

Minnesota Department of Human Services Managed Care Contracting and Rates Division

Request for Proposals for a Provider to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through Track 1 or Track 2 of the Integrated Health Partnerships (IHP) Program

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1. INTRODUCTION

1.1 Objective of RFP

The Minnesota Department of Human Services, through its Health Care Administration (STATE or DHS), is seeking Proposals from qualified Responders to perform the tasks and services set forth in this Request for Proposal. The term of any resulting contract is anticipated to be for four (4) years, from January 1, 2027, until December 31, 2030. STATE may extend the contract one additional year, for a total contract length of up to five (5) years.

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

The IHP Program allows provider organizations to voluntarily contract with DHS under a payment model that holds these organizations accountable for the total cost of care and the quality and efficiency of services provided to this population while providing high-quality coordinated care for Minnesota Health Care Programs (MHCP) recipients in both fee-for-service (FFS) and managed care. Within this structure, DHS seeks to expand the IHP Program and incentivizes the inclusion and integration of substance use and mental health services, safety net providers, social service agencies, and community-based organizations. The IHP Program includes incentives for improving quality of care, reducing health disparities, addressing health-related social needs, and targeted savings.

1.2 Proposal due date

Letters of Intent must be submitted electronically by 11:59 p.m. Central Time on Friday, July 31, 2026.

Letters must be submitted on letterhead via email to Jackie Sias, Manager of Care Deliver and Payment Reform, at Jackie.Sias@state.mn.us, cc IHP.Admin.DHS@state.mn.us. The Letter of Intent does not obligate the STATE to enter into negotiations with the Responder and does not serve as a substitute for the proposal. The Letter of Intent does not obligate the Responder to complete the proposal process. Responders that do not electronically submit a Letter of Intent by 11:59 p.m. Central Time on Friday, July 31, 2026, will not be considered for the IHP Program in 2027. A template for submission can be found in Appendix A1: Letter of Intent Template. **Faxed, mailed, or hand delivered Letters of Intent will not be accepted.**

Proposals must be electronically submitted by 11:59 p.m. Central Time on Wednesday, August 26, 2026. This Request for Proposal (RFP) does not obligate the STATE to award a contract or complete the project, and the STATE reserves the right to cancel the solicitation if it is considered to be in its best interest. All costs incurred in responding to this RFP will be borne by Responder. Details of proposal submission can be found in Section 4: RFP Process, Section 4.6: Proposal Submission, and Appendix A: Integrated Health Partnerships Application Template.

1.3 Background

The IHP Program, authorized by Minnesota Statute §256B.0755, has allowed DHS to engage in alternative payment arrangements directly with provider organizations that serve an attributed population, which may include an agreed-upon total cost of care and risk/gain sharing payment arrangement. Quality of care for different populations, patient experience, and disparities in care are measured and incorporated into the IHP payment models alongside cost of care. DHS is interested in advancing this accountable care model to continue to incentivize improved quality of and reduced costs of care provided to members of state's public healthcare programs, such as Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare.

The IHP Program was designed to reduce the Total Cost of Care (TCOC) for Medicaid members while maintaining or improving the quality of care. The first IHP RFP was issued in late 2011 following input from many providers, managed care organizations, consumers, community organizations, and professional associations. Trailblazing IHPs signed contracts for their first performance year starting in 2013, and new participants have been added in subsequent years. Beginning in 2018, the program expanded to include an increased focus on addressing health-related social needs, supporting community partnerships, and closing health disparity gaps within Minnesota's communities.

Combined, Minnesota's twenty-five (25) IHPs provide care to over 470,500 Minnesotans enrolled in MHCPs and have achieved an estimated savings of more than \$580 million. A portion of these savings are used by participating provider organizations to achieve the "Triple Aim" of health care (reduce the cost of care, improve health outcomes, and improve patient experience), through strategies such as expanding use of care coordinators, extending available hours for primary care clinics, and developing partnerships with community supports that impact the health of members. Additional background on the current IHP Program can be viewed at [DHS's IHP webpage \(link\)](#).¹

Some aspects of the IHP Program may be pending approval from federal authorities, which includes but is not limited to the State Plan Amendment (SPA).

¹ http://www.dhs.state.mn.us/dhs16_161441

2. SCOPE OF WORK

2.1 Scope of Work

The purpose of the IHP Program is to provide opportunities for providers and other organizations to develop innovative forms of care delivery through payment arrangements that reduce the cost of care, improve health outcomes, reduce health disparities, address health-related social needs, and improve overall patient experience. The contract agreements will be for a four-year contract cycle, with annual performance periods and will be conducted statewide and not limited to providers or MHCP beneficiaries in a specified geographic area. This RFP details application requirements and provides information about how a potential IHP can meet the objectives of the program.

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

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

2.2 Overview

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

2.3 Tasks and Deliverables

The goal of the IHP Program is to allow primary care providers to participate in value-based payment arrangements, support innovations that address health-related social needs and health disparities, and to continue to work towards achieving the Triple Aim of health care for patients in the State of Minnesota.

Core Principles of the program are:

- Recognition that “value-based” payment arrangements for health care consists of cost, utilization, and quality components.
- Emphasis on quality and quality improvement to close gaps in care and ensure equitable care for MHCP enrollees.
- Promoting IHP sustainability and innovation through population-based payments paid on a quarterly basis for IHP-attributed patients which encourages IHP responsibility for patient care coordination, quality of care provided, and Total Cost of Care.
- Addressing non-medical health-related factors by incentivizing community partnerships between medical and non-medical providers; both recognizing the additional risk and

investment required to establish and incorporate non-medical community partnerships into the health system, and rewarding non-medical providers appropriately for contributions to patient and population health.

- Commitment to the identification and elimination of health disparities faced by people enrolled in MHCP programs, whether based on race, ethnicity, sexual orientation, geography, age, sex, gender, disability status, socio-economic background, or other factors.
- Claims-based attribution with an emphasis on primary care, but is also flexible and considers services provided and coordinated by the IHP.
- Actuarially sound benchmarks, cost estimations, and payment mechanisms, for the benefit of the payer as well as the provider participating in the value-based payment arrangement.
- Ability to act upon, share, and strengthen health care data and technology in a timely and accurate way.
- Alignment with other federal, national, and state-based value-based payment arrangements and/or existing initiatives, to the extent possible.

3. PROPOSAL REQUIREMENTS

3.1 Overview

Proposals must conform to all instructions, conditions, and requirements included in this RFP. Responders are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the Proposal is at the Responder’s risk and may, at the discretion of the STATE, result in disqualification of the Proposal for non-responsiveness. Acceptable Proposals must offer all services identified in Section 2, “Scope of Work,” agree to the contract conditions specified throughout the RFP, and include all items referenced in the Required Statements and Applicable Forms sections. Responder must also agree to the terms and conditions in the attached sample contract unless specifically making an exception pursuant to Required Statement “Exception to Sample Contract and RFP Terms.”

3.2 Proposal Contents

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

Proposal Components	RFP Section
1. Table of Contents	3.3 (1)
2. Application	3.3 (2)
3. Application Supplementary Materials	3.3 (3)
a. Provider Roster	
b. Organization Chart with Tax Identification Numbers (TINs)	
c. Sample Agreement with IHP Participants	
d. List of Participating Clinics	
e. Equity Measures	
f. Promoting Interoperability	
g. Other Application Requirements, As Necessary	
4. Required Statements and Forms	3.4
a. Appendix K: Responder Information and Declarations	
b. Appendix L: Exceptions to Sample Contract and RFP Terms	
c. Appendix M: Disclosure of Funding Form	
d. Appendix N: Documentation to Establish Financial Stability	

3.3 Proposal Components Detail

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

- 1. Table of Contents:** List each section and the accompanying page number.

2. Application: This component of the proposal should demonstrate the Responder’s understanding of the applicant IHP’s eligibility to participate in the IHP Program, eligibility for Track 1 or Track 2 organizational structure, experiences and familiarity with value-based payments and risk-sharing arrangements, clinical care model, quality measurement, population health, health disparities, health-related social needs (HRSNs), and community partnerships. The required questions and information can be found in Appendix A: Integrated Health Partnerships (IHP) Program Application Template.

3. Application Supplementary Materials:	RFP Section
a. Provider Roster	(Appendix A3)
b. Organizational Chart with TINs	(Appendix A)
c. Sample Agreement with IHP Participants	(Appendix A)
d. List of Participating Clinics	(Appendix A)
e. Equity Measures	(Appendix E)
f. Other Application Requirements, As Necessary	(3.4 (e))

3.4 Required Statements and Forms

Complete the correlating forms found in **Appendix K, L, M, and N** and submit the completed forms in the “Required Statements and Forms” section of your Proposal.

a. Responder Information and Declarations (Appendix K): Complete the “Responder Information and Declarations” form available in Appendix K and submit it with the Proposal. If you are required to submit additional information as a result of the declarations, include the additional information as part of this form. Responder may fail the Required Statements Review in the event that Responder does not affirmatively warrant to any of the warranties in the Responder Information and Declarations. Additionally, STATE reserves the right to fail a Responder in the event the Responder does not make a necessary disclosure in the Responder Information and Declarations or makes a disclosure which evidences a conflict of interest.

b. Exceptions to Sample Contract and RFP Terms (Appendix L): The contents of this RFP and the Proposal(s) of the successful Responder(s) may become part of the final contract if a contract is awarded. A Responder who objects to any condition of this RFP or STATE’s sample contract terms and conditions (attached as **Appendix G: Sample Integrated Health Contract**) must note the objection(s) on the “Exceptions to Sample Contract and RFP Terms and Conditions” form available in Appendix L and submit it with its Proposal. Much of the language reflected in the sample contract is required by statute. **It is crucial that Responders review ALL sections, including boilerplate language, of the Sample Contract PRIOR to application submission and note any exceptions on the “Exceptions to Sample Contract and RFP Terms and Conditions” form. The State may limit negotiations or discussions to only those exceptions indicated in your response to the RFP.**

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

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

c. Disclosure of Funding Form (Appendix M):

(Applies if federal money will be used or may potentially be used to pay for all or part of the work under the contract). In order to comply with federal law, Responder is required to fill out the “Disclosure of Funding” form available in Appendix M and submit it with its Proposal. The form requires a Responder to provide its Unique Entity Identifier (UEI) to uniquely identify business entities. If a Responder does not already have a UEI, it may be obtained from SAM.gov.

d. Documentation to Establish Financial Stability (Appendix N):

For this RFP, a pre-award risk assessment is required for contract awards of \$50,000 or more.

All Providers applying for awards in the state of Minnesota must undergo a financial and capacity review prior to an award of \$50,000 and higher.

The information collected under this section will be used in STATE’s determination of the award of the contract. Responder must complete the “Documentation to Establish Financial Stability” form (Appendix N) and submit the form with its Proposal. STATE will request the applicable documentation upon its determination that Responder is a finalist in the solicitation process.

e. Optional – Additional Materials:

Responder may include any additional information thought to be relevant as a separate document and entitle it Appendix I.

4. RFP PROCESS

4.1 Timeline

This timeline outlines the tentative RFP process for the 2026 IHP Contract:

Activity	Date
Potential Responders to contact DHS to schedule Q&A session due date	July 1, 2026
Individual 30 Minute Meetings (Optional)	June 15th - July 10th, 2026
All RFP Questions Received	July 17, 2026
RFP Questions Answered and Posted on DHS Open RFPs Website	Anticipated - July 30, 2026
Letter of Intent Due	July 31, 2026
Proposal Responses Due	August 26, 2026
Notice of Intent to Contract	Anticipated - October 9, 2026

4.2 Communications

DHS may release periodic updates on the RFP as necessary. Updates and communications will occur on the IHP website at <http://www.dhs.state.mn.us/IHP>.

4.3 Responders' Questions

Responders' questions regarding this RFP must be submitted in writing via email to Jackie Sias at Jackie.Sias@state.mn.us, cc: IHP.Admin.DHS@state.mn.us prior to 11.59 p.m. Central Time on July 17, 2026.

Other personnel are NOT authorized to discuss this RFP with Responders before the Proposal submission deadline. **Contact regarding this RFP with any STATE personnel not listed above could result in disqualification.** STATE will not be held responsible for oral responses to Responders.

Questions will be addressed in writing and distributed to all identified prospective Responders. Every attempt will be made to provide answers timely, anticipated no later than July 30, 2026.

4.4 Optional Individual Questions and Answer Sessions

All potential Responders may request one optional 30-minute Question and Answer (Q&A) session from June 15th - July 10th, 2026, via conference call. The optional Q&A sessions will serve as an opportunity for Responders to ask specific questions of State staff concerning the project. A Q&A session is not mandatory. DHS staff will record all questions and answers provided in the individual sessions and post them to the DHS website. To schedule a Q&A session for your provider organization, please contact Jackie Sias at Jackie.Sias@state.mn.us, cc: IHP.Admin.DHS@state.mn.us, before or by July 1, 2026. Oral responses provided on the conference call will be non-binding. Written responses to questions asked at

the Q&A session(s) will be sent to all identified known Responders after the conference call(s) have been completed.

4.5 Letter of Intent

Letters of Intent must be submitted electronically by 11:59 p.m. Central Time on July 10, 2026. Letters must be submitted on organizational letterhead via email to Jackie Sias, Manager, Care Delivery and Payment Reform, at Jackie.Sias@state.mn.us, cc IHP.Admin.DHS@state.mn.us. The Letter of Intent does not obligate the STATE to enter into negotiations with the Responder, and does not serve as a substitute for the proposal. The Letter of Intent does not obligate the applicant to complete the proposal process. Responders that do not electronically submit a Letter of Intent by July 10, 2026 will not be considered for participation in the IHP Program in 2027. **Faxed, mailed, or hand delivered Letters of Intent will not be accepted.** A template for submission can be found in Appendix A1: Letter of Intent Template.

4.6 Proposal Submission

The Proposal must be submitted electronically by 11:59 p.m. Central Time on August 26, 2026 to be considered. Late Proposals will not be considered and will not be opened. **Faxed, mailed, or hand delivered Proposals will not be accepted.**

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

Proposals must be submitted in 12-point font, on letter size pages (8½" X 11"), and single spaced. The main body of the proposal page numbers must flow continuously in numeric order. Each of the sections must be clearly identified with its own heading. The size and/or style of graphics, tabs, attachments, margin notes, highlights, etc. are not restricted by this RFP and their use and style are at the Responder's discretion.

The proposal and all correspondence related to this RFP must be delivered via email to Jackie Sias at Jackie.Sias@state.mn.us. Please also cc: IHP.Admin.DHS@state.mn.us on your correspondence.

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

5. RESPONDER ELIGIBILITY AND PARTICIPATION REQUIREMENTS

5.1 System Requirements

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

1. Must provide or coordinate the full scope of health care services, as evidenced by provision of coordinated care, and/or prior/current participation in an outcomes-based contract with Centers for Medicare and Medicaid Services (CMS) or Medicaid. Accepted forms of evidence of provision of coordinated care include but are not limited to:
 - a. Health Care Home (HCH) Certification for the majority of clinics planning to participate in the Respondent's proposed IHP
 - b. National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Recognition
 - c. Additional evidence or documentation of ability to provide or coordinate full scope of health care services. See Appendix B1: Example IHP Health System Characteristics.
2. All health care providers included in the IHP Program must be enrolled MHCP providers.
3. Demonstrate, through the care delivery model, how the IHP will affect the total cost and quality of care of its MHCP beneficiaries regardless of whether the services are delivered by the IHP. MHCP beneficiaries included in the program are non-dually eligible Medical Assistance (MA) and MinnesotaCare enrollees attributed to the IHP for the performance period. See Appendix B2: Eligible and Excluded Populations.
4. If the Respondent is interested in participating in Track 1 (non-risk bearing), they must demonstrate why they are unable to take on financial risk for the total cost of care of attributed MHCP beneficiaries. If the Respondent is interested in participating in Track 2 (upside and downside risk), they must demonstrate the ability to take on financial risk for the total cost of care of attributed MHCP beneficiaries. IHPs will enter into variable payment arrangements (one of two IHP Tracks) with the State based on the assessed level of ability to take on financial risk. The State will evaluate applicants' ability to take on financial risk by looking at a nexus of variables and thresholds which capture this, including but not limited to:
 - a. Attributed population size,
 - b. The risk and cost variability of the attributed population,
 - c. The catastrophic claims cap (i.e., maximum amount of a patient's total cost of care that will be included in the IHP's total cost of care calculation) necessary to reach a stable total cost of care estimate,
 - d. The percent of claim costs paid inside the applicant's system,

- e. The organizational structure and geographic spread of the applicant’s system,
 - f. The electronic medical record (EMR) and health information exchange (HIE) environment,
 - g. Historical participation and/or progress in previous Integrated Health Partnership contracts, and
 - h. Other factors as deemed necessary by the State.
5. Demonstrate established processes to monitor and ensure the quality of care provided. Participate in quality measurement activities as required by the State and engage in quality improvement activities.
 6. Demonstrate the capacity to receive data from DHS via secure electronic processes and use it to identify opportunities for patient engagement and to stratify its population to determine the care model strategies needed to improve outcomes.
 7. Demonstrate and/or describe efforts related to addressing health--related social needs and the particular risk factors present in the applicant’s Medicaid patient population.
 8. Demonstrate and/or describe efforts related to identifying and addressing health disparities present in the Respondent’s Medicaid patient population, whether based on race, ethnicity, sexual orientation, geography, age, sex, gender, disability status, socio-economic background, or other factors.

5.2 Legal Entity, Governance Structure, Leadership

An IHP is made up of a network of providers, and may include an organizing entity and agreement of shared governance. This may include, but is not limited to, a non-profit, a county or group of counties, and other group types. The IHP, as a network of provider and organizational participants, must meet or demonstrate the ability to meet the requirements in Section 5.1., System Requirements, above. All IHP payments must be provided to and/or received from an MHCP enrolled provider. The IHP organizing entity must obtain agreement from all participating providers, clinics, and/or health systems in the IHP Program prior to execution of the IHP contract, and before the beginning of the contract period on January 1, 2027.

5.3 Health-Related Social Needs (HRSNs) and Community Engagement

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

It is important that IHPs are thoughtful about the context that creates and affects the health of individuals as well as communities, which is also known as health-related social needs. DHS recognizes that health systems may not be the best equipped to fully address the factors that affect health,

healthcare costs, and patient experience. However, the IHP Program is an opportunity for Responders and participants to innovate and advance efforts such as community partnerships, screening, referral, and care coordination for social needs, and other strategies.

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

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

Responders should describe how local providers, counties, organizations, county-based purchasing plans, and other relevant purchasers were consulted in developing the application to participate in the IHP Program. The Population Health Demonstration, documented in Appendix E: Population Health Demonstration Template, must include the target population, proposed solution, detailed intervention, historical background and other relevant context, and proposed measures.

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

*** Existing IHPs wishing to continue in the IHP Program:** Responders who participated in the IHP Program in performance year 2026 may propose to continue the intervention included in that contract, previously known as the equity intervention, in response to this RFP. However, these responders must either include a significant change to the intervention or have an intervention that is extremely comprehensive in its scope. These requirements are outlined in detail in Appendix E: Population Health Demonstration Template.

5.4 Promoting Health and Wellness Activities – Child and Teen Check-ups (C&TC)

Child and Teen Check-ups (C&TC) is the name for Minnesota's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Child & Teen Check-ups are covered services for children from birth through twenty (20) years who are enrolled in Medical Assistance (MA). For more information please visit: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/ctc.jsp>

IHPs are expected to conduct outreach for C&TC services for eligible members who are attributed to the IHP. The goal of the C&TC outreach and engagement work is to increase the number of children with completed C&TC visits. In exchange, IHPs will receive a \$1 per member per month (PMPM) payment for

each eligible attributed member, paid quarterly. This C&TC outreach-related PMPM payment is in addition to, and separate from, the IHP's population-based payment (PBP) or settlement payments noted in Section 6.4 of the RFP, and will not be considered part of an IHP's total cost of care (TCOC) calculation for settlement purposes. To fulfill this C&TC outreach requirement, applicants must be able to effectively ensure, provide, and document outreach activities for attributed enrollees in regard to C&TC services. C&TC outreach includes:

- Encouraging enrollees to complete timely well-child visits in accordance with the C&TC periodicity schedule.
- Having mechanisms in place to ensure referrals are followed up on in a proper and timely manner to ensure successful outcomes for C&TC utilization.
- Having outreach methods in place for contacting enrollees who do not complete their C&TC visits.
- Having systems in place to track individual level outreach efforts and responses, where applicable.

Applicants may seek an exemption from this responsibility due to the demographics of their patient population or the nature of their provider organization. For example, if only a small portion of the Applicant's patient population is under the age of 21, they may seek an exemption from this responsibility. Applicants seeking such an exemption must include sufficient detail within their Application for DHS staff to evaluate if such an exemption is appropriate (see Appendix A – RFP Application, Section V).

6. MODEL DESIGN ELEMENTS

6.1 Overview of Model

The IHP Program provides the option for organizations to participate as either a Track 1 or Track 2 IHP. All IHPs that meet the requirements and are accepted into the IHP Program, as evidenced by an executed IHP contract, will be eligible for a quarterly population-based payment (PBP) for the purposes of care coordination. Track 2 IHPs will also be eligible to receive a portion of shared-savings or required to pay the State a portion of the shared-losses as a result of yearly performance against a Total Cost of Care target (described in Section 6.3). An overview of the two tracks and the expected provider types that will participate in each model can be found in Tables 1 and 2 below.

STATE reserves the right, upon mutual agreement with Responder, to adjust final contract from Track 1 to Track 2 or vice versa and allow Responder to transition between risk tracks upon contract amendment. Please note, this is not a common occurrence.

Table 1: Summary of IHP Model Differences by Track

Track Type	Model Aspect	Expected Provider Types
Track 1	<ul style="list-style-type: none"> IHP entity will receive a quarterly risk-adjusted population-based payment (PBP). 	Track 1 IHPs typically have smaller attributed populations and sometimes consist of multiple independent provider organizations that coordinate and/or provide the full scope of care for attributed patients.
Track 2	<ul style="list-style-type: none"> IHP entity will enter into reciprocal risk agreement with shared-savings and shared-losses. IHP entity will receive a quarterly risk-adjusted quarterly PBP. 	Track 2 IHPs typically have larger attributed populations and are health systems or collaborative models with a greater level of integration between participating providers and ability to coordinate and/or provide the full scope of care for attributed patients.

Table 2: IHP Track Selection by Attributed Population Size

Attributed Population Size Guidelines*	Track Type	Important Notes
< 3,000 attributed members	Track 1	
3,000 – 8,000 attributed members	Track 1 or 2	May choose to apply as a Track 1 or Track 2 <ul style="list-style-type: none"> If applicant IHP chooses to opt in to Track 2 – applicant IHP must submit all application requirements for Track 2 consideration. Applicant IHP will need DHS’ approval prior to Track 2 contract execution (will be discussed during contract negotiations). Track 2 application requirements must be submitted at time of RFP proposal submission in order to be considered for Track 2 IHP participation.
≥ 8,000 attributed members	Track 2	Some larger Applicant IHPs with unique organizational and/or operational structure or

Attributed Population Size Guidelines*	Track Type	Important Notes
		certain federally required payment mechanisms, may only be permitted to participate as a Track 1 IHP, with no upside or downside risk. <ul style="list-style-type: none"> • This will be determined at STATE’s sole discretion. • Applicant IHPs with 8,000 or more estimated attributed members must submit all Track 2 application requirements.

* Applicant IHPs should apply based on the best estimate of the organization’s likely attributed population size. If unsure, Applicant IHP should apply as a Track 2.

Additional requirements for participation in the Track 1 and Track 2 IHP Program model can be found in Section 6.4, Payment Models, Mechanisms, Risk, and Section 7, Quality.

6.2 Member Eligibility and Attribution

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

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

Submission instructions can be found in Appendix A: Integrated Health Partnerships Application Template. A list of the eligible and excluded populations for attribution to IHP can be found in Appendix B2: Eligible and Excluded Populations.

STATE may adjust the roster submission type (All-in-Roster vs Billing and Treating Provider Roster) upon contract amendment.

Attribution Methodology

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

Attribution is run on a monthly basis. IHPs are sent monthly reports containing information on their attributed members via both the IHP portal and MN-ITS mailbox.

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

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

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

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

Population-Based Payment (PBP)

As mentioned above, MHCP beneficiaries will be attributed on a monthly basis by DHS to an IHP using retrospective claims data for the purposes of determining the per-member amount and risk adjustment level of quarterly population-based payments (PBPs).

In order to encourage efficient, effective care coordination and to ensure no duplication of billing or services, the PBP will take the place of any current Health Care Home (HCH) or in-reach service coordination (IRSC) payments currently being received by the IHP for an IHP attributed member. The population-based payment (PBP) is expected to contribute to care coordination and other related investments for individuals served by the IHP. As a result, the PBP specifically replaces both Health Care Home (HCH) and In-Reach Care Coordination (in-reach) payments. The PBP-eligible population consists of IHP attributed individuals for whom the IHP is not already receiving Behavioral Health Home (BHH) care coordination payments. To ensure that an IHP doesn't receive redundant payments, DHS reconciles the population-based payments on an annual basis following the close of each performance period.

Base and Performance Period

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

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

6.3 Definition of Total Cost of Care (TCOC)

Services Included in Total Cost of Care

Medicaid covered services included in the Total Cost of Care (TCOC), are shown in the IHP Sample Contract. Some examples of Medicaid covered services excluded from the TCOC are Long Term Care, Foster Care, and IEPs. All of the attributed patients' care, as provided in the total cost of care definition will be attributed to the IHP, regardless of whether the IHP delivered the services.

For a listing of categories of services (COS) included or excluded in TCOC, see Appendix G: Sample Contract Section Appendix 2: Included Services – Category of Service Table.

Calculation of Total Cost of Care: Specifications and Measurements

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

While Track 1 IHPs are not subject to shared losses or shared savings, Total Cost of Care is calculated for Track 1 IHPs in order to provide illustrative performance results. It is important that Track 1 IHPs are also mindful of their TCOC performance results.

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

- 1. Population Size:** Responders that apply to participate as a Track 1 IHP do not have a minimum population size. Responders that apply to participate in Track 2 must meet a minimum population size of at least 3,000 attributed patients. Any applicants with an estimated attributed population of 3,000 – 8,000 are able to participate as either a Track 1 or Track 2 IHP.² Applicants with Medicaid populations of over 8,000 that believe Track 1 participation

² A population of 3,000 or more does not guarantee that an entity will have sufficient population to participate as a Track 2 IHP, depending on the underlying risk, demographics and cost profile of their population. During contract negotiations, the State will run an analysis to determine if the Applicant IHP's patient population is sufficient for

would be more appropriate for their organization are expected to provide a detailed rationale in their response. The STATE will consider Applicant IHP's unique organizational and/or operational structure or certain federally required payment mechanisms, the organization's experience with value-based purchasing agreements and historical performance in that. At the STATE's sole discretion, these organization's may be permitted to participate as a Track 1 IHP, with no upside or downside risk. The prospective number of attributed patients is determined by the roster of providers which is submitted along with the RFP Application (Appendix A: Integrated Health Partnerships Application Template).

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

Shared-Savings Payments: A two percent (2%) minimum performance threshold must be met prior to the distribution of any shared-savings between the State (including its contracted MCOs, as applicable) and the IHP. Specifically, the Performance TCOC must be below 98% of the Adjusted Target TCOC for shared-savings payments to occur.

Shared-Losses Payments: A four percent (4%) minimum performance threshold must be met prior to the distribution of any shared-losses payments between the IHP and the State (including its contracted MCOs, as applicable). Specifically, the Performance TCOC must be above 104% of the Adjusted Target TCOC for shared-losses payments to occur.

Eligibility for Enhanced Threshold for Shared-Losses Payments: IHPs that demonstrate savings above 4% (i.e., < 96% of the IHP's Adjusted Target TCOC) at the end of their previous contract may be eligible for a higher minimum performance threshold for shared-losses payments for the duration of the next contract. The higher minimum performance threshold for shared-losses payments would be set equal to the IHP's percent (%) of Adjusted Target TCOC achieved between 4% and 6%. The higher minimum performance threshold for shared-losses payments is capped at 6%.

Track 2 participation, and will also consider the organization's experience with value-based purchasing agreements and historical performance in that context. If the State determines that Track 2 participation is not appropriate for an Applicant IHP, the Applicant IHP will be considered for participation in the IHP Program under a Track 1 model.

First dollar calculation: Once the performance target is met, shared-savings or shared-losses payments are calculated back to the first dollar (i.e., any amount above or below the TCOC target).

- 4. Shared Savings and Shared Losses Payment Distribution:** IHPs participating in Track 2 will enter into reciprocal upside and downside risk arrangements with DHS, within specific risk corridors. Savings and/or losses incurred will be shared at a rate of 50% by the IHP and 50% by DHS up to 4%, and at rates of 70% of savings and 35% of losses above 4%. Track 2 IHPs with 3,000 – 8,000 attributed members (i.e., “smaller” Track 2 IHPs) can share savings or losses up to 6% of TCOC and Track 2 IHPs with ≥ 8,000 attributed members (i.e., “larger” Track 2 IHPs) can share savings or losses up to 10% of TCOC.

A summary of the above requirements by IHP Track can be found in Tables 3 and 4 below.

Table 3: Total Cost of Care Specifications by IHP Track

IHP Track	Track 1	“Smaller” Track 2	“Larger” Track 2
Attributed Population Size Guidelines	< 3,000 attributed members	3,000 – 8,000 attributed members	≥ 8,000 attributed members
Claims Cap	Maximum of \$100,000	Maximum of \$200,000	Maximum of \$200,000
Shared Savings Model	N/A	Reciprocal upside and downside risk with 50% share of savings in each risk corridor 0-4%, then upside risk of 70% and downside risk of 35%.	Reciprocal upside and downside risk with 50% share of savings in each risk corridor 0-4%, then upside risk of 70% and downside risk of 35%.

Table 4: Risk-Sharing Requirements by IHP Track

% Below (-) / Above (+) Target	% of Adj. Target TCOC	Track 1 IHP / DHS Distribution	“Smaller” Track 2 IHP / DHS Distribution	“Larger” Track 2 IHP / DHS Distribution
> -10%	< 90%	N/A	N/A	N/A
-8% - -10%	90% - 92%	N/A	N/A	70 / 30
-6% - -8%	92% - 94%	N/A	N/A	70 / 30
-4% - -6%	94% - 96%	N/A	70 / 30	70 / 30
-2% - -4%	96% - 98%	N/A	50 / 50	50 / 50
0% - -2%	98% - 100%	N/A	50 / 50	50 / 50
0% - +2%	100% - 102%	N/A	50 / 50	50 / 50
+2% - +4%	102% - 104%	N/A	50 / 50	50 / 50

+4% - +6%	104% - 106%	N/A	35 / 65	35 / 65
+6% - +8%	106% - 108%	N/A	N/A	35 / 65
+8% - +10%	108% - 110%	N/A	N/A	35 / 65
> +10%	> 110%	N/A	N/A	N/A

6.4 Payment Models, Mechanisms, Risk

Payment in Track 1

Population-Based Payment

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

Supplemental Incentive Structure

A shared-savings incentive pool will be calculated for performance periods that yield sufficient savings across the IHP Program overall.³ These payments will be known as the Supplemental Incentive Structure Payment and will be calculated by the State following final settlement results. The initial iteration of the Supplemental Incentive Structure will be allocated based on the relative utilization of primary care by the IHP’s attributed members. The State will establish a formula that assigns a relative value to each primary care visit, which may include consideration of member risk, HRSNs and other IHP-specific factors (e.g., region, size, etc.). IHP eligibility to participate in the Supplemental Incentive Structure will be determined based on criteria that will be determined by STATE, though it is anticipated that most IHPs will be eligible to participate in the Supplemental Incentive Structure. Participation in the Supplemental Incentive Structure does not necessarily mean that an IHP will qualify for a share of the calculated savings. A detailed methodology for the Supplemental Incentive Structure will be shared with IHPs no later than twenty (20) months following the 2027 performance period (i.e., two months after the 2027 final settlement calculation results are completed).

³ The availability of Supplemental Incentive Structure Payments for IHPs is predicated and contingent on savings to the IHP Program overall. If the Program does not yield savings for a particular performance period, there will be no Supplemental Incentive Structure Payments associated with that performance period.

Payment in Track 2

Population-Based Payment

Track 2 IHPs will receive an aggregate monthly PBP, paid quarterly, for their respective attributed population (attribution is as described in Section 6.2 above), which encourages accountability for the total cost of care of attributed patients, resource utilization, and quality of health care services provided. The total amount paid to each IHP will be based on the number of attributed members and an average base rate for each individual attributed to the IHP. The base rate will vary by the medical and social complexity of each IHP's attributed population. Each quarter, the amount of the PBP will be adjusted to reflect changes to the population attributed to the IHP. An IHP's ability to continue participating in the IHP Program and receive the PBP will be contingent on successful implementation of their population health demonstration and their cooperation with and performance on quality measures as described in Section 7 Quality.

The full value of the quarterly PBPs received by the IHP will be included in their relevant performance period Total Cost of Care (TCOC) calculations for shared-savings and/or -losses, as described below in "Shared Risk Model".

Shared-Risk Model

Track 2 IHP performance assessment is based on a comparison of the observed TCOC for each performance period to a "TCOC Target."⁴ The share of the savings or losses under the shared risk model is described in Section 6.3 Definition of Total Cost of Care (TCOC) above. The TCOC Target is based on a base period TCOC (CY2026) after adjusting for expected trend and changes in attributed population size and relative risk from the base period to the performance periods. The target is expressed as a "per member per month" (PMPM) value.

The Base Period Attributed Population will be determined for each IHP using 2026 claims, MCO encounter data, and the attribution process as described in this RFP. Using this attributed population, the Base Period Total Cost of Care (Base TCOC) will be developed using a consistent set of Medicaid covered services, and as described in the IHP Contract. Claims for an individual member that fall outside of pre-determined thresholds will be capped to adjust the PMPM results to exclude "catastrophic cases" and better reflect the IHP's target population. In addition, the Base Period Risk Score will be assessed for the assigned members, using the Johns Hopkins ACG[®] risk adjustment tool to determine the relative risk of the base population.

For each performance period, DHS will develop an Expected Trend rate for the total cost of care based on the trend rates used to develop the annual expected cost increases for the aggregate MHCP population, with appropriate adjustments for services excluded from the Base TCOC or other factors

⁴ For purposes of contracts beginning in 2027, the performance periods are defined as calendar Year (CY) 2027, 2028, 2029, and 2030.

that are applicable to the total cost of care and goals of the program. An initial TCOC Target for the upcoming performance period will be established using the Base TCOC and Expected Trend. The target will ultimately be adjusted to reflect the relative risk of the actual population attributed to the IHP in the performance period.

At the end of each performance period, DHS will determine the Performance Period Attributed Population using retrospective claims data and the attribution process as described in this RFP. The Performance Period Total Cost of Care (Performance TCOC) will be calculated, based on the claims incurred by the attributed population during the performance period and the PBP received by the IHP. The TCOC will reflect adjustments for any claims for an individual member that fall outside of pre-determined catastrophic case thresholds. The risk score for the measurement period's attributed population will be used to calculate the change in relative risk from the base period to the performance period. Using the change in relative risk, the Target TCOC will be adjusted based on the increase or decrease in the risk of the attributed populations. The Adjusted Target TCOC will be compared to the Performance TCOC for purposes of determining the performance results and the basis for the calculation of shared savings and losses.

An example calculation of how the total cost of care target is calculated, the resulting shared savings and/or losses, and how the PBP may be calculated and/or included at the end of the year can be found in Appendix D, Payment Mechanism Methodology.

Accountable Care Partnership Arrangements

Track 2 IHPs must formally partner with community partner(s). Formal partnerships will include an ongoing and legally established relationship to provide services to address a population health goal within the Population Health Demonstration. The IHP's ACP arrangement must be a part of the IHP's Population Health Demonstration (see Appendix E: Population Health Demonstration Template). Examples of areas in which IHPs can pursue community partnerships include but are not limited to: housing, food security, social services, education, and transportation. The IHP will need to describe the relationship with the ACP and provide documentation on a formal legal agreement which describes the purpose of the arrangement, the terms of the relationship including the ACP and IHP roles and responsibilities, and what support will be provided by the ACP and the IHP to accomplish the goals of the ACP.

Accountable Care Partnerships will be monitored by DHS through at least yearly check-ins and reporting through the Population Health Report (see Appendix H).

Supplemental Incentive Structure

A shared-savings incentive pool will be calculated for performance periods that yield sufficient savings across the IHP Program overall.⁵ These payments will be known as the Supplemental Incentive Structure Payment and will be calculated by the State following final settlement results. The initial iteration of the Supplemental Incentive Structure will be allocated based on the relative utilization of primary care by the IHP's attributed members. The State will establish a formula that assigns a relative value to each primary care visit, which may include consideration of member risk, HRSNs and other IHP-specific factors (e.g., region, size, etc.). IHP eligibility to participate in the Supplemental Incentive Structure will be determined based on criteria that will be determined by STATE, though it is anticipated that most IHPs will be eligible to participate in the Supplemental Incentive Structure. Participation in the Supplemental Incentive Structure does not necessarily mean that an IHP will qualify for a share of the calculated savings. A detailed methodology for the Supplemental Incentive Structure will be shared with IHPs no later than twenty (20) months following the 2027 performance period (i.e., two months after the 2027 final settlement calculation results are completed).

6.5 Interaction with Managed Care Organizations (MCOs)

The IHP program will be implemented consistently at the delivery system level and for MHCP beneficiaries currently enrolled in both fee-for-service and managed care. DHS will implement and execute the IHP payment model, quality measures, patient attribution and methodology for both MHCP enrollees in fee-for-service and in MCOs under contract with the State to provide services to non-dually eligible Medical Assistance and MinnesotaCare enrollees. The MCOs will participate as a payer in the IHP payment process via their contract requirement with the State.

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

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

⁵ The availability of Supplemental Incentive Structure Payments for IHPs is predicated and contingent on savings to the IHP Program overall. If the Program does not yield savings for a particular performance period, there will be no Supplemental Incentive Structure Payments associated with that performance period.

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

6.6 Significant Changes in the Health Care Environment

Several instances of disruption to the health care environment have occurred over the course of the IHP Program's history, with varying degrees of impact. Some examples include but are not limited to the exit of a contracted MCO and redetermination following the end of the COVID-19 Public Health Emergency (PHE). The IHP Program's performance measurement process integrates both standard and customized adjustments for measuring changes to risk and cost expectations in the midst of those changes.

The performance measurement process includes adjustments for average member risk from period to period. The Johns Hopkins ACG risk adjustment model determines the relative risk of each attributed member for each performance period. When an IHP's performance is calculated, the targets are adjusted to reflect the observed annual increases and decreases in the average risk of each IHP's attributed population. If healthier members leave an IHP's attributed population, for example, the IHP's average risk and target would be expected to increase to reflect the reduced proportion of lower-risk enrollees. The risk-weights are based on actual program experience and vary by program (e.g., PMAP vs SNBC) to reflect the differential relative costs of the populations and capture changes in both risk and program enrollment.

The annual performance measurement process does not solely rely on risk adjustment to modify the IHP targets. Each year, the trend projections integrate the anticipated or observed impact of program changes, additional benefits, and/or emerging experience. These adjustments are intended to capture both prospective and retrospective cost changes (i.e., changes that are both anticipated and those that are observed changes occurring during the performance year. In cases where program expenses are higher or lower than the trend and risk-adjusted cost expectations, we have also developed supplemental trend adjustments to reflect the observed impact of broader environmental factors.

H.R. 1 Implementation

The federal budget reconciliation bill, H.R. 1, was signed into law on July 4, 2025. This law enacts major changes to Medicaid, including but not limited to work requirements, 6-month renewals, cost sharing requirements, changes to retroactive coverage, changes to federal funding, etc. The implementation of H.R. 1 may have an impact on the attributed populations for the IHPs. Currently, it is difficult to anticipate the changes in the population risk characteristics and costs resulting from the implementation of H.R. 1. However, the IHP performance measurement process integrates both risk and trend adjustments that are intended to reflect year-to-year changes in the attributed population for each IHP, general and benefit-specific changes to unit costs and utilization, and, where appropriate, broader environmental changes.

Although many of the adjustments for the impact of H.R. 1 will need to be calculated retrospectively to allow the full impact to be reflected in the data, DHS will monitor changes in the IHPs' attributed populations and anticipate potential performance changes. DHS remains committed to continuing the

operation of an equitable, conscientious, and data-driven performance measurement process that mitigates for the risk of unanticipated environmental changes that may impact IHP performance measurement results.

7. QUALITY

7.1 Overview

A core principle of the IHP model is that payment for health care is tied to the quality of the care provided. As explained in Section 6.2. of the RFP, Track 1 IHPs are eligible to receive the population-based payment (PBP), and Track 2 IHPs are eligible to receive both the PBP and potential shared savings through a shared risk model. The population-based payment is tied to various quality, population health, and utilization metrics. IHPs will be evaluated on quality, population health, and utilization measures to determine eligibility to continue participation in the IHP Program after the conclusion of each contract cycle.

Table 5: The Impact of quality on payment in the 2023 IHP model

Offered Payment Options	Quality Impact
Population-Based Payment	IHP will be evaluated on quality, population health, and utilization measures to determine eligibility to continue participation after the conclusion of each contract cycle.
Shared Risk Model	Quality results affect the IHP portion of shared savings amount and reduce the IHP portion of shared losses.

7.2 Quality and the Population-Based Payment

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

During contract discussions, the IHP's likely attributed population will be examined to determine its predominant health disparities using DHS data as well as information provided by the IHP. The IHP will be required to propose a population health intervention and evaluation measures tied to this intervention that are intended to incorporate services that are outside the scope of normal clinical care to help improve the health of the patient population. IHPs are required to propose an intervention, based on their knowledge of the health disparities and/or health-related social needs impacting their patient population. This proposal may be modified or refined during contract negotiations, based on data available and technical assistance from DHS. A template to propose an intervention is included in Appendix E: Population Health Demonstration Template.

The IHP will be annually evaluated across a set of agreed upon measures, including clinical, utilization, and population health domains. A lack of improvement or insufficient quality performance could result in modifications or discontinuation of the population-based payment after the conclusion of an IHP's contract cycle, or intervention by DHS staff during the contract cycle, which could include a corrective action plan or termination. The population health demonstration is assessed, in part, through a Population Health Report (see Appendix H) submitted by the IHP. Additionally, clinical and utilization

measures are selected, in collaboration with the IHP, based on the goals of the population health demonstration. Consequently, the evaluation of the intervention is based on both qualitative and quantitative metrics. The clinical and utilization measures are typically calculated or obtained by DHS for the purposes of the contract.

7.3 Quality and the Shared Risk Model

In Track 2, fifty percent (50%) of an IHP's shared savings and shared losses will be contingent on overall quality measurement results. For quality measurement purposes, DHS will utilize a total cost of care quality set, aligning with statewide and Medicaid measures. In certain circumstances, an IHP may propose additional or alternate measures, as detailed below in the Alternate Measures section. The core set of quality measures and the methodology used to calculate the overall total cost of care quality score are described below.

Total Cost of Care (TCOC) Quality Measures

The total cost of care (TCOC) set of quality measures is used for calculation of the overall total cost of care quality score, which affects an IHP's potential shared savings, and shared losses. The TCOC quality measures are organized into five domains, as listed in Table 6 below, which identify critical areas for focus and improvement: 1) quality core set, 2) care for children and adolescents, 3) quality improvement, 4) closing gaps, and 5) an equitable care measure. The intent behind each domain is discussed below. Examples of the measures in each domain are listed in Appendix F2, Quality Measures.

- The **quality core set domain** includes key measures selected from the Minnesota Department of Health (MDH) Statewide Quality Reporting and Measurement System (SQRMS), the Adult and Child Medicaid Core Measures Sets, the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA), and Patient Quality Indicators (PQI) developed by the Agency for Healthcare Quality and Research (AHRQ), as well as patient experience of care measures from AHRQ and CMS. This domain focuses on monitoring performance for a variety of conditions and aspects of care quality.
- The **care for children and adolescent domain** includes preventive health measures for those 21 years of age and younger. These measures focus on well visits and immunizations, as well as an oral health component. This domain highlights the importance of ensuring children and adolescents receive needed preventive care, which can catch items of concern early and lead to long term health benefits for this population.
- The **quality improvement domain** focuses solely on quality improvement for select measures. The measures in this domain will focus on priority area for the IHP Program and the state, specifically focusing on improving quality for the selected measures. The measures of focus will be selected collaboratively between the IHP and DHS from a subset of measures. The IHP will work on three measures with the option to select one additional measure under the bonus points option (see Bonus Points Option section).

- The **closing gaps domain** focuses on reducing and eliminating disparities in care for different populations. Currently, this domain will monitor disparities in care for the MHCP population compared to that of the commercial population for select measures. The measures of focus will be selected collaboratively between the IHP and DHS from a subset of measures. The IHP will work on two measures with the option to select one additional measure under the bonus points option (see Bonus Points Option section).
- The **equitable care domain** includes an array of NCQA HEDIS measures that align with the State’s goals to eliminate health disparities and ensure equitable care across racial and ethnic groups. The IHP will focus on one measure from this group, working toward closing gaps in care. The measure of focus will be selected collaboratively between the IHP and DHS. The IHP may propose a measure not included on this list, but in order to use other measures, DHS or the IHP would need to be able to obtain the data to assess performance for different racial and ethnic groups. The IHP will work on one measure with the option to select one additional measure under the bonus points option (see Bonus Points Option section).

Alternate Measures

An IHP may also propose alternative TCOC quality measures relevant for the IHP population. However, alternative measures will only be considered for IHPs with a significantly different population from the standard IHP’s attributed population, such as pediatric providers, where the current core set of measures does not fully measure the unique needs of those specific populations. Alternative TCOC quality measures will have to meet the following requirements to be accepted:

- Must utilize a state or nationally recognized quality measure specification.
- The data must be able to be collected by a third-party using an existing data collection mechanism.
- The data must be validated and audited by a third-party.
- Must not be a measure that is impacted by high variability due to coding changes.
- Must assess health care processes and/or outcomes desirable for the IHP population of patients.

Calculation of the Overall TCOC Quality Score

As explained above, DHS will compute the TCOC overall quality score using measures organized into five domains: 1) quality core set, 2) care for children and adolescents, 3) quality improvement, 4) closing gaps, and 5) equitable care. The domains will be weighted according to Table 6 below.

Table 6: Quality domains in the core measure set and proposed weights

Domain	Key Elements	Proposed Weights
Quality Core Set	Prevention & Screening for Adults (4%)	
Quality Core Set	Care for at Risk Populations (4%) Behavioral Health (4%) Patient-centered Care (6%)	20%

Domain	Key Elements	Proposed Weights
	Quality of Outpatient Care (2%) <i>(Category weights are noted in parenthesis next to each category above, but the "Quality Core Set" is worth 20% total.)</i>	
Care for Children and Adolescents	Focus on well-visits, immunizations, and oral health <i>(Each measure is weighted equally.)</i>	20%
Quality Improvement	Quality improvement focus for selected measures <i>(Each measure is weighted equally.)</i>	30%
Closing Gaps	Closing disparities between the MHCP and commercial populations <i>(Each measure is weighted equally.)</i>	20%
Equitable Care	Improving care for racial and ethnic groups <i>(One measure weighted at 10%.)</i>	10%

In the **quality core set and care for children and adolescent domains**, points will be awarded for achievement or for improvement as described below.

- Points for achievement will be awarded by comparing the IHP-level results to the statewide distribution of results, which uses Medicaid average rates for most measures. DHS will notify the IHP of the statewide distribution of results upon final calculation using the data based on the most recent quality measurement periods.
- Points for improvement will be awarded based on each measure’s relative improvement (i.e., the percent change between the performance years).
- DHS will use the greater of the achievement or improvement points to calculate the overall quality score. If any IHP’s participating providers do not report required quality measures, the awarded points will be reduced by the percent of IHP participants that did not report.

In the **quality improvement** domain, points will be awarded for relative improvement (i.e., percent change between the performance years). DHS will notify the IHP of the statewide distribution of results upon final calculation using the data based on the most recent quality measurement periods.

In the **closing gaps domain**, points will be awarded for achievement or for improvement as described below.

- Points for achievement will be awarded by comparing the IHP-level results to the statewide distribution of results, which uses Commercial rates. DHS will notify the IHP of the statewide distribution of results upon final calculation using the data based on the most recent quality measurement periods.

- Points for improvement will be awarded based on each measure’s relative improvement (i.e., the percent change between the performance years).
- DHS will use the greater of the achievement or improvement points to calculate the overall quality score. If any IHP’s participating providers do not report required quality measures, the awarded points will be reduced by the percent of IHP participants that did not report.

In the **equitable care domain**, points will be awarded as described below.

- For performance year 1, IHPs will be allowed a ramp up period which will focus on implementing interventions aimed at closing gaps in care before performance rates will be used for scoring purposes. IHPs will be required to complete a narrative template describing the efforts they are taking to address gaps in care (see Appendix I). Point assignment will be based on the completeness of this information.
- Starting with performance year 2, points will be awarded based on relative improvement (i.e., the percent change between the performance years) for each racial and ethnic group (i.e., Asian/Pacific Islander, Black, Hispanic, Native American, and Non-Hispanic White) compared to a baseline disparity gap with a reference group. In order to be eligible to receive points for a selected measure, the IHP must work to decrease the gap in care quality of all groups below the reference group and maintain or improve care quality of all other groups.
- DHS will provide the IHP with annual information regarding gaps in care, including baseline performance for each racial and ethnic group.

Bonus Points Option

IHPs will be able to obtain bonus points on the TCOC overall quality score by selecting additional measures in the following domains:

- Quality improvement
- Closing gaps
- Equitable care

Under the bonus points option, IHPs can work on a total of two additional measures, which cannot be in the same domain. The bonus measure in each domain will be weighted consistent with other measures in that domain. For example, each measure in the quality improvement domain is worth ten percent (10%) so the bonus measure would also be worth up to 10%.

IHPs will not be able to score more than 100% on the TCOC overall quality score. However, the bonus points option allows IHPs to earn more points by focusing on additional measures of interest to DHS and the IHP. The additional measures would be selected collaboratively between DHS and the IHP.

8. DATA SHARING AND REPORTS

8.1 IHP Data Portal and MN-ITS Mailbox

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

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

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

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

IHPs must designate, during time of application for IHP, who within their organization will be the primary administrator (PA) and secondary administrator (PPA) for the IHP Data Portal and MN-ITS Mailbox.

8.2 Learning Opportunities

IHPs will be invited, and are strongly encouraged, to participate in learning opportunities with DHS and other IHPs. IHP peer learning events are an opportunity for IHPs to communicate and collaborate with DHS and one another. DHS may present on data or other program related topics, answer questions, and facilitate data and program related discussions amongst IHPs.

DHS may schedule an IHP Learning Day, where IHPs are strongly encouraged to attend, network with other IHPs, and discuss key issues, potential strategies, and future opportunities for IHPs.

IHPs may also be invited to other learning activities and asked to present on things related to health care delivery and payment reform.

9. PROPOSAL EVALUATION AND SELECTION

9.1 Overview of Evaluation Methodology

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

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

- a. *Phase I* Required Statements Review
- b. *Phase II* Evaluation of Proposal Requirements
- c. *Phase III* Selection of the Successful Responder(s)

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

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

*** Special note for Existing IHPs wishing to continue in the IHP Program:** Existing IHPs whose contract expires 12/31/2026 or earlier must submit a response to this RFP in order to be considered for participation in the IHP Program for the next contract period beginning 1/1/2027.

9.2 Evaluation Team

1. An evaluation team will be selected to evaluate Responder Proposals.
2. STATE and professional staff, other than the evaluation team, may also assist in the evaluation process. This assistance could include, but is not limited to, the initial mandatory requirements review, contacting of references, or answering technical questions from evaluators.
3. STATE reserves the right to alter the composition of the evaluation team and their specific responsibilities.

9.3 Evaluation Phases

At any time during the evaluation phases, STATE may, at STATE's discretion, contact Responders to (1) provide clarification of their Proposal, (2) have each Responder provide an oral presentation of their Proposal, or (3) obtain the opportunity to interview the proposed key personnel. Reference checks may

also be made at this time. However, there is no guarantee that STATE will look for information or clarification outside of the submitted written Proposal. Therefore, it is important that the Responder ensure that all sections of the Proposal have been completed to avoid the possibility of failing an evaluation phase or having their score reduced for lack of information.

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

The Required Statements will be evaluated on a pass or fail basis. Responders must "pass" each of the requirements identified in section 3 to move to Phase II.

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

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

Proposal Components	Possible Points
1. Cover Sheet	5
2. Background Information and Organizational Structure	10
3. Leadership and Management	10
4. Financial Plan and Experience with Risk Sharing	10
5. Clinical Care Model	20
6. Quality Measurement	20
7. Population Health	15
8. Community Partnerships	10
Total:	100 points

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

- c. A minimum score of 60 out of 100 total possible points will be required for Responders to be considered for acceptance into potentially entering into contract negotiations for the IHP Program. A score greater than 60 does not guarantee participation in the program. Scoring will generally be used to determine the adequacy and completeness of an IHP's proposal.

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

- a. Only the Proposals found to be responsive under Phases I and II will be considered in Phase III.
- b. The evaluation team will review the scoring in making its recommendations of the successful Responder(s).
- c. STATE may submit a list of detailed comments, questions, and concerns to one or more Responders after the initial evaluation. STATE may require said response to be written, oral, or both. STATE will only use written responses for evaluation purposes. The total scores for

those Responders selected to submit additional information may be revised as a result of the new information.

- d. The evaluation team will make its recommendation based on the above-described evaluation process. The successful Responder(s), if any, will be selected approximately four (4) weeks after the Proposal submission due date.

9.4 Contract Negotiations and Unsuccessful Responder Notice

If a Responder(s) is selected, STATE will notify the successful Responder(s) in writing of their selection and STATE's desire to enter into contract negotiations. Contract negotiations with successful Responder(s) may include a plenary session and one optional individual IHP contract negotiation meeting.

As noted in the Exceptions to Sample Contract and RFP Terms section of this RFP, much of the language reflected in the sample contract is required by statute. **It is crucial that Responders review ALL sections, including boilerplate language, of the Sample Contract PRIOR to application submission and note any exceptions, including detailed information as to the reasoning for requesting an exception, on the "Exceptions to Sample Contract and RFP Terms and Conditions" form. The State may limit negotiations or discussions to only those exceptions indicated in your response to the RFP.**

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

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

10. REQUIRED CONTRACT TERMS AND CONDITIONS

- A. Requirements.** All Responders must be willing to comply with all state and federal legal requirements regarding the performance of the contract. **The full requirements are set forth throughout this RFP and are contained in the attached sample IHP contract in Appendix G. The attached sample IHP contract should be reviewed for the terms and conditions that will likely govern any resulting contract from this RFP.** Although this RFP establishes the basis for Responder Proposals, the detailed obligations and additional measures of performance will be defined in the final negotiated contract.
- B. Governing Law/Venue.** This RFP and any subsequent contract must be governed by the laws of State of Minnesota. Any and all legal proceedings arising from this RFP or any resulting contract in which STATE is made a party must be brought in the State of Minnesota, District Court of Ramsey County. The venue of any federal action or proceeding arising here from in which STATE is a party must be the United States District Court for the State of Minnesota in Ramsey County.
- C. Preparation Costs.** STATE is not liable for any cost incurred by Responders in the preparation and production of a Proposal. Any work performed prior to the issuance of a fully executed contract will be done only to the extent the Responder voluntarily assumes risk of non-payment.
- D. Contingency Fees Prohibited.** Pursuant to Minn. Stat. § 10A.06, no person may act as or employ a lobbyist for compensation that is dependent upon the result or outcome of any legislation or administrative action.
- E. Accessibility Standards.** Any information systems, tools, content, and work products produced under this CONTRACT, including but not limited to software applications, web sites, video, learning modules, webinars, presentations, etc., whether commercial, off-the-shelf (COTS) or custom, purchased or developed, must comply with the [State of Minnesota Accessibility Standard](#),⁶ as updated on July 1, 2024. This standard requires, in part, compliance with the Web Content Accessibility Guidelines (WCAG) 2.1 (Level AA) and Section 508 of the Rehabilitation Act of 1973

Information technology deliverables and services offered must comply with the [State of Minnesota Accessibility Standard](#).⁷ (The relevant requirements are contained under the “Standards” tab at the link above.) Information technology deliverables or services that do not meet the required number of standards or the specific standards required may be rejected and may not receive further consideration.

⁶ <https://mn.gov/mnit/about-mnit/accessibility/>

⁷ <https://mn.gov/mnit/about-mnit/accessibility/>

F. Insurance Requirements.

1. Responder shall not commence work under the contract until they have obtained all the insurance described below and the State of Minnesota has approved such insurance. All policies and certificates shall provide that the policies shall remain in force and effect throughout the term of the contract.
2. Responder is required to maintain and furnish satisfactory evidence of the following insurance policies:
 - a. Workers' Compensation Insurance: Except as provided below, Responder must provide Workers' Compensation insurance for all its employees and, in case any work is subcontracted, Responder will require the subcontractor to provide Workers' Compensation insurance in accordance with the statutory requirements of the State of Minnesota, including Coverage B, Employer's Liability. Insurance minimum amounts are as follows:
 - \$100,000 – Bodily Injury by Disease per employee
 - \$500,000 – Bodily Injury by Disease aggregate
 - \$100,000 – Bodily Injury by Accident

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

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

- b. General Commercial Liability Insurance: Responder is required to maintain insurance protecting it from claims for damages for bodily injury, including sickness or disease, death, and for care and loss of services as well as from claims for property damage, including loss of use which may arise from operations under the contract whether the operations are by the Responder or by a subcontractor or by anyone directly or indirectly employed by the Responder under the contract. Insurance minimum amounts are as follows:
 - \$2,000,000 – per occurrence
 - \$2,000,000 – annual aggregate

The following coverages shall be included:

- Premises and Operations Bodily Injury and Property Damage
- Personal and Advertising Injury

Blanket Contractual Liability
Products and Completed Operations Liability
State of Minnesota named as an Additional Insured, to the extent permitted by law.

c. Network Security and Privacy Liability Insurance.

Responder is required to 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.

Responder shall maintain insurance to cover claims which may arise from failure of Responder'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. Responder is required to carry the following minimum limits:

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

d. Additional Insurance Conditions:

- i. Responder's policy(ies) shall be primary insurance to any other valid and collectible insurance available to the State of Minnesota with respect to any claim arising out of Responder's performance under this IHP contract;
- ii. If Responder receives a cancellation notice from an insurance carrier affording coverage herein, Responder agrees to notify the State of Minnesota within five (5) business days with a copy of the cancellation notice, unless Responder's policy(ies) contain a provision that coverage afforded under the policy(ies) will not be cancelled without at least thirty (30) days advance written notice to the State of Minnesota;
- iii. Responder is responsible for payment of IHP contract related insurance premiums and deductibles;
- iv. If Responder is self-insured, a Certificate of Self-Insurance must be attached;
- v. Include legal defense fees in addition to its liability policy limits, with the exception of II.G.2.d. above; and
- vi. Obtain insurance policies from an insurance company having an "AM BEST" rating of A- (minus); Financial Size Category (FSC) VII or better and must be authorized to do business in the State of Minnesota; and
- vii. An Umbrella or Excess Liability insurance policy may be used to supplement the Responder's policy limits to satisfy the full policy limits required by the IHP contract.

3. The State reserves the right to immediately terminate the contract if the Responder is not in compliance with the insurance requirements and retains all rights to pursue any legal remedies against the Responder. All insurance policies must be open to inspection by the State, and copies of policies must be submitted to the State's authorized representative upon written request.
4. The successful Responder is required to submit Certificates of Insurance acceptable to the State of Minnesota as evidence of insurance coverage requirements prior to commencing work under the contract.

11. STATE'S AUTHORITY

1. STATE may:
 - A. Reject any and all Proposals received in response to this RFP;
 - B. Disqualify any Responder whose conduct or Proposal fails to conform to the requirements of this RFP;
 - C. Have unlimited rights to duplicate all materials submitted for purposes of RFP evaluation, and duplicate all public information in response to data requests regarding the Proposal;
 - D. Select for contract or for negotiations a Proposal which best represents "best value" as defined in Minnesota Statutes, section 16C.02, subdivision 4 and in this RFP document;
 - E. Consider a late modification of a Proposal if the Proposal itself was submitted on time and if the modifications were requested by STATE, and the modifications make the terms of the Proposal more favorable to STATE, and accept such Proposal as modified;
 - F. At its sole discretion, reserve the right to waive any non-material deviations from the requirements and procedures of this RFP;
 - G. Negotiate as to any aspect of the Proposal with any Responder and negotiate with more than one Responder at the same time, including asking for Responders' "Best and Final" offers;
 - H. Extend the contract, in increments determined by STATE, not to exceed a total contract term of five years;
 - I. Cancel the RFP at any time and for any reason with no cost or penalty to STATE; and
 - J. STATE will not be liable for any errors in the RFP or other responses related to the RFP.
2. The award decisions of STATE are final and not subject to appeal.
3. If federal funds are used in funding a contract that results from this RFP, in accord with 45 C.F.R. § 92.34, for Works and Documents created and paid for under the contract, the U.S. Department of Health and Human Services will have a royalty free, non-exclusive, perpetual and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the Works or Documents created and paid for under a resulting contract for federal government purposes.

12. GLOSSARY OF ACRONYMS

BHH – Behavioral Health Home
C&TC – Child and Teen Check-up
CCBHC – Certified Community Behavioral Health Clinic
CMS – Center for Medicare and Medicaid Services
DHS – Department of Human Services
IHP – Integrated Health Partnerships
E&M – Evaluation & Management
EAS – Encounter Alert System
EMR – Electronic Medical Record
FFS – Fee-for-Service
HCH – Health Care Home
HiAP - Health in All Policies
HIE – Health Information Exchange
HIT – Health Information Technology
HRSN – Health-Related Social Needs
MCO – Managed Care Organization
MHCP – Minnesota Health Care Program
MPIP – Medicaid Promoting Interoperability Program
NCQA – National Committee for Quality Assurance
PBP – Population-Based Payment
PCMH – Patient Centered Medical Home
PMPM – Per-Member-Per-Month
RFP – Request for Proposals
TCOC – Total Cost of Care

13. APPENDICES

Appendix A: Integrated Health Partnerships Application Template

Appendix A1: Letter of Intent Template

Appendix A2: IHP Roster Submission Process

Appendix A3: Sample Roster Template

Appendix B1: Example Health System Characteristics

Appendix B2: Eligible and Excluded Populations

Appendix C: Attribution Methodology

Appendix D: Payment Mechanism Methodology

Appendix E: Population Health Demonstration Template

Appendix F: IHP Reports and Data

Appendix F2: Quality Measures

Appendix G: Sample IHP Contract

Appendix H: Sample Population Health Report

Appendix I: Sample Equitable Care Report

Appendix J: Sample Child and Teen Checkups Report

Appendix K: Responder Information and Declarations

Appendix L: Exceptions to Sample Contract and RFP Terms

Appendix M: Disclosure of Funding Form

Appendix N: Documentation to Establish Financial Stability