvement compared to the baseline rate, between one (1) and two (2) points shall be awarded according to the following ranges:

Percent (%) Relative Improvement	Points Awarded
3% -< 4%	1.0
4% -< 5%	1.2
5% -< 6%	1.4
6% -< 7%	1.6
7% -< 8%	1.8
8% or greater	2.0

18.4.9 Awarding of Points for Equitable Care measures E1 and E2.

18.4.9.1 Awarding of points for Performance Period 1. For Performance Period 1, the IHP shall be awarded points for completing a template developed by the State focused on the IHP's work toward implementing interventions, processes, etc., aimed at closing gaps in care for the selected measures. The standard template shall be sent to the IHP by April 1st of Performance Period 1 and the IHP will submit the completed template to the State by March 1 of the year following the Performance Period. The State will provide the IHP with template evaluation criteria.

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18.4.9.1.1 Progress during Performance Period 1 must include at least one of the following,

- Improving data analysis and tools to better inform efforts on addressing health disparities.
- Engaging staff in efforts to address health disparities.
- Engaging patients to understand barriers and challenges.
- Increasing transparency of health disparities that exist in the IHP population.
- Implementing new process flows that address health disparities.

18.4.9.2 Awarding of points starting with Performance Period 2.

18.4.9.2.1 Awarding points based on relative change compared to the reference population. Points will be awarded based on relative improvement for each racial and ethnic group (e.g., Asian/Pacific Islander, Black, Hispanic, Native American, and White) compared to a baseline disparity gap with a reference population (i.e., White). In order to be eligible to receive points for a selected measure, the IHP must decrease the gap in care quality of all groups below the reference population and the IHP must either maintain or improve care quality of all other groups. If the IHP's overall performance or performance for any race or ethnicity group with a denominator of a hundred (100) or greater drops more than one percent (1%) in the performance year, then the IHP will not be eligible to receive points on the measure. If the IHP does not meet these criteria, no points will be awarded for the measure. If the IHP does meet these criteria, points will be awarded based on relative change compared to the reference population for each racial and ethnic group. Points shall be awarded according to the following ranges:

Percent (%) Relative Improvement	Points Awarded
Less than 5%	0
5% -< 10%	1.0
10% -< 20%	1.2
20% -< 30%	1.4
30% -< 40%	1.6
40% -< 50%	1.8
50% or greater	2.0

Example calculation:

Baseline rate = 25% (reference population) – 20% (group of interest) = 5% gap

Performance Period 2 rate = 25% (reference population) – 21% (group of interest) = 4% gap

Gap reduction from 5% (Baseline rate) to 4% (Performance Period 2 rate)
Improvement is 20% as (5-4)/5 = 0.20 or a 20% net change
Points earned for 20% net improvement on this measure = 1.4 points

18.4.9.2.2 Weighting performance below the reference population for point assignment. The point assignment for each race and ethnicity group where IHP performance rates are below the reference population will be weighted based on the proportion of that group's denominator compared to the total denominator of all race and ethnicity groups where IHP performance is below the reference population in the performance year.

18.4.10 Weights and Calculation of the Overall Quality Score. For all Performance Periods, the total points earned by IHP in each measure category shall be summed and divided by the total points available for that category to produce a category score of the percentage of points earned versus points available for the Performance Period. The points score shall be converted to an overall quality score, considering the weights listed below and Performance Periods in Section **Error! Reference source not found.**.

Measure Category	Weights
Quality Core Set *(Weights vary by category.)*	**20%**
Care Quality, Prevention & Screening for Adults	4%
Care Quality, Care for at Risk Populations	4%
Care Quality, Behavioral Health	4%
Care Quality, Patient-centered Care	6%
Care Quality, Quality of Outpatient Care	2%
Care for Children and Adolescents *(Measures will be equally weighted.)*	**20%**
Quality Improvement *(Measures will be equally weighted.)*	**30%**
Closing Gaps *(Measures will be equally weighted.)*	**10%**
Equitable Care *(Measures will be equally weighted.)*	**20%**

18.4.11 The portion of the available Shared Savings Final Payment from Section 5.4.3 of the Contract that is affected by the quality measures shall be multiplied by the IHP's overall quality score. The remainder of the available Shared Savings Final Payments shall not be reducible by the effect of the quality and patient experience scores. The sum should be paid to the IHP following the schedule in Section 5.4.3 of the Contract.

18.4.12 The portion of the available Shared Losses Final Payment from Section 5.4.3 of the Contract that is affected by the quality measures shall be multiplied by the IHP's overall quality score. The remainder of the available Shared Losses Final Payments shall not be

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reducible by the effect of the quality and patient experience scores. The sum should be paid by the IHP following the schedule in Section 5.4.3 of the Contract.

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List of Technical Sections and Appendices

Section 13. Eligible and Excluded Populations, Patient Attribution Method
Section 14. IHP-Specific Description and Governance
Section 15. IHP Payment Methodology - Population-Based Payment
Section 16. Total Cost of Care - Financial Calculation Information
Section 17. Population-Based Payment - Equity, Utilization, and Quality Measures
Section 18: Total Cost of Care - Quality Measures (Applicable to Track 2 only)

Appendix 1: Provider Taxonomy
See DHS web site at https://mn.gov/dhs/assets/ihp-contract-appendix-1-provider-taxonomy_tcm1053-327832.pdf

Appendix 2: Included Services - Category of Service Table

Categories of Service Included or Excluded from IHP TCOC		
Service Class	**Category of Service**	**Included / Excluded**
Inpatient Claims	001 - INPATIENT HOSPITAL GENERAL	I
Inpatient Claims	006 - INPATIENT HOSP REHABILITATION	I
Inpatient Claims	014 - INPATIENT HOSPITAL IMD	I
Inpatient Claims	014 - INPATIENT HOSPITAL IMD	I
Inpatient Claims	015 - INPATIENT LONG-TERM HOSPITAL	I
Inpatient Claims	074 - INP HOSPITAL NON DRG (psych contract beds)	I
Inpatient Claims	074 - INP HOSPITAL NON DRG (psych contract beds)	I
Inpatient Claims	999 - UNCATEGORIZED - EXCLUDED	I
Inpatient Claims	999 - UNCATEGORIZED - INCLUDED	I
Long Term Care Services	011 - NURSING FACILITY LEVEL I	E
Long Term Care Services	013 - ICF-MR	E
Long Term Care Services	017 - NURSING FACILITY LEVEL II	E
Long Term Care Services	019 - DAY TRAINING AND HABILITATION	E
Long Term Care Services	021 - CONSUMER DIRECTED CARE	E
Long Term Care Services	033 - MODIFICATIONS AND ADAPTATIONS	E
Long Term Care Services	038 - PERSONAL CARE SERVICES	E
Long Term Care Services	084 - SWING BED SERVICES	E
Long Term Care Services	092 - NUTRITION SERVICES	E
Long Term Care Services	093 - CHORE	E
Long Term Care Services	094 - COMPANION SERVICES	E
Long Term Care Services	095 - HOME DELIVERED MEALS	E
Long Term Care Services	096 - HOMEMAKER SERVICES	E

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Long Term Care Services	102 - ADULT DAY CARE	E
Long Term Care Services	104 - SUPPORTED EMPLOYMENT SERVICES	E
Long Term Care Services	105 - SUPPORTED LIVING SERVICES	E
Long Term Care Services	106 - STRUCTURED DAY PROGRAM SVC	E
Long Term Care Services	107 - RESPITE CARE	E
Long Term Care Services	108 - ASSISTED LIVING SERVICES	E
Long Term Care Services	109 - INDEPENDENT LIVING SKILLS	E
Long Term Care Services	110 - IN-HOME FAMILY SUPPORT	E
Long Term Care Services	111 - DEV DISABILITIES SCREENING	E
Long Term Care Services	114 - EXTENDED HOME HEALTH AIDE	E
Long Term Care Services	116 - EXTENDED MEDICAL SUPPLIES/DME	E
Long Term Care Services	119 - EXTENDED PERSONAL CARE	E
Long Term Care Services	122 - EXTENDED PRIVATE DUTY NURSING	E
Long Term Care Services	126 - EXTENDED TRANSPORTATION	E
MH/CD	029 - RTC - MENTAL HEALTH	I
MH/CD	034 - FAMILY COUNSELING & TRAINING	I
MH/CD	034 - FAMILY COUNSELING & TRAINING	I
MH/CD	035 - BEHAVIORAL PROGRAM SERVICES	I
MH/CD	035 - BEHAVIORAL PROGRAM SERVICES	I
MH/CD	046 - MENTAL HEALTH	I
MH/CD	046 - MENTAL HEALTH	I
MH/CD	048 - EARLY INTENSE DEV BEHAVE INTER	I
MH/CD	062 - CONSOLIDATED TREATMENT FUND	I
MH/CD	062 - CONSOLIDATED TREATMENT FUND	I
MH/CD	063 - CTF EXTND CARE/HALFWAY HOUSE	I
MH/CD	063 - CTF EXTND CARE/HALFWAY HOUSE	I
MH/CD	071 - CASE MGMNT MENTAL HEALTH - SPMI/SED	I
MH/CD	071 - CASE MGMNT MENTAL HEALTH - SPMI/SED	I
MH/CD	113 - PASARR - MENTAL HEALTH	I
MH/CD	999 - UNCATEGORIZED - EXCLUDED	I
MH/CD	999 - UNCATEGORIZED - INCLUDED	I
Other	005 - CHILD WLFR TARGETED CASE MGMNT	I
Other	032 - MEDICAL SUPPLY/DME	I
Other	032 - MEDICAL SUPPLY/DME	I
Other	036 - TRANSPORT, SPECIAL	E
Other	037 - TRANSPORT, AMBULANCE	E
Other	045 - DENTAL	I
Other	045 - DENTAL	I
Other	052 - IEP (Individual Education Plan for children with disabilities)	E
Other	075 - EYEGLASSES/CONTACT LENSES	I
Other	076 - PROSTHETICS AND ORTHOTICS	I
Other	077 - HEARING AIDS	I

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Other	100 - ACCESS SERVICES	E
Other	103 - FOSTER CARE	E
Outpatient Facility	007 - OUTPATIENT HOSPITAL SERVICES	I
Outpatient Facility	020 - HOME HEALTH SERVICES	I
Outpatient Facility	025 - UNKNOWN (Birth Center Facility Fee)	I
Outpatient Facility	041 - ANESTHESIA	I
Outpatient Facility	043 - PHYSICIAN SERVICES	I
Outpatient Facility	051 - PHYSICAL THERAPY	I
Outpatient Facility	053 - SPEECH THERAPY	I
Outpatient Facility	054 - OCCUPATIONAL THERAPY	I
Outpatient Facility	056 - AMBULATORY SURGERY	I
Outpatient Facility	058 - AUDIOLOGY	I
Outpatient Facility	072 - HOSPICE	I
Outpatient Facility	078 - VISION	I
Outpatient Facility	079 - RADIOLOGY, TECHNICAL COMPONENT	I
Outpatient Facility	080 - LABORATORY	I
Outpatient Facility	082 - FED QUALIFIED HEALTH CNTR SVC	I
Outpatient Facility	083 - RURAL HEALTH CLINIC SERVICES	I
Outpatient Facility	087 - END-STAGE RENAL DIALYSIS	E
Outpatient Facility	088 - PUBLIC HEALTH NURSING	I
Outpatient Facility	089 - PRIVATE DUTY NURSING	I
Outpatient Facility	118 - EXTENDED OCCUPATIONAL THERAPY	I
Outpatient Facility	121 - EXTENDED PHYSICAL THERAPY	I
Outpatient Facility	999 - UNCATEGORIZED - EXCLUDED	E
Pharmacy	030 - Pharmacy	I
Professional	020 - HOME HEALTH SERVICES	I
Professional	022 - UNKNOWN (Transitional Services)	E
Professional	040 - CHILD AND TEEN CHECKUP	I
Professional	041 - ANESTHESIA	I
Professional	043 - PHYSICIAN SERVICES	I
Professional	044 - CASE MANAGEMENT OTHER	I
Professional	051 - PHYSICAL THERAPY	I
Professional	053 - SPEECH THERAPY	I
Professional	054 - OCCUPATIONAL THERAPY	I
Professional	055 - PODIATRY	I
Professional	057 - CHIROPRACTIC	I
Professional	058 - AUDIOLOGY	I
Professional	078 - VISION	I
Professional	079 - RADIOLOGY, TECHNICAL COMPONENT	I
Professional	080 - LABORATORY	I
Professional	088 - PUBLIC HEALTH NURSING	I
Professional	089 - PRIVATE DUTY NURSING	I
Professional	090 - NURSE MIDWIFE SERVICES	I

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Professional	091 - NURSE PRACTITIONER SERVICES	I
Professional	143 - BUY-IN PART B	E
Professional	999 - UNCATEGORIZED - EXCLUDED	I

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Appendix 3: Data Sharing and Business Associate Agreement Terms and Conditions

TERMS AND CONDITIONS

This Appendix sets forth the terms and conditions in which STATE will share data with and permit IHP to Use or Disclose Protected Information that the parties are legally required to safeguard pursuant to the Minnesota Government Data Practices Act ("MGDPA") under Minnesota Statutes, chapter 13, the Health Insurance Portability and Accountability Act rules and regulations codified at 45 C.F.R. Parts 160, 162, and 164 ("HIPAA"), and other Applicable Safeguards.

The parties agree to comply with all applicable provisions of the MGDPA, HIPAA, and any other Applicable Safeguard that applies to the Protected Information.

General Description of Protected Information That Will Be Shared: This section governs the data that will be exchanged pursuant to IHP performing the services described in the Contract. The data exchanged under the Contract will include clinical data, enrollment data, ACG risk adjustment output, and claims-level data as described in Section 4.6 and 4.11 of the Contract.

Purpose for Sharing Protected Information and Expected Outcomes: The data exchanged under the Contract is provided in order for IHP to perform program operations and analysis to improve its performance under the Contract, support care coordination and care delivery to their IHP attributed population, and perform evaluations of interventions and programs developed or enhanced through participation in this Contract.

STATE is permitted to share the Protected Information with IHP pursuant to: Minnesota Statutes, § 13.46, Minnesota Statutes, § 256B.0755, 42 CFR 431 Subpart F, and the laws listed below.

With regard to IHP's performance of certain activities under the Contract (defined below), it is expressly agreed that IHP is a "business associate" of STATE, as defined by HIPAA under 45 C.F.R. § 160.103, "Definitions." The Disclosure of Protected Health Information to IHP that is subject to the Health Insurance Portability Accountability Act (HIPAA) is permitted by 45 C.F.R. § 164.502(e)(1)(i), "Standard: Disclosures to Business Associates."

It is understood by IHP that, as a business associate under HIPAA, IHP is directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making Uses and Disclosures of Protected Health Information that are not authorized by contract or permitted by law. IHP is also directly liable and subject to civil penalties for failing to safeguard electronic Protected Health Information in accordance with the HIPAA Security Rule, Subpart C of 45 C.F.R. Part 164, "Security and Privacy."

DEFINITIONS

A. "Agent" means IHP's employees, contractors, subcontractors, and other non-employees and representatives.

B. "Applicable Safeguards" means the state and federal safeguards listed in subsection 2.1.A of this Appendix.

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C. “Breach” means the acquisition, access, Use, or Disclosure of unsecured Protected Health Information in a manner not permitted by HIPAA, which compromises the security or privacy of Protected Health Information.

D. “Business Associate” shall generally have the same meaning as the term “business associate” found in 45 C.F.R. § 160.103, and in reference to the party in the Contract and this Appendix, shall mean IHP.

E. “Contract” means the Contract between STATE and IHP to which this Appendix is attached.

F. “Disclose” or “Disclosure” means the release, transfer, provision of access to, or divulging in any manner of information by the entity in possession of the Protected Information.

G. “HIPAA” means the rules and regulations codified at 45 C.F.R. Parts 160, 162, and 164.

H. “Individual” means the person who is the subject of protected information.

I. “Privacy Incident” means a violation of an information privacy provision of any applicable state and federal law, statute, regulation, rule, or standard, including those listed in the Contract and this Appendix.

J. “Protected Information” means any information, regardless of form or format, which is or will be Used by STATE or IHP under the Contract that is protected by federal or state privacy laws, statutes, regulations, policies, or standards, including those listed in this Appendix. This includes, but is not limited to, individually identifiable information about a State, county or tribal human services agency client or a client’s family member. Protected Information also includes, but is not limited to, Protected Health Information, as defined below, and Protected Information maintained within or accessed via a State information management system, including a State “legacy system” and other State application.

K. “Protected Health Information” is a subset of Protected Information (defined above) and has the same meaning as the term “protected health information” found in 45 C.F.R. § 160.103. For the purposes of this Appendix, it refers only to that information that is received, created, maintained, or transmitted by IHP as a Business Associate on behalf of STATE.

L. “Security Incident” means the attempted or successful unauthorized accessing, Use, or interference with system operations in an information management system or application. “Security Incident” does not include pings and other broadcast attacks on a system’s firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, provided that such activities do not result in the unauthorized exposure, viewing, obtaining, accessing, or Use of Protected Information.

M. “Use” or “Used” means any activity involving Protected Information including its creation, collection, access, acquisition, modification, employment, application, utilization, examination, analysis, manipulation, maintenance, dissemination, sharing, Disclosure, transmission, or destruction. “Use” includes any of these activities whether conducted manually or by electronic or computerized means.

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1. INFORMATION EXCHANGED

1.1 This Appendix governs the data that will be exchanged pursuant to IHP performing the services described in the Contract. The data exchanged under the Contract will include will include clinical data, enrollment data, ACG risk adjustment output, and claims-level data as described in Section 4.6 and 4.11 of the Contract.

1.2 The data exchanged under the Contract is provided to IHP to perform program operations and analysis to improve its performance under the Contract, support care coordination and care delivery to their IHP attributed population, and perform evaluations of interventions and programs developed or enhanced through participation in this Contract.

1.3 STATE is permitted to share the Protected Information with IHP pursuant to: Minnesota Statutes, § 13.46, Minnesota Statutes, § 256B.0755, 42 CFR 431 Subpart F, and the laws listed below.

2. INFORMATION PRIVACY AND SECURITY

IHP and STATE must comply with the MGDPA, HIPAA, and all other Applicable Safeguards as they apply to all data provided by STATE under the Contract, and as they apply to all data created, collected, received, stored, Used, maintained, or disseminated by IHP under the Contract. The civil remedies of Minn. Stat. § 13.08, “Civil Remedies,” apply to IHP and STATE. Additionally, the remedies of HIPAA apply to the release of data governed by HIPAA.

2.1 Compliance with Applicable Safeguards.

A. State and Federal Safeguards. The parties acknowledge that the Protected Information to be shared under the terms of the Contract may be subject to one or more of the laws, statutes, regulations, rules, policies, and standards, as applicable and as amended or revised (“Applicable Safeguards”), listed below, and agree to abide by the same.

1. Health Insurance Portability and Accountability Act rules and regulations codified at 45 C.F.R. Parts 160, 162, and 164 (“HIPAA”);
2. Minnesota Government Data Practices Act (Minn. Stat. Chapter 13);
3. Minnesota Health Records Act (Minn. Stat. § 144.291–144.34);
4. Confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C. § 290dd-2, “Confidentiality of Records,” and 42 C.F.R. Part 2, “Confidentiality of Substance Use Disorder Patient Records”);
5. Tax Information Security Guidelines for Federal, State and Local Agencies (26 U.S.C. § 6103, “Confidentiality and Disclosure of Returns and Return Information,” and Internal Revenue Service Publication 1075;
6. U.S. Privacy Act of 1974;
7. Computer Matching Requirements (5 U.S.C. § 552a, “Records Maintained on Individuals”);
8. Social Security Data Disclosure (section 1106 of the Social Security Act: 42 USC § 1306, “Disclosure of information in Possession of Social Security Administration or Department of Health and Human Services”);

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9. Disclosure of Information to Federal, State and Local Agencies (DIFSLA Handbook, Internal Revenue Service Publication 3373);
10. Final Exchange Privacy Rule of the Affordable Care Act (45 C.F.R. § 155.260, "Privacy and Security of Personally Identifiable Information,");
11. NIST Special Publication 800-53, "Security and Privacy Controls for Federal Information Systems and Organizations," Revision 4 (NIST.SP.800-53r4), and;
12. All state of Minnesota "Enterprise Information Security Policies and Standards."[2]

The parties further agree to comply with all other laws, statutes, regulations, rules, and standards, as amended or revised, applicable to the exchange, Use and Disclosure of data under the Contract.

B. Statutory Amendments and Other Changes to Applicable Safeguards. The Parties agree to take such action as is necessary to amend the Contract and this Appendix from time to time as is necessary to ensure, current, ongoing compliance with the requirements of the laws listed in this Section or in any other applicable law.

2.2 IHP Data Responsibilities

A. Use Limitation.

1.Restrictions on Use and Disclosure of Protected Information. Except as otherwise authorized in the Contract or this Appendix , IHP may only Use or Disclose Protected Information as minimally necessary to provide the services to STATE as described in the Contract and this Appendix , or as otherwise required by law, provided that such Use or Disclosure of Protected Information, if performed by STATE, would not violate the Contract, this Appendix, HIPAA, or state and federal statutes or regulations that apply to the Protected Information.

2.Federal tax information. To the extent that Protected Information Used under the Contract constitutes "federal tax information" (FTI), IHP shall ensure that this data only be Used as authorized under the Patient Protection and Affordable Care Act, the Internal Revenue Code, 26 U.S.C. § 6103(C), and IRS Publication I 075.

B. Individual Privacy Rights. IHP shall ensure Individuals are able to exercise their privacy rights regarding Protected Information, including but not limited to the following:

1.Complaints. IHP shall work cooperatively and proactively with STATE to resolve complaints received from an Individual; from an authorized representative; or from a state, federal, or other health oversight agency.

2.Amendments to Protected Information Requested by Data Subject Generally. Within ten (10) business days, IHP must forward to STATE any request to make any amendment(s) to Protected Information in order for STATE to satisfy its obligations under Minn. Stat. § 13.04, "Rights of Subjects of Data," subd. 4. If the request to amend Protected Information pertains to Protected Health Information, then IHP must also make any amendment(s) to Protected Health

[2] *See* https://mn.gov/mnit/government/policies/security/

Information as directed or agreed to by STATE pursuant to 45 C.F.R. § 164.526, "Amendment of Protected Health Information," or otherwise act as necessary to satisfy STATE or IHP's obligations under 45 CF.R. § 164.526 (including, as applicable, Protected Health Information in a designated record set).

C. Ongoing Responsibilities to Safeguard Protected Information.

1.Privacy and Security Safeguards. IHP shall develop, maintain, and enforce policies, procedures, and administrative, technical, and physical safeguards that comply with the Applicable Safeguards to ensure the privacy and security of the Protected Information, and to prevent the Use or Disclosure of Protected Information, except as expressly permitted by the Contract and this Appendix.

2 Electronic Protected Information. IHP shall implement and maintain appropriate safeguards with respect to electronic Protected Information, and comply with Subpart C of 45 C.F.R. Part 164 (HIPAA Security Rule) with respect to prevent the Use or Disclosure other than as provided for by the Contract or this Appendix.

3.Monitoring Agents. IHP shall ensure that any Agent to whom IHP Discloses Protected Information on behalf of STATE, or whom IHP employs or retains to create, receive, Use, store, Disclose, or transmit Protected Information on behalf of STATE, agrees in writing to the same restrictions and conditions that apply to IHP under the Contract and this Appendix with respect to such Protected Information, and in accordance with 45 C.F.R. §§ 164.502, "Use and Disclosure of Protected Health Information: General Rules," subpart (e)1)(ii) and 164.308, "Administrative Safeguards," subpart (b)(2).

4.Encryption. According to the state of Minnesota's "Enterprise Information Security Policies and Standards,"[3] IHP must use encryption to store, transport, or transmit Protected Information and must not use unencrypted email to transmit Protected Information.

5.Minimum Necessary Access to Protected Information. IHP shall ensure that its Agents acquire, access, Use, and Disclose only the minimum necessary Protected Information needed to complete an authorized and legally permitted activity.

6.Training and Oversight. IHP shall ensure that Agents are properly trained and comply with all Applicable Safeguards and the terms of the Contract and this Appendix.

D. Responding to Privacy Incidents, Security Incidents, and Breaches. IHP will comply with this Section for all Protected Information shared under the Contract. Additional obligations for specific kinds of Protected Information shared under the Contract are addressed in subsection 2.2(F), "Reporting Privacy Incidents, Security Incidents, and Breaches."

[3] https://mn.gov/mnit/government/policies/security/

1. Mitigation of harmful effects. Upon discovery of any actual or suspected Privacy Incident, Security Incident, and/or Breach, IHP will mitigate, to the extent practicable, any harmful effect of the Privacy Incident, Security Incident, and/or Breach. Mitigation may include, but is not limited to, notifying and providing credit monitoring to affected Individuals.

2. Investigation. Upon discovery of any actual or suspected Privacy Incident, Security Incident, and/or Breach, IHP will investigate to (1) determine the root cause of the incident, (2) identify Individuals affected, (3) determine the specific Protected Information impacted, and (4) comply with notification and reporting provisions of the Contract, this Appendix, and applicable law.

3. Corrective action. Upon identifying the root cause of any Privacy Incident, Security Incident, and/or Breach, IHP will take corrective action to prevent, or reduce to the extent practicable, any possibility of recurrence. Corrective action may include, but is not limited to, patching information system security vulnerabilities, sanctioning Agents, and/or revising policies and procedures.

4. Notification to Individuals and others; costs incurred.

a. **Protected Information.** Following its discovery of a Privacy Incident or a Security Incident, IHP will determine whether notice to data subjects and/or any other external parties regarding any Privacy Incident or Security Incident is required by law. If such notice is required, GRANTEE will fulfill the STATE's and IHP's obligations under any applicable law requiring notification, including, but not limited to, Minn. Stat. §§ 13.05, "Duties of Responsible Authority," and 13.055, "Disclosure of Breach in Security."

b. **Protected Health Information.** If a Privacy Incident or Security Incident results in a Breach of Protected Health Information, as these terms are defined in this Appendix and under HIPAA, then IHP will provide notice to Individual data subjects under any applicable law requiring notification, including but not limited to providing notice as outlined in 45 C.F.R. § 164.404, "Notification to Individuals."

c. **Failure to notify.** If IHP fails to timely and appropriately notify Individual data subjects or other external parties under subparagraph (a), then IHP will reimburse STATE for any costs, fines, or penalties incurred as a result of IHP's failure to timely provide appropriate notification.

5. Obligation to report to STATE. Upon discovery of a Privacy Incident, Security Incident, and/or Breach, IHP will report to STATE in writing as further specified in subsection 2.2(F).

a. **Communication with authorized representative.** IHP will send any

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written reports to, and communicate and coordinate as necessary with, STATE's authorized representative or designee.

b. **Cooperation of response.** IHP will cooperate with requests and instructions received from STATE regarding activities related to investigation, containment, mitigation, and eradication of conditions that led to, or resulted from, the Security Incident, Privacy Incident, and/or Breach, and all matters pertaining to reporting and notification of a Security Incident, Privacy Incident, and/or Breach.

c. **Information to respond to inquiries about an investigation.** IHP will, as soon as possible, but not later than two business days after a request from STATE, provide STATE with any reports or information requested by STATE related to an investigation of a Security Incident, Privacy Incident, and/or Breach.

6. Documentation. IHP will document actions taken under paragraphs 1 through 5 of this Section, and retain this documentation for a minimum of six (6) years from the date it discovered the Privacy Incident, Security Incident, and/or Breach or the time period required by Section G, whichever is longer. IHP shall provide such documentation to STATE upon request.

E. **Reporting Privacy Incidents, Security Incidents, and Breaches.** IHP will comply with the reporting obligations of this Section as they apply to the kind of Protected Information involved. IHP will also comply with Subsection 2.2(E), "Responding to Privacy Incidents, Security Incidents, and Breaches," above in responding to any Privacy Incident, Security Incident, and/or Breach.

1. Social Security Administration Data. IHP will report all actual or suspected unauthorized Uses or Disclosures of Social Security Administration (SSA) data. SSA data is information protected by section 1106 of the Social Security Act.

a. **Initial report.** IHP will, in writing, immediately report all actual or suspected unauthorized Uses or Disclosures of SSA data to STATE. IHP will include in its initial report to STATE all information under subsections 2.2(E)(1)–(4), of this Appendix that is available to IHP at the time of the initial report, and provide updated reports as additional information becomes available.

b. **Final report.** IHP will, upon completion of its investigation of and response to any actual or suspected unauthorized Uses or Disclosures of SSA data, or upon STATE's request in accordance with subsection 2.2(E)(5), promptly submit a written report to STATE documenting all actions taken under subsections 2.2(E) (1)–(4), of this Appendix.

2. Protected Health Information. IHP will report Privacy Incidents, Security Incidents, and/or Breaches involving Protected Health Information as follows:

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a. **Reporting Breaches to STATE.** IHP will report, in writing, any Breach involving Protected Health Information to STATE within five (5) business days of discovery, as defined in 45 C.F.R. § 164.410, “Notification by a Business Associate,” subpart (a)(2), for all Breaches involving fewer than 500 Individuals, and immediately for all Breaches involving 500 or more Individuals. These reports shall include, at a minimum, the following information:

1. Identity of each Individual whose unsecured Protected Health Information has been, or is reasonably believed by IHP, to have been accessed, acquired, Used, or Disclosed during the incident or Breach.
2. Description of the compromised Protected Health Information.
3. Date of the Breach.
4. Date of the Breach’s discovery.
5. Description of the steps taken to investigate the Breach, mitigate its impact, and prevent future Breaches.
6. Sanctions imposed on IHP’s Agents involved in the Breach.
7. All other information that must be included in notification to the Individual under 45 C.F.R. § 164.404(c).
8. Statement that IHP has notified, or will notify, impacted Individuals in accordance with 45 C.F.R. § 164.404 and, upon the completion of said notifications, provide through documentation of the recipients, date, content, and manner of the notifications.

b. **Reporting Breaches to external parties.** IHP shall timely report all Breaches involving Protected Health Information to the impacted Individuals (as specified in 45 C.F.R. § 164.404), the U.S. Department of Health and Human Services (as specified in 45 C.F.R § 164.408, “Notification to the Secretary”), and, for Breaches involving 501 or more Individuals, to the media (as specified in 45 C.F.R. § 164.406, “Notification to the Media”). As soon as possible and no later than 10 (ten) business days prior to any report to the media required by 45 C.F.R. § 164.406, IHP shall draft and provide to STATE for its review and approval all Breach-related reports or statements intended for the media.

c. **Reporting Security Incidents that do not result in a Breach to STATE.** IHP will report, in writing, all Security Incidents that do not result in a Breach, but involve systems maintaining Protected Health Information created, received, maintained, or transmitted by IHP or its Agents on behalf of STATE, to STATE on a monthly basis, in accordance with 45 C.F.R § 164.314, “Organizational Requirements.”

d. **Reporting other violations to STATE.** IHP will report, in writing, any other Privacy Incident and/or violation of an Individual’s privacy rights as it pertains to Protected Health Information to STATE without unreasonable delay and in no case later than fourteen (14) calendar days of discovery as defined in 45 C.F.R. § 164.410(a)(2). This includes, but is not limited to, any violation of Subpart E of 45 C.F.R. Part 164.

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4.Other Protected Information. IHP will report Privacy Incidents, Security Incidents, and/or Breaches not involving Protected Health Information to STATE.

a. **Initial report.** IHP will report all Privacy Incidents, Security Incidents, and/or Breaches not involving Protected Health Information to STATE, in writing, within thirty (30) calendar days of discovery. If IHP is unable to complete its investigation of, and response to, a Privacy Incident, Security Incident, and/or Breach within thirty (30) calendar days of discovery, then IHP will provide STATE with all information under subsections 2.2(E)(1)– (4), of this Appendix that are available to IHP at the time of the initial report, and provide updated reports as additional information becomes available.

b. **Final report.** IHP will, upon completion of its investigation of and response to a Privacy Incident, Security Incident, and/or Breach reported in accordance with the prior subparagraph, or upon STATE's request in accordance with subsection 2.2€ (5) submit in writing a report to STATE documenting all actions taken under subsections 2.2(E)(1)–(4), of this Appendix.

F. Designated Record Set—Protected Health Information. If, on behalf of STATE, IHP maintains a complete or partial designated record set, as defined in 45 C.F.R. § 164.501, "Definitions," upon request by STATE, IHP shall, in a time and manner that complies with HIPAA or as otherwise directed by STATE:

1. Provide the means for an Individual to access, inspect, or receive copies of the Individual's Protected Health Information.

2. Provide the means for an Individual to make an amendment to the Individual's Protected Health Information.

G. Access to Books and Records, Security Audits, and Remediation. IHP shall conduct and submit to audits and necessary remediation as required by this Section to ensure compliance with all Applicable Safeguards and the terms of the Contract and this Appendix.

1. IHP represents that it has audited and will continue to regularly audit the security of the systems and processes used to provide services under the Contract and this Appendix, including, as applicable, all data centers and cloud computing or hosting services under contract with IHP. IHP will conduct such audits in a manner sufficient to ensure compliance with the security standards referenced in this Appendix.

2. This security audit required above will be documented in a written audit report which will, to the extent permitted by applicable law, be deemed confidential security information and not public data under the Minnesota Government Data Practices Act, Minn. Stat. § 13.37, "General Nonpublic Data," subd. 1(a) and 2(a).

3. IHP agrees to make its internal practices, books, audits, and records related to its obligations under the Contract and this Appendix available to STATE or a STATE

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designee upon STATE's request for purposes of conducting a financial or security audit, investigation, or assessment, or to determine IHP's or STATE's compliance with Applicable Safeguards, the terms of this Appendix and accounting standards. For purposes of this provision, other authorized government officials include, but is not limited to, the Secretary of the United States Department of Health and Human Services.

4. IHP will make and document best efforts to remediate any control deficiencies identified during the course of its own audit(s), or upon request by STATE or other authorized government official(s), in a commercially reasonable timeframe.

H. Documentation Required. Any documentation required by this Appendix , or by applicable laws, standards, or policies, of activities including the fulfillment of requirements by IHP, or of other matters pertinent to the execution of the Contract, must be securely maintained and retained by IHP for a period of six years from the date of expiration or termination of the Contract, or longer if required by applicable law, after which the documentation must be disposed of consistent with subsection 2.6 of this Appendix.

IHP shall document Disclosures of Protected Health Information made by IHP that are subject to the accounting of disclosure requirement described in 45 C.R.F. 164.528, "Accounting of Disclosures of Protected Health Information," and shall provide to STATE such documentation in a time and manner designated by STATE at the time of the request.

I. Requests for Disclosure of Protected Information. If IHP or one of its Agents receives a request to Disclose Protected Information, IHP shall inform STATE of the request and coordinate the appropriate response with STATE. If IHP Discloses Protected Information after coordination of a response with STATE, it shall document the authority used to authorize the Disclosure, the information Disclosed, the name of the receiving party, and the date of Disclosure. All such documentation shall be maintained for the term of the Contract or six years after the date of the Disclosure, whichever is later, and shall be produced upon demand by STATE.

J. Conflicting Provisions. IHP shall comply with all applicable provisions of HIPAA and with the Contract and this Appendix. To extent that the parties determine, following consultation, that the terms of this Appendix are less stringent than the Applicable Safeguards, IHP must comply with the Applicable Safeguards. In the event of any conflict in the requirements of the Applicable Safeguards, IHP must comply with the most stringent Applicable Safeguard.

K. Data Availability. IHP, or any entity with legal control of any Protected Information provided by STATE, shall make any and all Protected Information under the Contract and this Appendix available to STATE upon request within a reasonable time as is necessary for STATE to comply with applicable law.

2.3 Data Security.

A. STATE Information Management System Access. If STATE grants IHP access to

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Protected Information maintained in a STATE information management system (including a STATE “legacy” system) or in any other STATE application, computer, or storage device of any kind, then IHP agrees to comply with any additional system- or application-specific requirements as directed by STATE.

B. Electronic Transmission. The parties agree to encrypt electronically transmitted Protected Information in a manner that complies with NIST Special Publications 800-52, “Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations”; 800-77, “Guide to IPsec VPNs”; 800-113, “Guide to SSL VPNs,” or other methods validated under Federal Information Processing Standards (FIPS) 140-2, “Security Requirements for Cryptographic Modules.” As part of its compliance with the NIST publications, and the State of Minnesota’s “Enterprise Information Security Policies and Standards,” DATA SHARING PARTNER must use encryption to store, transport, or transmit any Protected Information. DATA SHARING PARTNER must not use unencrypted email to send any Protected Information to anyone, including STATE.

C. Portable Media and Devices. The parties agree to encrypt Protected Information written to or stored on portable electronic media or computing devices in a manner that complies with NIST SP 800-111, “Guide to Storage Encryption Technologies for End User Devices.”

2.4 IHP Permitted Uses and Responsibilities.

A. Management and Administration. Except as otherwise limited in the Contract or this Appendix, IHP may:

1. Use Protected Health Information for the proper management and administration of IHP or to carry out the legal responsibilities of IHP.

2. Disclose Protected Health Information for the proper management and administration of IHP, provided that:

    a. The Disclosure is required by law; or

    b. The Disclosure is required to perform the services provided to or on behalf of STATE or the Disclosure is otherwise authorized by STATE, and IHP:

        i. Obtains reasonable assurances from the entity to whom the Protected Health Information will be Disclosed that the Protected Health Information will remain confidential and Used or further Disclosed only as required by law or for the purposes for which it was Disclosed to the entity; and

        ii. Requires the entity to whom Protected Health Information is Disclosed to notify IHP of any instances of which it is aware in which the confidentiality of Protected Health Information has been Breached or otherwise compromised.

B. Notice of Privacy Practices. If IHP’s duties and responsibilities require it, on

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behalf of STATE, to obtain individually identifiable health information from Individual(s), then IHP shall, before obtaining the information, confer with STATE to ensure that any required Notice of Privacy Practices includes the appropriate terms and provisions.

C. De-identify Protected Health Information. IHP may use Protected Health Information to create de-identified Protected Health Information provided that IHP complies with the de-identification methods specified in 45 C.F.R. § 164.514, “Other Requirements Relating to Uses and Disclosures of Protected Health Information” and provided that IHP does not maintain or disclose any code or other means of record identification that would allow de-identified information to be re-identified.

D. Aggregate Protected Health Information. IHP may use Protected Health Information to perform data aggregation services for STATE, and any such aggregated data remains the sole property of STATE. The IHP must have the written approval of STATE prior to using Protected Health Information to perform data analysis or aggregation for parties other than STATE.

2.5 STATE Data Responsibilities

A. STATE shall Disclose Protected Information to IHP only as authorized by law to IHP.

B. STATE shall obtain any consents or authorizations that may be necessary for it to Disclose Protected Information with IHP.

C. STATE shall notify IHP of any limitations that apply to STATE’s Use and Disclosure of Protected Information—including any restrictions on certain Disclosures of Protected Health Information requested under 45 C.F.R. § 164.522, “Rights to Request Privacy Protection for Protected Health Information,” subpart (a), to which STATE has agreed and that would also limit the Use or Disclosure of Protected Information by IHP.

D. STATE shall refrain from requesting IHP to Use or Disclose Protected Information in a manner that would violate applicable law or would be impermissible if the Use or Disclosure were performed by STATE.

2.6 Obligations of IHP Upon Expiration or Cancellation of the Contract. Upon expiration or termination of the Contract for any reason:

A. In compliance with the procedures found in the Applicable Safeguards listed in subsection 2.1.A, or as otherwise required by applicable industry standards, or directed by STATE, IHP shall immediately destroy or sanitize (permanently de-identify without the possibility of re-identification) or return in a secure manner to STATE all Protected Information that it still maintains.

B. IHP shall ensure and document that the same action is taken for all Protected Information shared by STATE that may be in the possession of its Agents. Whenever feasible, IHP and its Agents shall not retain copies of any Protected Information.

C. In the event that IHP determines that returning or destroying the Protected Information is not feasible or would interfere with its ability to carry out its legal responsibilities,

SAMPLE

maintain appropriate safeguards, and/or comply with Subpart C of 45 C.F.R. Part 164, it shall notify STATE of the specific laws, rules, policies, or other circumstances that make return or destruction not feasible or otherwise inadvisable. Upon mutual agreement of the Parties that return, or destruction of Protected Information is not feasible or otherwise inadvisable, IHP will continue to extend the protections of the Contract and this Appendix to the Protected Information and take all reasonable measures to limit further Uses and Disclosures of the Protected Information for so long as it is maintained by IHP or its Agents.

D. IHP shall document and verify in a written report to STATE the disposition of Protected Information. The report shall include at a minimum the following information:

1. A description of all Protected Information that has been sanitized or destroyed, whether performed internally or by a service provider;

2. The method by which, and the date when, the Protected Data were destroyed, sanitized, or securely returned to STATE; and

3. The identity of organization name (if different than IHP), and name, address, and phone number, and signature of Individual, that performed the activities required by this Section.

E. Documentation required by this Section shall be made available upon demand by STATE.

F. Any costs incurred by IHP in fulfilling its obligations under this Section will be the sole responsibility of IHP.

3. INSURANCE REQUIREMENTS

3.1 Network Security and Privacy Liability Insurance. IHP shall, at all times during the term of the Contract, keep in force a network security and privacy liability insurance policy. The coverage may be endorsed on another form of liability coverage or written on a standalone policy.

IHP shall maintain insurance to cover claims which may arise from failure of IHP's security or privacy practices resulting in, but not limited to, computer attacks, unauthorized access, Disclosure of not public data including but not limited to confidential or private information or Protected Health Information, transmission of a computer virus, or denial of service. IHP is required to carry the following **minimum** limits:

$2,000,000 per occurrence
$2,000,000 annual aggregate

4. INTERPRETATION

4.1 Any ambiguity in this Agreement shall be interpreted to permit compliance with all Applicable Safeguards.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK.

Signature page follows.

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IN WITNESS WHEREOF, the Parties hereto have executed this Contract. This Contract is hereby accepted and considered binding in accordance with the terms outlined in the preceding statements.

STATE OF MINNESOTA **DEPARTMENT OF HUMAN SERVICES**	**<IHP NAME>**
	(Two corporate officers must execute)
By:	By:
Name: Julie Marquardt	Print Name:
Title: Acting Acting Assistant Commissioner, State Medicaid Director	Title:
Date:	Date:
	and
	By:
	Print Name:
	Title:
	Date:
Contract #: <Insert Number>	

SAMPLE