

# Request for Proposals

Minnesota Department of Health

Minnesota e-Health Roadmaps to Advance  
the Minnesota Accountable Health Model

April 14, 2014

**Table of Contents**

Introduction ..... 3  
    Request for Proposal Purpose ..... 3  
    Background ..... 3  
Request for Proposal Overview ..... 7  
    Key Procurement Dates ..... 7  
    Funding ..... 8  
    Additional Details..... 8  
Tasks..... 8  
    Minnesota e-Health Roadmaps Tasks ..... 8  
    Lessons Learned and Evaluation Report Tasks ..... 13  
    Required Additional Tasks ..... 13  
Proposal Instructions ..... 14  
Proposal Content Requirements..... 17  
    Proposal Mandatory Requirements ..... 18  
Proposal Evaluation ..... 20  
    Evaluation Criteria ..... 21  
General Requirements..... 23  
    CERTIFICATION REGARDING LOBBYING ..... 32  
    State Of Minnesota – Affirmative Action Certification..... 33  
    STATE OF MINNESOTA AFFIDAVIT OF NONCOLLUSION ..... 34  
    STATE OF MINNESOTA VETERAN-OWNED PREFERENCE FORM..... 35  
    STATE OF MINNESOTA RESIDENT VENDOR FORM ..... 36  
    State of Minnesota Professional and Technical Services Contract ..... 37  
Appendices..... 43  
    Appendix A: Minnesota Accountable Health Model Glossary ..... 44  
    Appendix B: Cost Proposal Form ..... 51

# Introduction

## Request for Proposal Purpose

The Minnesota Department of Health (MDH) requests proposals to develop and disseminate *Minnesota e-Health Roadmaps to Advance the Minnesota Accountable Health Model* (e-Health Roadmaps) for the settings of long-term and post-acute care, local public health, behavioral health, and social services. Each e-Health Roadmap will describe a path forward and a framework for each setting to enable providers to effectively use e-health to participate in the [Minnesota Accountable Health Model](http://www.mn.gov/sim) (<http://www.mn.gov/sim>). The e-Health Roadmaps should include both concrete, achievable short and medium term steps and longer-term aspirational goals. In addition, the e-Health Roadmaps must be action oriented and based on use cases. The e-Health Roadmaps will recommend actions primarily to the setting but may include actions for other stakeholders, including the State, providers, payers, EHR vendors and legislators. The e-Health Roadmaps will support: 1) the readiness for and participation in the Minnesota Accountable Health Model within each setting; and 2) the achievement of the Triple Aim of improved consumer experience of care, improved population health, and lower per capita health care costs. [The Institute for Healthcare Improvement Triple Aim for Populations](http://www.ihl.org/explore/tripleaim/pages/default.aspx) (<http://www.ihl.org/explore/tripleaim/pages/default.aspx>).

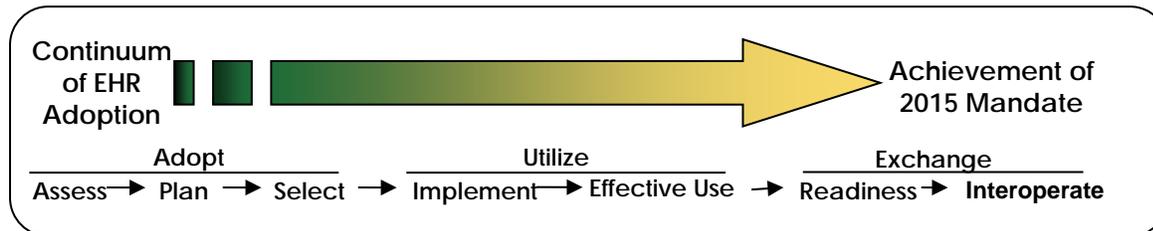
Refer to the Minnesota Accountable Health Model Glossary in Appendix A for selected terms related to the RFP and e-Health Roadmaps.

## Background

E-health is the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT), including health information exchange, to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions. Minnesota has been a leader in e-health by leveraging a public-private collaborative, the [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/abouthome.html) (Initiative) (<http://www.health.state.mn.us/e-health/abouthome.html>). Established in 2004, the Initiative was established to pursue strong policies and practices to accelerate e-health with a focus on achieving interoperability (the ability to share information seamlessly) across the continuum of care. Policy makers in Minnesota have recognized that more effective use of health information technology – including timely exchange of information – is needed to improve quality and safety of care, as well as to help control costs. As such, Minnesota enacted legislation in 2007 that requires all health and health care providers in the state to implement an interoperable EHR system by January 1, 2015 ([Minn. Stat. §62J.495](https://www.revisor.mn.gov/statutes/?id=62j.495)) (<https://www.revisor.mn.gov/statutes/?id=62j.495>).

In order to help providers achieve the 2015 interoperable EHR mandate, the Initiative developed the Minnesota Model for Adopting Interoperable EHRs (Figure 1) in 2008 to outline seven practical steps leading up to and including EHR interoperability. This model groups each of the steps into three major categories that apply to all aspects of the Initiative's work and policy development.

**Figure 1. Minnesota Model for Adopting Interoperable Electronic Health Records**



In recent years, federal funding has supported Minnesota's e-health efforts and contributed to high rates of EHR adoption and growing rates of effective use and health information exchange (see [Minnesota e-Health Profile](http://www.health.state.mn.us/e-health/assessment.html#brief) (<http://www.health.state.mn.us/e-health/assessment.html#brief>). However, this support ends in 2014, and e-health challenges and disparities still exist in settings including long-term and post-acute care, local public health, behavioral health, social services, and other settings. In addition, there is a need for e-health technical assistance and education in the areas such as privacy and security, standards and interoperability, and health information exchange sustainability.

The Minnesota Accountable Health Model is a State Innovation Model (SIM) testing grant awarded by the [Center for Medicare & Medicaid Innovation](http://innovations.cms.gov) (<http://innovations.cms.gov>) and administered in partnership by the Minnesota Department of Human Services (DHS) and Minnesota Department of Health (MDH). The purpose of the Minnesota Accountable Health Model is to provide Minnesotans with better value in health care through integrated, accountable care using innovative payment and care delivery models that are responsive to local health needs. The funds will be used to help providers and communities work together to create healthier futures for Minnesotans, and drive health care reform in the state. The vision of the Minnesota Accountable Health Model is:

- Every patient receives coordinated, patient-centered primary care.
- Providers are held accountable for the care provided to Medicaid enrollees and other populations, based on quality, patient experience and cost performance measures.
- Financial incentives are fully aligned across payers and the interests of patients, through payment arrangements that reward providers for keeping patients healthy and improving quality of care.
- Provider organizations effectively and sustainably partner with community organizations, engage consumers, and take responsibility for a population's health through accountable communities for health that integrate medical care, mental/chemical health, community health, public health, social services, schools and long term supports and services.

The Minnesota Model will test whether increasing the percentage of Medicaid enrollees and other populations (i.e. commercial, Medicare) in accountable care payment arrangements will improve the health of communities and lower health care costs. To accomplish this, the state will expand the [Integrated Health Partnerships \(IHP\) demonstration](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_161441](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441)), formerly called the Health Care Delivery Systems (HCDS) demonstration, administered by the Department of Human Services.

The expanded focus will be on the development of integrated community service delivery models and use coordinated care methods to integrate health care, behavioral health, long-term and post-acute care, local public health, and social services centered on patient needs.

To achieve the vision of shared cost and coordinated care, the Minnesota Accountable Health Model includes key investments in five Drivers that are necessary for accountable care models to be successful. (see [Minnesota Accountable Health Model Driver Diagram](http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_182962.pdf) [http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16\\_182962.pdf](http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_182962.pdf))

- Driver-1**      Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement--HIT/HIE
- Driver-2**      Providers have analytic tools to manage cost/risk and improve quality--Data Analytics
- Driver-3**      Expanded numbers of patients are served by team-based integrated/coordinated care--Practice Transformation
- Driver-4**      Provider organizations partner with communities and engage consumers, to identify health and cost goals, and take on accountability for population health—ACH
- Driver-5**      ACO performance measurement, competencies, and payment methodologies are standardized, and focus on complex populations--ACO Alignment

The activities contained in this RFP are linked to Driver-1 Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement--HIT/HIE.

Through the Minnesota Accountable Health Model, Minnesota is working to achieve the vision of the Triple Aim: improved consumer experience of care, improved population health, and lower per capita health care costs. The [Minnesota Accountable Health Model: Continuum of Accountability Matrix](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836) ([http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_181836](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181836)) is designed to illustrate the basic capabilities, relationships, and functions that organizations or partnerships should have in place in order to achieve the long-term vision of the Minnesota Accountable Health Model. It will help the state identify criteria and priorities for investment, and lay out developmental milestones that demonstrate organizations or partnerships are making progress towards the vision.

In addition, the [Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool](http://www.health.state.mn.us/e-health/mahmassessmenttool.docx) (<http://www.health.state.mn.us/e-health/mahmassessmenttool.docx>) is an interactive tool that allows organizations to answer questions to determine their location on the matrix continuum. MDH and DHS will use this tool to better understand SIM-Minnesota participants and status in achieving the goals of the Minnesota Accountable Health Model, what SIM supports are needed to achieve the goals, and how we may be able to provide additional tools or resources. This tool will be used to help us develop targets and goals for participating organizations, and to assess their progress.

For more information on the SIM grant, the Minnesota Accountable Health Model and other health reform activities visit [State Innovation Model Grant](http://www.mn.gov/sim) (<http://www.mn.gov/sim>).

The Minnesota Department of Health will be releasing three e-health RPFs for the SIM-Minnesota funding:

1. Minnesota e-Health Roadmaps to Advance the Minnesota Accountable Health Model.
2. Minnesota Accountable Health Model e-Health Grant Program.
3. Privacy, Security and Consent Management for Electronic Health Information Exchange.

The following RFP is for the **Minnesota e-Health Roadmaps to Advance the Minnesota Accountable Health Model**.

# Request for Proposal Overview

Key Procurement Dates		
#	Event	Day/Date/Time
1	RFP posted	Monday, April 14, 2014
2	<p>RFP Informational Webinar</p> <ol style="list-style-type: none"> <li>Go to <a href="https://health-state-mn-ustraining.webex.com/health-state-mn-ustraining/k2/j.php?MTID=tdeab504c0e2f3fdb37214016d0ef8440">https://health-state-mn-ustraining.webex.com/health-state-mn-ustraining/k2/j.php?MTID=tdeab504c0e2f3fdb37214016d0ef8440</a></li> <li>Enter your name and email address.</li> <li>Enter the session password: Roadmap14!</li> <li>Click "Join Now".</li> <li>Follow the instructions that appear on your screen.</li> </ol> <p>To join the teleconference only: Dial-in Number: 1-888-742-5095 Access Code: 4477200226</p> <p>For assistance regarding the webinar, contact Susie Veness at: <a href="mailto:susie.veness@state.mn.us">susie.veness@state.mn.us</a> or 1-651-201-5508</p>	Tuesday, April 22, 2014, 10:00 a.m. – 12:00 p.m. Central Time
3	All written questions due to MDH (Note: after this date no more questions will be addressed by MDH)	Monday, May 5, 2014, 4:00 p.m. Central Time
4	Responses to written questions posted on the <a href="http://www.mn.gov/sim">State Innovation Model Grant</a> ( <a href="http://www.mn.gov/sim">http://www.mn.gov/sim</a> )	Tuesday, May 13, 2014, 4:00 p.m. Central Time
5	Non-binding Letters of Intent to Respond due to MDH	Friday, May 16, 2014, 4:00 p.m. Central Time
6	Proposals due to MDH	Thursday, June 19, 2014, 4:00 pm Central Time
7	Anticipated proposal review period	Friday, June 20 – Monday, July 21, 2014
8	Oral presentations/demonstrations by invitation only (if necessary)	Monday, June 30, 2014 – Thursday, July 10, 2014
9	Anticipated notice of intent to award	Monday, July 21, 2014
10	Anticipated negotiation period	Monday, July 21 – Tuesday, September 30, 2014
11	Desired contract execution	Wednesday, October 1, 2014
12	Desired contract end date	18 months after contract execution

In the remainder of the document, the vendor is referred to as “Responder” with regard to procurement-related activities and “Contractor” after contract execution.

## Funding

There is up to \$600,000 available to be distributed competitively through the e-Health Roadmap Request for Proposal (RFP). The state desires to fund e-Health Roadmaps in each of the four settings of long-term and post-acute care, local public health, behavioral health, and social services. This could include funding an e-Health Roadmap for specific sub-setting such as skilled nursing facilities, local health departments, home care providers, or chemical dependency providers. The state reserves the right not to fund an e-Health Roadmap in each of the four settings if the proposals do not meet the criteria of the RFP. In the event that proposals are not received or do not meet the criteria of the RFP for each setting, the state reserves the right to adjust the amount of the contract award(s). The state may award one or multiple contracts for the RFP.

## Additional Details

### Contract Details

The term of the contract(s) is anticipated to run for 18 months. The contract(s) will begin on the date stated in the contract or upon full execution of the contract, whichever is later. Execution of the contract is dependent on Center of Medicare and Medicaid Innovation (CMMI) approval of the contractor, contractor’s budget, and the release of funds from CMMI. The contractor shall perform additional duties as specified by the contract.

### Amendments to the RFP

This request for proposal 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. The state may award one or multiple contracts for the RFP.

## Tasks

The end deliverables include:

1. e-Health Roadmaps for each setting that a contract is awarded;
2. Lessons Learned and Evaluation Report from each contractor; and
3. Required Additional Tasks.

## Minnesota e-Health Roadmaps Tasks

Each e-Health Roadmap should describe a path forward and a framework for each setting to enable providers to effectively use e-health to participate in the Minnesota Accountable Health Model. The minimum components for participating in the Minnesota Accountable Health Model are described in the Minnesota Accountable Health Model: Continuum of Accountability Matrix (Matrix). Each e-Health Roadmap should focus on advancing the setting through the two e-health components of the Matrix, EHR adoption and effective use and health information

exchange, and must include recommendations for action that are tied to these components of the Matrix. For this RFP, use cases will describe the future state, how e-health could be used by the setting to participate in the Minnesota Accountable Health Model.

The e-Health Roadmaps should include both concrete, achievable short and medium term steps and longer-term aspirational goals. In addition, the e-Health Roadmaps must be action oriented and based on use cases. The e-Health Roadmaps will recommend action primarily to the setting but may include actions for other stakeholders, including the State, providers, payers, EHR vendors and legislators. The e-Health Roadmaps will be 1) driven by needs existing and anticipated; 2) built on a vision of where the setting needs to go in order to advance through the Matrix and what solutions are needed to get there; and 3) a route for achieving the vision.

The following are the major tasks required for each e-Health Roadmap:

1. Engage setting-specific key stakeholders including: 1) local, state, and national associations, partners and experts; 2) local providers representing a mix of practice size, services provided, patients served, and locations; and 3) the consumer/patient/client. The contractor will facilitate discussions with the priority stakeholders to reach community consensus and make recommendations on the use cases, priorities, strategies, resources and needs for the setting to advance through the Matrix, focused on the e-health components.
2. Evaluate the setting using the [Minnesota Accountable Health Model: Continuum of Accountability Matrix Assessment Tool](http://www.health.state.mn.us/e-health/mahmassessmenttool.docx) (<http://www.health.state.mn.us/e-health/mahmassessmenttool.docx>). This tool will be used to assess, identify, and document e-health gaps and needs of the setting for the e-health components of the Matrix. This evaluation should include analysis of the level or range of levels the setting is at for the e-health components and identify what factors such as practice size, services provided, patients served and locations of provider affect the level. Additional areas of analysis, which will be identified in consultation with MDH, may include organizational support, standards, workflow issues, governance, privacy and security, legal issues, technical infrastructure, finance and financial risk, and data quality issues. The evaluation should leverage the [Minnesota e-Health Profile](http://www.health.state.mn.us/e-health/abouthome.html) (<http://www.health.state.mn.us/e-health/abouthome.html>).
3. Consider and/or incorporate into the e-Health Roadmap applicable federal and state laws and mandates and resources including, but not limited to:
  - a. [Health Information Technology and Infrastructure \(2015 Interoperable Electronic Health Record Mandate](https://www.revisor.mn.gov/statutes/?id=62J.495) (<https://www.revisor.mn.gov/statutes/?id=62J.495>) and [Guidance for Understanding the Minnesota 2015 Interoperable EHR Mandate](http://www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf) (<http://www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf>)

- b. [Electronic Prescription Drug Program](https://www.revisor.mn.gov/statutes/?id=62J.497)  
(<https://www.revisor.mn.gov/statutes/?id=62J.497>) and [Guidance for Understanding the 2011 e-Prescribing Mandate](http://www.health.state.mn.us/e-health/eprescribing/erx032011guidance.pdf) (<http://www.health.state.mn.us/e-health/eprescribing/erx032011guidance.pdf>)
- c. [Health Information Exchange Oversight](https://www.revisor.mn.gov/statutes/?id=62J.498)  
(<https://www.revisor.mn.gov/statutes/?id=62J.498>) [Health Information Exchange \(HIE\) Oversight: Overview of Minnesota Law](http://www.health.state.mn.us/divs/hpsc/ohit/hieoversightlaw.pdf)  
(<http://www.health.state.mn.us/divs/hpsc/ohit/hieoversightlaw.pdf>)
- d. [Minnesota Health Records Act](https://www.revisor.mn.gov/statutes/?id=144.291) (<https://www.revisor.mn.gov/statutes/?id=144.291>) and [Minnesota Health Records Act fact sheet](http://www.health.state.mn.us/e-health/hrafactsheet2007.pdf) (<http://www.health.state.mn.us/e-health/hrafactsheet2007.pdf>)
- e. [Minnesota Health Records Access Study legislative report](http://www.health.state.mn.us/e-health/hras/hras021913report.pdf)  
(<http://www.health.state.mn.us/e-health/hras/hras021913report.pdf>)
- f. [Uniform Electronic Transactions & Implementation Guide Standards](https://www.revisor.mn.gov/statutes/?id=62J.536)  
(<https://www.revisor.mn.gov/statutes/?id=62J.536>) Minnesota's requirements for the standard, electronic exchange of health care administrative transactions)
- g. [Health Care Administrative Simplification](http://www.health.state.mn.us/asa/index.html)  
(<http://www.health.state.mn.us/asa/index.html>)
- h. [Health Information Technology for Economic and Clinical Health \(HITECH\) Programs & Advisory Committees Act](http://www.healthit.gov/policy-researchers-implementers/hitech-act-0) (<http://www.healthit.gov/policy-researchers-implementers/hitech-act-0>)
- i. [Administrative Data Standards and Related Requirements](http://www.ecfr.gov/cgi-bin/text-idx?SID=2e7dc674e5f28683aab627ae1e1e7b31&c=ecfr&tpl=/ecfrbrowse/Title45/45cfrv1_02.tpl)  
([http://www.ecfr.gov/cgi-bin/text-idx?SID=2e7dc674e5f28683aab627ae1e1e7b31&c=ecfr&tpl=/ecfrbrowse/Title45/45cfrv1\\_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?SID=2e7dc674e5f28683aab627ae1e1e7b31&c=ecfr&tpl=/ecfrbrowse/Title45/45cfrv1_02.tpl)) HIPAA administrative simplification and privacy and security rules- see Subchapter C)
- j. Health Insurance Portability Accountability Act (HIPAA), 45 CFR section 164.501
- k. Health Insurance Portability Accountability Act (HIPAA) Privacy and Security Rule added in 2000<sup>a</sup>
- l. Health Insurance Portability Accountability Act (HIPAA) Omnibus Final Rule added in 2013<sup>b</sup>

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<sup>a</sup> 45 C.F.R. 160 and 164 modifications made for the HIPAA final rule effective March 26, 2013

- m. [Minnesota Government Data Practices Act, Minnesota Statute Chapter 13](https://www.revisor.mn.gov/statutes/?id=13.01&year=2013&keyword_type=exact&keyword=Minnesota+Government+Data+Practices+Act) (https://www.revisor.mn.gov/statutes/?id=13.01&year=2013&keyword\_type=exact&keyword=Minnesota+Government+Data+Practices+Act)
  - n. Family Educational Rights and Privacy Act (FERPA)
  - o. Federal Alcohol and Substance Abuse Treatment Records statutes, 42 USC section 290dd-2 and 42 CFR section 2.1 to 2.67
  - p. Title 38 Section 7332 Protections Confidentiality of Certain Medical Records
  - q. [Standards and Interoperability framework](http://www.siframework.org/index.html) (http://www.siframework.org/index.html) facilitated by the Office of the National Coordinator for Health Information Technology (ONC)
4. Review and leverage existing e-health resources and tools, including, but not limited to:
- a. [Minnesota e-Health Guides](http://www.health.state.mn.us/e-health/reports.html) (http://www.health.state.mn.us/e-health/reports.html)
  - b. [E-Health toolkits](http://www.stratishealth.org/expertise/healthit/index.html) (http://www.stratishealth.org/expertise/healthit/index.html)
  - c. [Minnesota e-Health Advisory Committee](http://www.health.state.mn.us/e-health/advcommittee/index.html) (http://www.health.state.mn.us/e-health/advcommittee/index.html) and [Minnesota e-Health Advisory Committee workgroups](http://www.health.state.mn.us/e-health/wgshome.html) (http://www.health.state.mn.us/e-health/wgshome.html)
  - d. [Minnesota e-Health Profile](http://www.health.state.mn.us/e-health/assessment.html) (http://www.health.state.mn.us/e-health/assessment.html)
  - e. [ONC Beacon Program Learning Guides](http://www.healthit.gov/policy-researchers-implementers/beacon-community-program/learning-guides) (http://www.healthit.gov/policy-researchers-implementers/beacon-community-program/learning-guides)
  - f. [Minnesota EHR Loan Program](http://www.health.state.mn.us/divs/orhpc/funding/#ehrloan) (http://www.health.state.mn.us/divs/orhpc/funding/#ehrloan)
  - g. The [Regional Extension Center for Health IT \(REACH\)](http://www.khareach.org/) (http://www.khareach.org/)
  - h. [Minnesota e-Health Connectivity for Health Information Exchange Grant Program](http://www.health.state.mn.us/divs/hpsc/ohit/hiegrants.html) (http://www.health.state.mn.us/divs/hpsc/ohit/hiegrants.html)
5. Identify and describe 10 use cases, which represent the future state of using e-health to participate in the Minnesota Accountable Health Model. The use cases should include, but are not limited to, the components of the [User Story Template](http://wiki.siframework.org/file/detail/PHRIUserStoryTemplate121113.docx) (http://wiki.siframework.org/file/detail/PHRIUserStoryTemplate121113.docx) developed by the ONC, Standards and Interoperability (S&I) Framework, Public Health Reporting Initiative. The use cases will be identified through discussions with the priority stakeholders and MDH. At least 4 of the 10 use cases must involve transitions of care. In addition, at least 1 use case should involve:

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<sup>b</sup> 65 Fed. Reg. 82,474 (Dec. 28, 2000).

- a. a patient with multiple chronic conditions, including behavioral health as well as physiological health conditions;
  - b. a patient in rural areas, as defined by the Office of Rural Health and Primary Care, MDH;
  - c. an individual and/or patient that is part of a health care home or an Integrated Health Partnership or accountable care organization and that is receiving social services
  - d. a patient in Health Professional Shortage Areas or Medically Underserved Areas/Population in Minnesota, as defined by the Office of Rural Health and Primary Care, MDH;
  - e. a patient where smoking, obesity and/or diabetes is being treated or addressed through care of a provider;
  - f. health information exchange between the setting and a patient's health care home or accountable care organization;
  - g. using e-health for primary prevention (e.g., screenings, immunizations);
  - h. quality improvement or health analytics; and
  - i. health information exchange between the setting and the Minnesota Department of Health or Minnesota Department of Human Services or other state agency.
6. Prioritize 3 to 5 of the 10 use cases for which the setting and providers within the setting should focus resources. One of the "priority use cases" must involve transition of care. The prioritization will be established through discussions with the priority stakeholders and the State.
  7. Develop the approach to achieve each "priority use case." The approach should include recommended actions to all stakeholders including, but not limited to, the individual providers, the setting as a whole, the Minnesota Department of Health, the Minnesota Department of Human Services, other state agencies, HIT vendors, exchange partners, consumers/patients/clients, and others as identified throughout the process. Action topics can include but are not limited to policy/governance, workforce, workflow, information technology, privacy, security, consent, legal issues, infrastructure, finance, data quality issues, and public health reporting to the Minnesota Department of Health and other state agencies. The approach should also include guidance to settings on identification, adoption and use of recommended national standards, protocols and transport methods as applicable and consistent with those endorsed by the Minnesota e-Health Initiative. This includes standards identified by Meaningful Use and the ONC. Roadmaps should promote use of recommended national and state standards and provide directions to settings for which standards are being developed.
  8. Compile findings from Tasks #1 - #7, and any additional activities to develop a roadmap for participating in the Minnesota Accountable Health Model. The focus will be on the e-health components of the Matrix but other components may be identified through the work. The e-Health Roadmap will have two final products: 1) a narrative report and 2) a

visual summary. The narrative report needs to include all findings and actions, as well as an overview of how the findings were developed and who was involved in the process. The visual summary is an easy-to-share visual of the e-Health Roadmap. Each of these documents should stand on its own and not require additional explanation or materials. Each document should be developed to allow MDH to modify if required.

9. Disseminate the e-Health Roadmaps to the settings. This includes:
  - a. Provide at least three opportunities for learning about the e-Health Roadmap, requiring:
    - i. A minimum of one webinar or similar open access training requiring no or minimal traveling for participants; and
    - ii. A minimum of one training opportunity that will be recorded and available on the MDH website.
  - b. Host all materials on the Minnesota Department of Health website.
  - c. Publish all materials for the public domain.

## Lessons Learned and Evaluation Report Tasks

The following are the major tasks required for each Lessons Learned and Evaluation Report.

1. Develop a Lessons Learned and Evaluation Report, which will be in the form of a written report that documents the detailed process used to develop the e-Health Roadmaps and provides lessons learned and an evaluation of the process. The evaluation should discuss the applicability of using the process with other settings, including tips, tools and templates developed for the e-Health Roadmaps.
2. Provide feedback and recommendations on current e-health tools, resources and technical assistance. This can be included in the body of the Lessons Learned and Evaluation Report or as an appendix.
3. Disseminate the Lessons Learned and Evaluation Report with partners and stakeholders including but not limited to the MDH, Minnesota Department of Human Services, the Minnesota e-Health Initiative, SIM Community Advisory Task Force and SIM Multi-Payer Task Force.

## Required Additional Tasks

In addition to the development of the e-Health Roadmap and Lessons Learned and Evaluation Report, the contract(s) shall:

1. Develop and implement an MDH approved project plan that includes the approach to address each task and has following the components: schedule, scope, cost, resources, quality and risk.

2. Provide monthly written progress reports to MDH, Office of Health Information Technology. These reports should include status overview and detail on the scope, cost, schedule, resources, quality and risk.
3. Engage and incorporate direction and feedback from MDH on methodology, engagement strategies, use cases and all other activities.
4. Work with SIM-Minnesota project evaluation staff to develop and participate in the SIM-Minnesota project evaluation.
5. Participate in MDH provided or identified trainings, meetings and technical assistance.
6. Collaborate with other contractor(s), should more than one contract be awarded, and MDH-identified partners on intersecting issues.
7. Collaborate with any other contractors, grantees or partners associated with the SIM-Minnesota grant and the Minnesota Accountable Health Model.
8. Prepare and release all deliverables, materials, and reports for the public domain with approval of MDH.

Responders are encouraged to propose additional tasks or activities if they will substantially improve the results of the project. These items should be separated from the required items on the cost proposal.

## Proposal Instructions

### Examination of All Requirements

Responders should thoroughly examine this document and be knowledgeable of the scope of work required for all parts of this RFP. Responses must be based solely on the information and materials contained in the RFP, as well as any amendments or other subsequent written materials issued by MDH, and any written answers MDH provides in response to Responders' written questions. Responders are to disregard anything else, including oral representations made, with the exception of any oral comments made at the RFP Informational Meeting. Responders are encouraged to propose additional tasks or activities if they will substantially improve the results of the project. **Responders must submit a separate proposal for each setting specific e-Health Roadmap.**

## MDH RFP Contact Person

All correspondence regarding this RFP should be directed in writing to:

Kari Guida  
Minnesota Department of Health  
Office of Health Information Technology  
[Kari.Guida@state.mn.us](mailto:Kari.Guida@state.mn.us)

Other personnel are **NOT** authorized to discuss this request for proposal with Responders, with the exception of the RFP Informational Meeting, before the proposal submission deadline. Contact regarding this RFP with any personnel not listed above could result in disqualification.

## Written Questions

Questions regarding this RFP must be submitted in writing by the date listed in the Key Procurement Table via e-mail to:

Kari Guida  
Minnesota Department of Health  
Office of Health Information Technology  
[Kari.Guida@state.mn.us](mailto:Kari.Guida@state.mn.us)

## **No additional questions will be addressed by MDH after the date listed in the Key Procurement Table.**

All written questions and answers that MDH has addressed will be posted on the [State Innovation Model Grant](http://www.mn.gov/sim) (<http://www.mn.gov/sim>) by the date listed in the Key Procurement Table.

Other personnel are **NOT** authorized to discuss this request for proposal with Responders, before the proposal submission deadline. Contact regarding this RFP with any personnel not listed above could result in disqualification.

## Intent to Respond

Responders must submit a written Intent to Respond via e-mail to MDH by the date listed in the Key Procurement Table in order to receive any direct communications regarding this RFP. The Intent to Respond should indicate the Responders name, contact information and setting for which a roadmap proposal may be submitted. If a written Intent to Respond is not sent, a proposal may still be submitted; however, any further notices issued by MDH will only be sent to Responders that have an Intent to Respond on file. Updates will also be posted at [State Innovation Model Grant](http://www.mn.gov/sim) (<http://www.mn.gov/sim>).

MDH will send a list of Responders who have submitted an Intent to Respond upon request. The list may include the Responders name, contact information and setting for which a roadmap proposal may be submitted. This list will be posted at [State Innovation Model Grant](http://www.mn.gov/sim) (<http://www.mn.gov/sim>).

Letters of Intent to Respond should be submitted by the date listed in the Key Procurement Table via e-mail to:

Kari Guida  
Minnesota Department of Health  
Office of Health Information Technology  
[Kari.Guida@state.mn.us](mailto:Kari.Guida@state.mn.us)

### Proposal Submission

All responses and all requested documents should be structured in the same order and lettering/numbering format as shown in Proposal Mandatory Requirements, submitted in a 3-ring binder, on 8 ½ x 11 paper, and using at least 11-point font, double-spaced, consecutively numbered and sections clearly marked or labeled. **Responders must submit a separate proposal for each e-Health Roadmap.**

Ten copies of the proposal should be submitted to MDH. The cost proposal should be submitted in a separate sealed envelope clearly marked on the outside "Cost Proposal" along with the setting and Responder's name. **In addition, please submit an electronic copy of the proposal and cost proposal, as a separate file, on a USB drive included in the package with the paper copies of the proposal.**

All proposals must be delivered to:

Kari Guida  
Minnesota Department of Health  
Office of Health Information Technology  
85 East 7<sup>th</sup> Place, Ste. 220  
St. Paul, MN 55101

### Additional Instructions

- Late proposals will not be considered.
- All costs incurred in responding to this RFP will be borne by the Responder.
- Fax and e-mail responses will not be considered.
- Submit ten copies of the proposal.
- Responders must submit a separate proposal for each e-Health Roadmap.
- Proposals are to be sealed in mailing envelopes or packages with the Responder's name and address written on the outside.
- Provide one copy of the cost proposal in a separately sealed envelope clearly marked on the outside "Cost Proposal" along with the organization's name.
- For purposes of completing the cost proposal, the state does not make regular payments based upon the passage of time; it only pays for services performed or work delivered after it is accomplished.
- Proposals will be evaluated on "best value" as specified under Evaluation Process. The cost proposal will not be opened by the review committee until after the qualifications points are awarded.

- Price will be a significant factor in the evaluation of proposals.

\*\*All proposals must be received no later than the date listed in the Key Procurement Table as indicated by a notation made by the MDH Receptionist, 2<sup>nd</sup> Floor (Suite 220), 85 East 7<sup>th</sup> Place, St. Paul, MN.

## Proposal Content Requirements

MDH reserves the right to reject any/all proposals received in response to this RFP. Any information obtained will be used, along with other information that MDH deems appropriate, in determining suitability of proposed offer. Responders whose proposals were not accepted will be notified that a selection is made, or if it is decided, that no proposals are accepted. MDH has no obligation to explain the basis of or reasons for the decision it makes relating to the proposals and/or this RFP. MDH may identify multiple Responders who are determined suitable and negotiate with each of them on parallel tracks, pending a final contracting decision. Any proposal failing to respond to all requirements may be eliminated from consideration and declared not accepted.

Responders are expected to provide MDH with as much information as necessary in their proposal for MDH to objectively evaluate the proposal and Responder qualifications. At a minimum, proposals must be fully responsive to the specific requirements stated in this RFP. Responders must identify any requirements of this RFP that they cannot satisfy. All responses to the RFP must comply with the requirements of this section.

Failure to submit all information listed under this section, may at the discretion of MDH, result in the rejection of the proposal. If all Responders fail to meet one or more of the mandatory requirements, MDH reserves the right to continue evaluating the proposals. Responders must complete and submit the Proposal Mandatory Requirements.

## Proposal Mandatory Requirements

Response Section	Title & Description	Format/Page Limit
A	<p><b>Cover Letter</b>                      Responder must submit a cover letter indicating that the Responder is responding to the RFP and that all of the mandatory requirements in RFP have been met. The letter must be signed by a representative that is legally authorized to contractually bind the Responder. Responder must also disclose any potential, actual or apparent conflicts of interest that may arise between any of the Responder's current clients and/or employees, and MDH. Because of the complexities involved in defining conflicts of interest, please identify any potential conflicts. MDH will make a final determination as to whether a disqualifying conflict exists. Note: If there are no known conflicts, provide a statement to this effect.</p>	Letter on organization's letterhead signed by representative with legal contracting capacity.
B	<p><b>Table of Contents</b>                      Provide a table of contents for the remainder of the proposal</p>	No page limit
C	<p><b>Response to Minimum (Pass/Fail) Requirements</b>                      Describe how the Responder complies with the following Pass/Fail requirements:</p> <ul style="list-style-type: none"> <li>• Inclusion of letters of support from associations, organizations, and stakeholders that represent the setting(s) for which the proposal is submitted.</li> <li>• Certifies they have a mechanism to effectively negotiate and balance the needs of settings and other stakeholders.</li> <li>• Agrees to incorporate the Minnesota Information Technology Accessibility Standards identified at: <a href="http://mn.gov/oet/policies-and-standards/accessibility/">MN.IT Services Web Accessibility Policy and Accessibility Issue Resolution</a> (http://mn.gov/oet/policies-and-standards/accessibility/)</li> </ul>	No page limit
D	<p><b>Overall Understanding of Goals &amp; Tasks</b>                      A statement of the goals and tasks to show or demonstrate the Responder's view and understanding of the nature of the contract including how the project connects to the Minnesota e-Health Initiative and Minnesota Accountable Health Model.</p>	No more than 5 pages
E	<p><b>Setting Description and Needs</b>                      A clear description of the setting and the setting's need that includes known or perceived barriers and needs to using e-health for advancing through the Minnesota Accountable Health Model: Continuum of Accountability Matrix.</p>	No more than 5 pages

## Proposal Mandatory Requirements

Response Section	Title & Description	Format/Page Limit
F	<p><b>Stakeholder Engagement</b>                      A detailed description of the strategies to engage stakeholders including: 1) local, state, and national associations, partners and experts; 2) local providers including representation of different sizes, types and locations; and 3) the consumer/patient/client. In addition, a list of tentative key stakeholders to engage that includes a brief description of the stakeholder (i.e. local, state, national, size of organization, location, type of population served).</p>	No more than 5 pages
G	<p><b>Deliverable Description and Work plan</b>                      A description of the deliverables to be provided by the Responder along with a detailed work plan that identifies the major tasks for the e-Health Roadmap, Lessons Learned and Evaluation Report, and Required Additional Tasks. If the Responders propose additional major tasks or activities, they are to be clearly indicated in the work plan.</p>	No more than 10 pages
H	<p><b>Responder's Experience</b>                      An outline of the Responder's background and experience with examples of similar work done by the Responder and examples of work with settings done by the Responder. This will include a list of key personnel, including contractors, which details training, work experience, skill sets related this contract, and number of years of experience.</p> <p>Include resumes for key personnel in Appendix A. Resumes or other information about project personnel should not contain, if possible, personal telephone numbers, home addresses or home email addresses. If it is necessary to include personal contact information, please clearly indicate in the proposal that personal contact information is being provided.</p>	No more than 5 pages  Appendices (Response Section J)
I	<p><b>Submit the following forms as identified in the General Requirements Section of the RFP:</b></p> <ul style="list-style-type: none"> <li>• Affidavit of Non Collusion</li> <li>• Certificate Regarding Lobbying (if proposal exceeds \$100,000, including extension options)</li> <li>• Affirmative Action Certification (if proposal exceeds \$100,000, including extension options)</li> <li>• Veterans Preference Form (if applicable)</li> <li>• Resident Vendor Form (if applicable)</li> </ul>	No page limit

Proposal Mandatory Requirements		
Response Section	Title & Description	Format/Page Limit
J	<p><b>Appendices</b></p> <ol style="list-style-type: none"> <li>1. Letters of support from local, state, and national associations, partners and experts; local providers including representation of different sizes, types and locations; and additional stakeholders that represent the setting(s) for which the proposal is submitted for.</li> <li>2. Resumes of key personnel, including contractors, identified in Response Section H. Resumes or other information about project personnel should not contain, if possible, personal telephone numbers, home addresses or home email addresses. If it is necessary to include personal contact information, please clearly indicate in the proposal that personal contact information is being provided.</li> </ol>	No page limit

### Cost Proposal

In addition to the above-required components, a Cost Proposal is required to be submitted separately. Provide one copy of the cost proposal in a separately sealed envelope clearly marked on the outside with “Cost Proposal” along with the setting and organization’s name. Use the attached format in Appendix B.

## Proposal Evaluation

The proposal must be organized to correspond with all requirements and formats set forth in this RFP. The proposal should be clear, concise and must be complete. All information must be contained in the proposal. No assumptions will be made by MDH regarding the intentions of the Responder in submitting the proposal. Responders not providing all requested information may be rejected. Written proposals must be bound and organized in a manner to facilitate ease of review by evaluators.

All proposals submitted will be evaluated for form and content in accordance with the provisions stated in the final solicitation document. Clarifications may be requested from the Responder at any phase of the evaluation process for the purpose of clarifying ambiguities in the information presented in the proposal.

Each proposal will be date and time marked as it is received. All proposals received by the time and date specified in Key Procurement Dates, will be checked for the presence of proper identification, conformance with the proposal submittal requirements of this RFP, and the

satisfaction of the minimum qualifications. Absence of required information may deem the proposal non-responsive and may be cause for rejection.

Proposals that pass the prequalification evaluation will undergo an evaluation process conducted by an evaluation committee composed Minnesota Department of Health staff, Minnesota Department of Human Services staff and stakeholders selected by MDH. These may be supported by external consultants or other designees (e.g. an extended evaluation team of subject matter experts). All responses received by the deadline will be evaluated. In some instances, an interview may be part of the evaluation process. A 100-point scale will be used to create the final evaluation recommendation. The factors and weighting on which proposals will be judged are:

<b>Evaluation Criteria</b>		
#	Criteria	Points Awarded or Pass Fail
1	Responder includes cover letter that indicates the Responder is responding to the RFP and that all of the mandatory requirements of the RFP are met.	Prequalification Evaluation: Pass/Fail
2	Responder includes letters of support from associations, organizations, and stakeholders that represent the setting(s) for which the proposal is submitted.	Prequalification Evaluation: Pass/Fail
3	Responder demonstrates they have a mechanism to effectively negotiate and balance the needs of settings and other stakeholders.	Prequalification Evaluation: Pass/Fail
4	Responder agrees to incorporate the Minnesota Information Technology Accessibility Standards identified at: <a href="http://mn.gov/oet/policies-and-standards/accessibility/">MN.IT Services Web Accessibility Policy and Accessibility Issue Resolution</a> ( <a href="http://mn.gov/oet/policies-and-standards/accessibility/">http://mn.gov/oet/policies-and-standards/accessibility/</a> )	Prequalification Evaluation: Pass/Fail
5	<p><b>Overall Understanding of Goals &amp; Tasks</b></p> <ul style="list-style-type: none"> <li>• The Responder’s description of goals and tasks show or demonstrate the responder's view and understanding of the nature of the contract.</li> <li>• The Responder’s description shows or demonstrates the connection between the contract and the Minnesota e-Health Initiative.</li> <li>• The Responder’s description shows or demonstrates the connection between the contract and the Minnesota Accountable Health Model.</li> </ul>	10 Points

<b>Evaluation Criteria</b>		
#	Criteria	Points Awarded or Pass Fail
6	<p><b>Setting Description and Needs</b></p> <ul style="list-style-type: none"> <li>• The Responder clearly defines the setting.</li> <li>• The Responder demonstrates understanding of the variety of providers within the setting (i.e. acknowledging types, sizes, locations)</li> <li>• The Responder demonstrates understanding of perceived or known barriers and needs for using e-health for advancing through the Minnesota Accountable Health Model: Continuum of Accountability Matrix.</li> </ul>	10 Points
7	<p><b>Stakeholder Engagement</b></p> <ul style="list-style-type: none"> <li>• Responder provides a detailed description of effective and practical strategies to be used to engage stakeholders including: 1) local, state, and national associations, partners and experts; 2) local providers including representation of different sizes, types and locations; and 3) the consumer/patient/client.</li> <li>• Responder identifies a comprehensive list of tentative key stakeholders to engage that includes a brief description of the stakeholder (i.e. local, state, national, size of organization, location, type of population served).</li> <li>• Responder has the necessary letters of support from key stakeholders for the contract to be successful.</li> </ul>	10 Points
8	<p><b>Deliverable Description and Work plan</b></p> <ul style="list-style-type: none"> <li>• Responder provides a comprehensive proposed approach that achieves the three deliverables along with a detailed work plan that identifies the major tasks for each deliverable.</li> <li>• Responder’s approach to project management includes but not limited to scope, schedule, resources, quality and risk and likelihood of success in managing the contract.</li> <li>• Responder’s work plan is achievable in listed timeline and current environment.</li> <li>• If the Responders proposed additional major tasks or activities, they are clearly indicated in the work plan.</li> </ul>	30 Points

Evaluation Criteria		
#	Criteria	Points Awarded or Pass Fail
9	<p><b>Responder's Experience</b></p> <ul style="list-style-type: none"> <li>• Responder's background and experience and/or personnel demonstrate previous similar work to the contract tasks.</li> <li>• Responder's background and experience and/or personnel demonstrate ability to achieve contract tasks.</li> <li>• Responder's background and experience and/or personnel demonstrate ability to work with setting and stakeholders.</li> <li>• Responder's demonstrates the ability to manage the grant (project management)</li> </ul>	10 Points
10	<p><b>Cost proposal</b></p> <p>The proposal with the lowest cost will receive the total amount of available points. Other price proposals will be scored proportionately utilizing the following formula: (Price of lowest cost proposal/price of proposal being evaluated) x 30 available points.</p>	30 points

The highest scoring Responders, based on both technical and cost scores, may be selected as Finalists and be invited to interview with MDH. Key personnel identified in the proposal must participate in the interview. Date, time, and additional details regarding the interviews will be provided to the selected Responders.

## General Requirements

### Affidavit of Noncollusion

Each Responder must complete the attached Affidavit of Noncollusion and include it with the response.

### Conflicts of Interest

Responder must provide a list of all entities with which it has relationships that create, or appear to create, a conflict of interest with the work that is contemplated in this request for proposals. The list should indicate the name of the entity, the relationship, and a discussion of the conflict.

### Proposal Contents

By submission of a proposal, Responder warrants that the information provided is true, correct, and reliable for purposes of evaluation for potential contract award. The submission of inaccurate or misleading information may be grounds for disqualification from the award as

well as subject the Responder to suspension or debarment proceedings as well as other remedies available by law.

### **Disposition of Responses**

All materials submitted in response to this RFP will become property of the State and will become public record in accordance with Minnesota Statutes, section 13.591, after the evaluation process is completed. Pursuant to the statute, completion of the evaluation process occurs when the government entity has completed negotiating the contract with the selected vendor. If the Responder submits information in response to this RFP that it believes to be trade secret materials, as defined by the Minnesota Government Data Practices Act, Minnesota Statute § 13.37, the Responder must:

- clearly mark all trade secret materials in its response at the time the response is submitted,
- include a statement with its response justifying the trade secret designation for each item, and
- defend any action seeking release of the materials it believes to be trade secret, and indemnify and hold harmless the State, its agents and employees, from any judgments or damages awarded against the State in favor of the party requesting the materials, and any and all costs connected with that defense. This indemnification survives the State's award of a contract. In submitting a response to this RFP, the Responder agrees that this indemnification survives as long as the trade secret materials are in possession of the State.

The State will not consider the prices submitted by the Responder to be proprietary or trade secret materials.

Notwithstanding the above, if the State contracting party is part of the judicial branch, the release of data shall be in accordance with the Rules of Public Access to Records of the Judicial Branch promulgated by the Minnesota Supreme Court as the same may be amended from time to time.

### **Contingency Fees Prohibited**

Pursuant to Minnesota Statutes Section 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.

### **Sample Contract**

You should be aware of the State's standard contract terms and conditions in preparing your response. A sample State of Minnesota Professional/Technical Services Contract is attached for your reference. Much of the language reflected in the contract is required by statute. If you take exception to any of the terms, conditions or language in the contract, you must indicate those exceptions in your response to the RFP; certain exceptions may result in your proposal

being disqualified from further review and evaluation. Only those exceptions indicated in your response to the RFP will be available for discussion or negotiation.

### **Reimbursements**

Reimbursement for travel and subsistence expenses actually and necessarily incurred by the contractor as a result of the contract will be in no greater amount than provided in the current "Commissioner's Plan" promulgated by the commissioner of Employee Relations.

Reimbursements will not be made for travel and subsistence expenses incurred outside Minnesota unless it has received the State's prior written approval for out of state travel. Minnesota will be considered the home state for determining whether travel is out of state.

### **Organizational Conflicts of Interest**

The Responder warrants that, to the best of its knowledge and belief, and except as otherwise disclosed, there are no relevant facts or circumstances which could give rise to organizational conflicts of interest. An organizational conflict of interest exists when, because of existing or planned activities or because of relationships with other persons, a vendor is unable or potentially unable to render impartial assistance or advice to the State, or the vendor's objectivity in performing the contract work is or might be otherwise impaired, or the vendor has an unfair competitive advantage. The Responder agrees that, if after award, an organizational conflict of interest is discovered, an immediate and full disclosure in writing must be made to the Assistant Director of the Department of Administration's Materials Management Division ("MMD") which must include a description of the action which the contractor has taken or proposes to take to avoid or mitigate such conflicts. If an organizational conflict of interest is determined to exist, the State may, at its discretion, cancel the contract. In the event the Responder was aware of an organizational conflict of interest prior to the award of the contract and did not disclose the conflict to MMD, the State may terminate the contract for default. The provisions of this clause must be included in all subcontracts for work to be performed similar to the service provided by the prime contractor, and the terms "contract," "contractor," and "contracting officer" modified appropriately to preserve the State's rights.

### **Preference to Targeted Group and Economically Disadvantaged Business and Individuals**

In accordance with Minnesota Rules, part 1230.1810, subpart B and Minnesota Rules, part 1230.1830, certified Targeted Group Businesses and individuals submitting proposals as prime contractors will receive a six percent preference in the evaluation of their proposal, and certified Economically Disadvantaged Businesses and individuals submitting proposals as prime contractors will receive a six percent preference in the evaluation of their proposal. Eligible TG businesses must be currently certified by the Materials Management Division prior to the solicitation opening date and time. For information regarding certification, contact the Materials Management Helpline at 651.296.2600, or you may reach the Helpline by email at [mmdhelp.line@state.mn.us](mailto:mmdhelp.line@state.mn.us). For TTY/TDD communications, contact the Helpline through the Minnesota Relay Services at 1.800.627.3529.

## Veteran-Owned Preference

In accordance with Minn. Stat. § 16C.16, subd. 6a, (a) Except when mandated by the federal government as a condition of receiving federal funds, the commissioner shall award up to a six percent preference on state procurement to **certified small businesses** that are **majority-owned and operated by**:

- (1) recently separated veterans who have served in active military service, at any time on or after September 11, 2001, and who have been discharged under honorable conditions from active service, as indicated by the person's United States Department of Defense form DD-214 or by the commissioner of veterans affairs;
- (2) veterans with service-connected disabilities, as determined at any time by the United States Department of Veterans Affairs; or
- (3) any other veteran-owned small businesses certified under section 16C.19, paragraph (d).

In accordance with Minn. Stat. § 16C.19 (d), a veteran-owned small business, the principal place of business of which is in Minnesota, is certified if it has been verified by the United States Department of Veterans Affairs as being either a veteran-owned small business or a service disabled veteran-owned small business, in accordance with Public Law 109-461 and Code of Federal Regulations, title 38, part 74.

To receive a preference the veteran-owned small business must meet the statutory requirements above by the solicitation opening date and time.

If you are claiming the veteran-owned preference, **attach documentation, sign and return the Veteran-Owned Preference Form with your response to the solicitation.** Only eligible veteran-owned small businesses that meet the statutory requirements and provide adequate documentation will be given the preference.

## Human Rights Requirements

For all contracts estimated to be in excess of \$100,000, Responders are required to complete the attached Affirmative Action Data page and return it with the response. As required by Minnesota Rule 5000.3600, "It is hereby agreed between the parties that Minnesota Statute § 363A.36 and Minnesota Rule 5000.3400 - 5000.3600 are incorporated into any contract between these parties based upon this specification or any modification of it. A copy of Minnesota Statute § 363A.36 and Minnesota Rule 5000.3400 - 5000.3600 are available upon request from the contracting agency."

## Certification Regarding Lobbying

Federal money will be used or may potentially be used to pay for all or part of the work under the contract, therefore the Proposer must complete the attached **Certification Regarding Lobbying** and submit it as part of its proposal.

## Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion.

Federal money will be used or may potentially be used to pay for all or part of the work under the contract, therefore the Proposer must certify the following, as required by the regulations implementing Executive Order 12549.

## Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -- Lower Tier Covered Transactions

### Instructions for Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
4. The terms *covered transaction*, *debarred*, *suspended*, *ineligible*, *lower tier covered transaction*, *participant*, *person*, *primary covered transaction*, *principal*, *proposal*, and *voluntarily excluded*, as used in this clause, have the meaning set out in the Definitions and Coverages sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this response that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the

- eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
  9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 C.F.R. 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

#### **Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions**

1. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

#### **Insurance Requirements**

- A. Contractor 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. Contractor shall maintain such insurance in force and effect throughout the term of the contract.
- B. Contractor is required to maintain and furnish satisfactory evidence of the following insurance policies:
  1. **Workers' Compensation Insurance:** Except as provided below, Contractor must provide Workers' Compensation insurance for all its employees and, in case any work is subcontracted, Contractor 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** limits are as follows:

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

\$100,000 – Bodily Injury by Accident

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

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

2. **Commercial General Liability Insurance:** Contractor 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 Contractor or by a subcontractor or by anyone directly or indirectly employed by the Contractor under the contract. Insurance **minimum** limits are as follows:

\$2,000,000 – per occurrence

\$2,000,000 – annual aggregate

\$2,000,000 – annual aggregate – Products/Completed Operations

The following coverages shall be included:

Premises and Operations Bodily Injury and Property Damage

Personal and Advertising Injury

Blanket Contractual Liability

Products and Completed Operations Liability

Other; if applicable, please list \_\_\_\_\_

State of Minnesota named as an Additional Insured, to the extent permitted by law

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

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

In addition, the following coverages should be included:

Owned, Hired, and Non-owned Automobile

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

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

Contractor is required to carry the following **minimum** limits:

\$2,000,000 – per claim or event

\$2,000,000 – annual aggregate

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

The retroactive or prior acts date of such coverage shall not be after the effective date of this Contract and Contractor shall maintain such insurance for a period of at least three (3) years, following completion of the work. If such insurance is discontinued, extended reporting period coverage must be obtained by Contractor to fulfill this requirement.

**C. Additional Insurance Conditions:**

- Contractor'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 Contractor's performance under this contract;
- If Contractor receives a cancellation notice from an insurance carrier affording coverage herein, Contractor agrees to notify the State of Minnesota within five (5) business days with a copy of the cancellation notice, unless Contractor'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;

- Contractor is responsible for payment of Contract related insurance premiums and deductibles;
  - If Contractor is self-insured, a Certificate of Self-Insurance must be attached;
  - Contractor's policy(ies) shall include legal defense fees in addition to its liability policy limits, with the exception of B.4 above;
  - Contractor shall obtain insurance policy(ies) from insurance company(ies) having an "AM BEST" rating of A- (minus); Financial Size Category (FSC) VII or better, and authorized to do business in the State of Minnesota; and
  - An Umbrella or Excess Liability insurance policy may be used to supplement the Contractor's policy limits to satisfy the full policy limits required by the Contract.
- D. The State reserves the right to immediately terminate the contract if the contractor is not in compliance with the insurance requirements and retains all rights to pursue any legal remedies against the contractor. 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.
- E. The successful Responder is required to submit Certificates of Insurance acceptable to the State of MN as evidence of insurance coverage requirements prior to commencing work under the contract.

#### **E-Verify Certification (In accordance with Minn. Stat. §16C.075)**

By submission of a proposal for services in excess of \$50,000, Contractor certifies that as of the date of services performed on behalf of the State, Contractor and all its subcontractors will have implemented or be in the process of implementing the federal E-Verify program for all newly hired employees in the United States who will perform work on behalf of the State. In the event of contract award, Contractor shall be responsible for collecting all subcontractor certifications and may do so utilizing the E-Verify Subcontractor Certification Form available at <http://www.mmd.admin.state.mn.us/doc/EverifySubCertForm.doc>. All subcontractor certifications must be kept on file with Contractor and made available to the State upon request.

# CERTIFICATION REGARDING LOBBYING

For State of Minnesota Contracts and Grants over \$100,000

The undersigned certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, A Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, Disclosure Form to Report Lobbying in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

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Organization Name

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Name and Title of Official Signing for Organization

By: \_\_\_\_\_  
Signature of Official

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Date

# State Of Minnesota - Affirmative Action Certification

If your response to this solicitation is or could be in excess of \$100,000, complete the information requested below to determine whether you are subject to the Minnesota Human Rights Act (Minnesota Statutes 363A.36) certification requirement, and to provide documentation of compliance if necessary. It is your sole responsibility to provide this information and—if required—to apply for Human Rights certification prior to the due date of the bid or proposal and to obtain Human Rights certification prior to the execution of the contract. The State of Minnesota is under no obligation to delay proceeding with a contract until a company receives Human Rights certification.

**BOX A – For companies which have employed more than 40 full-time employees within Minnesota on any single working day during the previous 12 months. All other companies proceed to BOX B.**

Your response will be rejected unless your business:

- has a current Certificate of Compliance issued by the Minnesota Department of Human Rights (MDHR)
- or–
- has submitted an affirmative action plan to the MDHR, which the Department received prior to the date the responses are due.

Check one of the following statements if you have employed more than 40 full-time employees in Minnesota on any single working day during the previous 12 months:

- We have a current Certificate of Compliance issued by the MDHR. **Proceed to BOX C. Include a copy of your certificate with your response.**
- We do not have a current Certificate of Compliance. However, we submitted an Affirmative Action Plan to the MDHR for approval, which the Department received on \_\_\_\_\_ (date). **Proceed to BOX C.**
- We do not have a Certificate of Compliance, nor has the MDHR received an Affirmative Action Plan from our company. **We acknowledge that our response will be rejected. Proceed to BOX C. Contact the Minnesota Department of Human Rights for assistance.** (See below for contact information.)

**Please note:** Certificates of Compliance must be issued by the Minnesota Department of Human Rights. Affirmative Action Plans approved by the Federal government, a county, or a municipality must still be received, reviewed, and approved by the Minnesota Department of Human Rights before a certificate can be issued.

**BOX B – For those companies not described in BOX A**

Check below.

- We have not employed more than 40 full-time employees on any single working day in Minnesota within the previous 12 months. **Proceed to BOX C.**

**BOX C – For all companies**

By signing this statement, you certify that the information provided is accurate and that you are authorized to sign on behalf of the Responder. You also certify that you are in compliance with federal affirmative action requirements that may apply to your company. (These requirements are generally triggered only by participating as a prime or subcontractor on federal projects or contracts. Contractors are alerted to these requirements by the federal government.)

Name of Company: \_\_\_\_\_ Date \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

**For assistance with this form, contact:**

Minnesota Department of Human Rights, Compliance & Community Relations

Mail: The Freeman Building 625 Robert Street North, Saint Paul, MN 55155 TC Metro: (651) 296-5663 Toll Free: 800-657-3704

Web: [www.humanrights.state.mn.us](http://www.humanrights.state.mn.us) Fax: (651) 296-9042 TTY: (651) 296-1283

Email: [compliance.mdhr@state.mn.us](mailto:compliance.mdhr@state.mn.us)

Affirmative Action Certification Page, Revised 6/11 - MDHR

# STATE OF MINNESOTA AFFIDAVIT OF NONCOLLUSION

I swear (or affirm) under the penalty of perjury:

1. That I am the Responder (if the Responder is an individual), a partner in the company (if the Responder is a partnership), or an officer or employee of the responding corporation having authority to sign on its behalf (if the Responder is a corporation);
2. That the attached proposal submitted in response to the \_\_\_\_\_ Request for Proposals has been arrived at by the Responder independently and has been submitted without collusion with and without any agreement, understanding or planned common course of action with, any other Responder of materials, supplies, equipment or services described in the Request for Proposal, designed to limit fair and open competition;
3. That the contents of the proposal have not been communicated by the Responder or its employees or agents to any person not an employee or agent of the Responder and will not be communicated to any such persons prior to the official opening of the proposals; and
4. That I am fully informed regarding the accuracy of the statements made in this affidavit.

Responder's Firm Name: \_\_\_\_\_

Authorized Representative (Please Print) \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Subscribed and sworn to me this \_\_\_\_\_ day of \_\_\_\_\_

Notary Public Signature: \_\_\_\_\_

My commission expires: \_\_\_\_\_

# STATE OF MINNESOTA VETERAN-OWNED PREFERENCE FORM

In accordance with Minn. Stat. § 16C.16, subd. 6a, (a) Except when mandated by the federal government as a condition of receiving federal funds, the commissioner shall award up to a six percent preference in the amount bid on state procurement to **certified small businesses** that are **majority-owned and operated by:**

(1) recently separated veterans who have served in active military service, at any time on or after September 11, 2001, and who have been discharged under honorable conditions from active service, as indicated by the person's United States Department of Defense form DD-214 or by the commissioner of veterans affairs;

(2) veterans with service-connected disabilities, as determined at any time by the United States Department of Veterans Affairs; or

(3) any other veteran-owned small businesses certified under section 16C.19, paragraph (d).

In accordance with Minn. Stat. § 16C.19 (d), a veteran-owned small business, the principal place of business of which is in Minnesota, is certified if it has been verified by the United States Department of Veterans Affairs as being either a veteran-owned small business or a service disabled veteran-owned small business, in accordance with Public Law 109-461 and Code of Federal Regulations, title 38, part 74.

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To receive a preference the veteran-owned small business must meet the statutory requirements above by the solicitation opening date and time. When responding to a Request for Bid (RFB), the preference is applied only to the first \$500,000 of the response. When responding to a Request for Proposal (RFP), the preference is applied as detailed in the RFP.

If you are claiming the veteran-owned preference, **attach documentation, sign and return this form with your response to the solicitation.** Only eligible veteran-owned small businesses that meet the statutory requirements and provide adequate documentation will be given the preference.

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## I HEREBY CERTIFY THAT THE FIRM LISTED BELOW:

My firm is a certified small business and it is majority-owned and operated by an eligible person as defined by Minn. Stat. § 16C.16, subd. 6a.

**Yes**  **No** (must check yes or no) **State the type of documentation attached:** \_\_\_\_\_

## DOCUMENTATION MUST BE PROVIDED FOR ONE OF THE FOLLOWING REQUIREMENTS:

(1) recently separated veterans who have served in active military service, at any time on or after September 11, 2001, and who have been discharged under honorable conditions from active service, as indicated by the person's United States Department of Defense form DD-214 or by the commissioner of veterans affairs;

**State the type of documentation attached:** \_\_\_\_\_

(2) veterans with service-connected disabilities, as determined at any time by the United States Department of Veterans Affairs;

**State the type of documentation attached:** \_\_\_\_\_

(3) any other veteran-owned small businesses certified under Minnesota Statute Section 16C.19, paragraph (d).

**State the type of documentation attached:** \_\_\_\_\_

Name of Company: \_\_\_\_\_

Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Telephone: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

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**IF YOU ARE CLAIMING THE VETERAN-OWNED PREFERENCE, ATTACH DOCUMENTATION, SIGN AND RETURN THIS FORM WITH YOUR RESPONSE TO THE SOLICITATION.**

# STATE OF MINNESOTA RESIDENT VENDOR FORM

In accordance with Laws of Minnesota 2013, Chapter 142, Article 3, Section 16, amending Minn. Stat. § 16C.02, subd. 13, a "Resident Vendor" means a person, firm, or corporation that:

- (1) is authorized to conduct business in the state of Minnesota on the date a solicitation for a contract is first advertised or announced. It includes a foreign corporation duly authorized to engage in business in Minnesota;
- (2) has paid unemployment taxes or income taxes in this state during the 12 calendar months immediately preceding submission of the bid or proposal for which any preference is sought;
- (3) has a business address in the state; and
- (4) has affirmatively claimed that status in the bid or proposal submission.

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To receive recognition as a Minnesota Resident Vendor ("Resident Vendor"), your company must meet each element of the statutory definition above by the solicitation opening date and time. If you wish to affirmatively claim Resident Vendor status, you should do so by submitting this form with your bid or proposal.

Resident Vendor status may be considered for purposes of resolving tied low bids or the application of a reciprocal preference.

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## I HEREBY CERTIFY THAT THE COMPANY LISTED BELOW:

1. Is authorized to conduct business in the State of Minnesota on the date a solicitation for a contract is first advertised or announced. *(This includes a foreign corporation duly authorized to engage in business in Minnesota.)*  
 Yes  No (must check yes or no)
2. Has paid unemployment taxes or income taxes in the State of Minnesota during the 12 calendar months immediately preceding submission of the bid or proposal for which any preference is sought.  
 Yes  No (must check yes or no)
3. Has a business address in the State of Minnesota.  
 Yes  No (must check yes or no)
4. Agrees to submit documentation, if requested, as part of the bid or proposal process, to verify compliance with the above statutory requirements.  
 Yes  No (must check yes or no)

**BY SIGNING BELOW**, you are certifying your compliance with the requirements set forth herein and claiming Resident Vendor status in your bid or proposal submission.

Name of Company: \_\_\_\_\_ Date: \_\_\_\_\_  
Authorized Signature: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

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**IF YOU ARE CLAIMING RESIDENT VENDOR STATUS, SIGN AND RETURN THIS FORM WITH YOUR BID OR PROPOSAL SUBMISSION.**

**If you take exception to any of the terms, conditions or language in the contract, you must indicate those exceptions in your response to the RFP; certain exceptions may result in your proposal being disqualified from further review and evaluation. Only those exceptions indicated in your response to the RFP will be available for discussion or negotiation.**

## State of Minnesota Professional and Technical Services Contract

SWIFT Contract No. :

This Contract is between the State of Minnesota, acting through its \_\_\_\_\_ ("State") and \_\_\_\_\_ ("Contractor").

### Recitals

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1. Under Minn. Stat. § 15.061 the State is empowered to engage such assistance as deemed necessary.
2. The State is in need of \_\_\_\_\_.
3. The Contractor represents that it is duly qualified and agrees to perform all services described in this Contract to the satisfaction of the State.

### Contract

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#### 1. Term of Contract

- 1.1 Effective date:** \_\_\_\_\_, or the date the State obtains all required signatures under Minn. Stat. § 16C.05, subd. 2, whichever is later. The Contractor must not begin work under this Contract until this Contract is fully executed and the Contractor has been notified by the State's Authorized Representative to begin the work.
- 1.2 Expiration date:** \_\_\_\_\_, or until all obligations have been satisfactorily fulfilled, whichever occurs first.
- 1.3 Survival of terms:** The following clauses survive the expiration or cancellation of this Contract: 8. Indemnification; 9. State audits; 10. Government data practices and intellectual property; 14. Publicity and endorsement; 15. Governing law, jurisdiction, and venue; and 16. Data disclosure.

#### 2. Contractor's duties

The Contractor, who is not a State employee, will:

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#### 3. Time

The Contractor must comply with all the time requirements described in this Contract. In the performance of this Contract, time is of the essence.

#### 4. Consideration and payment

**4.1 Consideration.** The State will pay for all services performed by the Contractor under this Contract as follows:

- (a) *Compensation.* The Contractor will be paid \$ \_\_\_\_\_.
- (b) *Travel expenses.* Reimbursement for travel and subsistence expenses actually and necessarily incurred by the Contractor as a result of this Contract will not exceed \$ \_\_\_\_\_; provided that the Contractor will be reimbursed for travel and subsistence expenses in the same manner and in no greater amount than provided in the current "Commissioner's Plan" established by the Commissioner of Minnesota Management and Budget which is incorporated in to this Contract by reference. The Contractor will not be reimbursed for travel and subsistence expenses incurred outside Minnesota unless it has received the State's prior written approval for out-of-state travel. Minnesota will be considered the home state for determining whether travel is out of state.
- (c) *Total obligation.* The total obligation of the State for all compensation and reimbursements to the Contractor under this Contract will not exceed \$ \_\_\_\_\_.

#### 4.2 Payment.

- (a) *Invoices.* The State will promptly pay the Contractor after the Contractor presents an itemized invoice for the services actually performed and the State's Authorized Representative accepts the invoiced services.

Invoices must be submitted timely and according to the following schedule:

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- (b) *Retainage.* Under Minn. Stat. § 16C.08, subd. 5(b), no more than 90 percent of the amount due under this Contract may be paid until the final product of this Contract has been reviewed by the State's agency head. The balance due will be paid when the State's agency head determines that the Contractor has satisfactorily fulfilled all the terms of this Contract.
- (c) *Federal funds.* (Where applicable, if blank this section does not apply.) Payments under this Contract will be made from federal funds obtained by the State through \_\_\_\_\_. The Contractor is responsible for compliance with all federal requirements imposed on these funds and accepts full financial responsibility for any requirements imposed by the Contractor's failure to comply with federal requirements.

## 5. Conditions of payment

All services provided by the Contractor under this Contract must be performed to the State's satisfaction, as determined at the sole discretion of the State's Authorized Representative and in accordance with all applicable federal, state, and local laws, ordinances, rules, and regulations including business registration requirements of the Office of the Secretary of State. The Contractor will not receive payment for work found by the State to be unsatisfactory or performed in violation of federal, state, or local law.

## 6. Authorized Representative

The State's Authorized Representative is \_\_\_\_\_, or his/her successor, and has the responsibility to monitor the Contractor's performance and the authority to accept the services provided under this Contract. If the services are satisfactory, the State's Authorized Representative will certify acceptance on each invoice submitted for payment.

The Contractor's Authorized Representative is \_\_\_\_\_, or his/her successor. If the Contractor's Authorized Representative changes at any time during this Contract, the Contractor must immediately notify the State.

## 7. Assignment, amendments, waiver, and contract complete

**7.1 Assignment.** The Contractor may neither assign nor transfer any rights or obligations under this Contract without the prior consent of the State and a fully executed assignment agreement, executed and approved by the same parties who executed and approved this Contract, or their successors in office.

**7.2 Amendments.** Any amendment to this Contract must be in writing and will not be effective until it has been executed and approved by the same parties who executed and approved the original Contract, or their successors in office.

**7.3 Waiver.** If the State fails to enforce any provision of this Contract, that failure does not waive the provision or its right to enforce it.

**7.4 Contract complete.** This Contract contains all negotiations and agreements between the State and the Contractor. No other understanding regarding this Contract, whether written or oral, may be used to bind either party.

## 8. Indemnification

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

- a) Intentional, willful, or negligent acts or omissions; or
- b) Actions that give rise to strict liability; or
- c) Breach of contract or warranty.

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

## 9. State audits

Under Minn. Stat. § 16C.05, subd. 5, the Contractor's books, records, documents, and accounting procedures and practices relevant to this Contract are subject to examination by the State and/or the State Auditor or Legislative Auditor, as appropriate, for a minimum of six years from the end of this Contract.

## 10. Government data practices and intellectual property

**10.1 Government data practices.** The Contractor and State must comply with the Minnesota Government Data Practices Act, Minn. Stat. ch. 13, (or, if the State contracting party is part of the Judicial Branch, with the Rules of Public Access to Records of the Judicial Branch promulgated by the Minnesota Supreme Court as the same may be amended from time to time) as it applies to all data provided by the State under this Contract, and as it applies to all data created, collected, received, stored, used, maintained, or disseminated by the Contractor under this Contract. The civil remedies of Minn. Stat. § 13.08 apply to the release of the data governed by the Minnesota Government Practices Act, Minn. Stat. ch. 13, by either the Contractor or the State.

If the Contractor receives a request to release the data referred to in this clause, the Contractor must immediately notify and consult with the State's Authorized Representative as to how the Contractor should respond to the request. The Contractor's response to the request shall comply with applicable law.

**10.2 Intellectual property rights.**

(a) *Intellectual property rights.* The State owns all rights, title, and interest in all of the intellectual property rights, including copyrights, patents, trade secrets, trademarks, and service marks in the works and documents created and paid for under this Contract. The "works" means all inventions, improvements, discoveries (whether or not patentable), databases, computer programs, reports, notes, studies, photographs, negatives, designs, drawings, specifications, materials, tapes, and disks conceived, reduced to practice, created or originated by the Contractor, its employees, agents, and subcontractors, either individually or jointly with others in the performance of this Contract. "Works" includes documents. The "documents" are the originals of any databases, computer programs, reports, notes, studies, photographs, negatives, designs, drawings, specifications, materials, tapes, disks, or other materials, whether in tangible or electronic forms, prepared by the Contractor, its employees, agents, or subcontractors, in the performance of this Contract. The documents will be the exclusive property of the State and all such documents must be immediately returned to the State by the Contractor upon completion or cancellation of this Contract. To the extent possible, those works eligible for copyright protection under the United States Copyright Act will be deemed to be "works made for hire." The Contractor assigns all right, title, and interest it may have in the works and the documents to the State. The Contractor must, at the request of the State, execute all papers and perform all other acts necessary to transfer or record the State's ownership interest in the works and documents.

(b) *Obligations*

- (1) *Notification.* Whenever any invention, improvement, or discovery (whether or not patentable) is made or conceived for the first time or actually or constructively reduced to practice by the Contractor, including its employees and subcontractors, in the performance of this Contract, the Contractor will immediately give the State's Authorized Representative written notice thereof, and must promptly furnish the State's Authorized Representative with complete information and/or disclosure thereon.
- (2) *Representation.* The Contractor must perform all acts, and take all steps necessary to ensure that all intellectual property rights in the works and documents are the sole property of the State, and that neither Contractor nor its employees, agents, or subcontractors retain any interest in and to the works and documents. The Contractor represents and warrants that the works and documents do not and will not infringe upon any intellectual property rights of other persons or entities. Notwithstanding Clause 8, the Contractor will indemnify; defend, to the extent permitted by the Attorney General; and hold harmless the State, at the Contractor's expense, from any action or claim brought against the State to the extent that it is based on a claim that all or part of the works or documents infringe upon the intellectual property rights of others. The Contractor will be responsible for payment of any and all such claims, demands, obligations, liabilities, costs, and damages, including but not limited to, attorney fees. If such a claim or action arises, or in the Contractor's or the State's opinion is likely to arise, the Contractor must, at the State's discretion, either procure for the State the right or license to use the intellectual property rights at issue or replace or modify the allegedly infringing works or documents as necessary and appropriate to obviate the infringement claim. This remedy of the State will be in addition to and not exclusive of other remedies provided by law.

**11. Workers' compensation and other insurance**

Contractor certifies that it is in compliance with all insurance requirements specified in the solicitation document relevant to this Contract. Contractor shall not commence work under the Contract until they have obtained all the insurance specified in the solicitation document. Contractor shall maintain such insurance in force and effect throughout the term of the Contract.

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

**12. Debarment by State, its departments, commissions, agencies, or political subdivisions**

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

**13. Certification regarding debarment, suspension, ineligibility, and voluntary exclusion**

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

**14. Publicity and endorsement**

**14.1 Publicity.** Any publicity regarding the subject matter of this Contract must identify the State as the sponsoring agency and must not be released without prior written approval from the State's Authorized Representative.

For purposes of this provision, publicity includes notices, informational pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the Contractor individually or jointly with others, or any subcontractors, with respect to the program, publications, or services provided resulting from this Contract.

**14.2 Endorsement.** The Contractor must not claim that the State endorses its products or services.

**15. Governing law, jurisdiction, and venue**

Minnesota law, without regard to its choice-of-law provisions, governs this Contract. Venue for all legal proceedings out of this Contract, or its breach, must be in the appropriate state or federal court with competent jurisdiction in Ramsey County, Minnesota.

**16. Data disclosure**

Under Minn. Stat. § 270C.65, subd. 3 and other applicable law, the Contractor consents to disclosure of its social security number, federal employer tax identification number, and/or Minnesota tax identification number, already provided to the State, to federal and state agencies, and state personnel involved in the payment of state obligations. These identification numbers may be used in the enforcement of federal and state laws which could result in action requiring the Contractor to file state tax returns, pay delinquent state tax liabilities, if any, or pay other state liabilities.

**17. Payment to subcontractors**

(If applicable) As required by Minn. Stat. § 16A.1245, the prime Contractor must pay all subcontractors, less any retainage, within 10 calendar days of the prime Contractor's receipt of payment from the State for undisputed services provided by the subcontractor(s) and must pay interest at the rate of one and one-half percent per month or any part of a month to the subcontractor(s) on any undisputed amount not paid on time to the subcontractor(s).

**18. Termination**

**18.1 Termination by the State.** The State or Commissioner of Administration may cancel this Contract at any time, with or without cause, upon 30 days' written notice to the Contractor. Upon termination, the Contractor will be entitled to payment, determined on a pro rata basis, for services satisfactorily performed.

**18.2 Termination for insufficient funding.** The State may immediately terminate this Contract if it does not obtain funding from the Minnesota Legislature, or other funding source; or if funding cannot be continued at a level sufficient to allow for the payment of the services covered here. Termination must be by written or fax notice to the Contractor. The State is not obligated to pay for any services that are provided after notice and effective date of termination. However, the Contractor will be entitled to payment, determined on a pro rata basis, for services satisfactorily performed to the extent that funds are available. The State will not be assessed any penalty if the Contract is terminated because of the decision of the Minnesota Legislature, or other funding source, not to appropriate funds. The State must provide the Contractor notice of the lack of funding within a reasonable time of the State's receiving that notice.

**19. Non-discrimination (In accordance with Minn. Stat. § 181.59)**

The Contractor will comply with the provisions of Minn. Stat. § 181.59 which require:

*“Every contract for or on behalf of the state of Minnesota, or any county, city, town, township, school, school district, or any other district in the state, for materials, supplies, or construction shall contain provisions by which the contractor agrees:*

- (1) that, in the hiring of common or skilled labor for the performance of any work under any contract, or any subcontract, no contractor, material supplier, or vendor, shall, by reason of race, creed, or color, discriminate against the person or persons who are citizens of the United States or resident aliens who are qualified and available to perform the work to which the employment relates;*
- (2) that no contractor, material supplier, or vendor, shall, in any manner, discriminate against, or intimidate, or prevent the employment of any person or persons identified in clause (1) of this section, or on being hired, prevent, or conspire to prevent, the person or persons from the performance of work under any contract on account of race, creed, or color;*
- (3) that a violation of this section is a misdemeanor; and*
- (4) that this contract may be canceled or terminated by the state, county, city, town, school board, or any other person authorized to grant the contracts for employment, and all money due, or to become due under the contract, may be forfeited for a second or any subsequent violation of the terms or conditions of this contract.”*

**20. Affirmative action requirements for contracts in excess of \$100,000 and if the Contractor has more than 40 full-time employees in Minnesota or its principal place of business**

The State intends to carry out its responsibility for requiring affirmative action by its contractors.

**20.1 Covered contracts and contractors.** If the Contract exceeds \$100,000 and the Contractor employed more than 40 full-time employees on a single working day during the previous 12 months in Minnesota or in the state where it has its principal place of business, then the Contractor must comply with the requirements of Minn. Stat. § 363A.36 and Minn. R. 5000.3400-5000.3600. A contractor covered by Minn. Stat. § 363A.36 because it employed more than 40 full-time employees in another state and does not have a certificate of compliance, must certify that it is in compliance with federal affirmative action requirements.

**20.2 Minn. Stat. § 363A.36.** Minn. Stat. § 363A.36 requires the Contractor to have an affirmative action plan for the employment of minority persons, women, and qualified disabled individuals approved by the Minnesota Commissioner of Human Rights (“Commissioner”) as indicated by a certificate of compliance. The law addresses suspension or revocation of a certificate of compliance and contract consequences in that event. A contract awarded without a certificate of compliance may be voided.

**20.3 Minn. R. 5000.3400-5000.3600.**

- (a) General.* Minn. R. 5000.3400-5000.3600 implements Minn. Stat. § 363A.36. These rules include, but are not limited to, criteria for contents, approval, and implementation of affirmative action plans; procedures for issuing certificates of compliance and criteria for determining a contractor’s compliance status; procedures for addressing deficiencies, sanctions, and notice and hearing; annual compliance reports; procedures for compliance review; and contract consequences for non-compliance. The specific criteria for approval or rejection of an affirmative action plan are contained in various provisions of Minn. R. 5000.3400-5000.3600 including, but not limited to, Minn. R. 5000.3420-5000.3500 and 5000.3552-5000.3559.
- (b) Disabled Workers.* The Contractor must comply with the following affirmative action requirements for disabled workers.
  - (1) The Contractor must not discriminate against any employee or applicant for employment because of physical or mental disability in regard to any position for which the employee or applicant for employment is qualified. The Contractor agrees to take affirmative action to employ, advance in employment, and otherwise treat qualified disabled persons without discrimination based upon their physical or mental disability in all employment practices such as the following: employment, upgrading, demotion or transfer, recruitment, advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.
  - (2) The Contractor agrees to comply with the rules and relevant orders of the Minnesota Department of Human Rights issued pursuant to the Minnesota Human Rights Act.
  - (3) In the event of the Contractor's noncompliance with the requirements of this clause, actions for noncompliance may be taken in accordance with Minn. Stat. § 363A.36, and the rules and relevant orders of the Minnesota Department of Human Rights issued pursuant to the Minnesota Human Rights Act.
  - (4) The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices in a form to be prescribed by the Commissioner. Such notices must state the

Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified disabled employees and applicants for employment, and the rights of applicants and employees.

- (5) The Contractor must notify each labor union or representative of workers with which it has a collective bargaining agreement or other contract understanding, that the Contractor is bound by the terms of Minn. Stat. § 363A.36, of the Minnesota Human Rights Act and is committed to take affirmative action to employ and advance in employment physically and mentally disabled persons.
- (c) *Consequences.* The consequences for the Contractor's failure to implement its affirmative action plan or make a good faith effort to do so include, but are not limited to, suspension or revocation of a certificate of compliance by the Commissioner, refusal by the Commissioner to approve subsequent plans, and termination of all or part of this Contract by the Commissioner or the State.
- (d) *Certification.* The Contractor hereby certifies that it is in compliance with the requirements of Minn. Stat. § 363A.36 and Minn. R. 5000.3400-5000.3600 and is aware of the consequences for noncompliance.

**21. E-Verify certification (In accordance with Minn. Stat. § 16C.075)**

For services valued in excess of \$50,000, Contractor certifies that as of the date of services performed on behalf of the State, Contractor and all its subcontractors will have implemented or be in the process of implementing the federal E-Verify Program for all newly hired employees in the United States who will perform work on behalf of the State. Contractor is responsible for collecting all subcontractor certifications and may do so utilizing the *E-Verify Subcontractor Certification Form* available at <http://www.mmd.admin.state.mn.us/doc/EverifySubCertForm.doc>. All subcontractor certifications must be kept on file with Contractor and made available to the State upon request.

**[Signatures as required by the State.]**

SAMPLE

# Appendices

## Appendix A: Minnesota Accountable Health Model Glossary

### **2015 Mandate for Interoperable EHR**

The 2007 Minnesota Legislature mandated in Minnesota Statute §62J.495 (Electronic Health Record Technology), that “By January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee, shall develop a statewide plan to meet this goal, including uniform standards to be used for the interoperable system for sharing and synchronizing patient data across systems.”

Source: [Guidance for Understanding the Minnesota 2015 Interoperable EHR Mandate](http://www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf)  
(www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf)

### **Accountable Care**

The terms “accountable care” or “Accountable Care Organization,” or “ACO” are being used to reflect the concept of a group of diverse health care providers that have collective responsibility for patient care and that coordinate services. This term is meant to include the broad range of health and health care providers that are not formally part of an existing ACO as defined by the Centers for Medicare and Medicaid Services (CMS) or other payers, but that are also moving towards greater accountability for the quality and cost of care they provide to their patients.

Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models

### **Accountable Care Organizations (ACOs)**

An accountable care organization is a group of health care providers with collective responsibility for patient care that helps providers coordinate services—delivering high-quality care while holding down costs.

Source: [Robert Wood Johnson Foundation Accountable Care Organizations](http://www.rwjf.org/en/topics/search-topics/A/accountable-care-organizations-acos.html),  
(www.rwjf.org/en/topics/search-topics/A/accountable-care-organizations-acos.html)

### **Behavioral Health**

The term “behavioral health” is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders. Behavioral health includes the identification, treatment of, and recovery from mental health and substance use disorders. It also increasingly refers to lifestyle changes and actions which improve physical and emotional health, as well as the reduction or elimination of behaviors which create health risks.

Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models

### **Care Coordination**

Care coordination is a function that supports information-sharing across providers, patients, types and levels of service, sites and time frames. The goal of coordination is to ensure that patients’ needs and preferences are achieved and that care is efficient and of high quality. Care coordination is most needed by

persons who have multiple needs that cannot be met by a single clinician or by a single clinical organization, and which are ongoing, with their mix and intensity subject to change over time.

Source: U.S. Department of Health and Human Services, [www.ncvhs.hhs.gov/091013p9.pdf](http://www.ncvhs.hhs.gov/091013p9.pdf)

### **Care Coordinator**

A care coordinator is a person who has primary responsibility to organize and coordinate care and services for clients/patients served in a variety of settings, e.g. health care homes, behavioral health clinics, acute care settings and so on.

### **Care Manager**

A care manager is a person who has primary responsibility to organize and coordinate care based on a set of evidence-based, integrated clinical care activities that are tailored to the individual patient, and that ensure each patient has his or her own coordinated plan of care and services

### **Care Plan**

A care plan is the structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

### **Continuum of care**

The continuum of care is the full array of services, from prevention to treatment to rehabilitation and maintenance, required to support optimum health and well-being of a population.

Source: Adapted from [Alaska Health Care Commission](http://dhss.alaska.gov/ahcc/Documents/definitions.pdf) (<http://dhss.alaska.gov/ahcc/Documents/definitions.pdf>)

### **Data Analytics**

Data analytics is the systematic use of data and related business insights to drive fact-based decision making for planning, management, measurement and learning. Analytics may be descriptive, predictive or prescriptive.

Source: [IBM Institute for Business Value: The value of analytics in healthcare](https://www.ibm.com/smarterplanet/global/files/the_value_of_analytics_in_healthcare.pdf) ([https://www.ibm.com/smarterplanet/global/files/the\\_value\\_of\\_analytics\\_in\\_healthcare.pdf](https://www.ibm.com/smarterplanet/global/files/the_value_of_analytics_in_healthcare.pdf))

### **Electronic Health Records (EHR)**

EHR is a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting. EHR is considered more comprehensive than the concept of an Electronic Medical Record (EMR).

Source: [Office of the National Coordinator for HIT Health IT Glossary](http://www.hhs.gov/healthit/glossary.html) (<http://www.hhs.gov/healthit/glossary.html>)

### **Emerging professionals**

Emerging professionals include Community Health Workers, Community Paramedics, Dental Therapists and Advanced Dental Therapists, with possible future inclusion of other practitioners such as Doulas and Certified Peer Support Specialists.

### **E-health**

E-health is the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT) including health information exchange to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions.

Source: [Minnesota e-Health](http://www.health.state.mn.us/e-health/) (http://www.health.state.mn.us/e-health/)

### **Health Care Home**

A "health care home," also called a "medical home," is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.

Source: [Minnesota Department of Health Health Care Homes \(aka Medical Homes\)](http://www.health.state.mn.us/healthreform/homes/) (www.health.state.mn.us/healthreform/homes/)

### **Health Information Exchange (HIE)**

Health information exchange or HIE means the electronic transmission of health related information between organizations according to nationally recognized standards.

Source: [Minnesota Statutes §62J.498 sub. 1\(f\)](https://www.revisor.mn.gov/statutes/?id=62J.498) (https://www.revisor.mn.gov/statutes/?id=62J.498)

### **Health Information Technology (HIT)**

HIT is the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

Source: [Office of the National Coordinator for HIT Glossary](http://www.healthit.gov/policy-researchers-implementers/glossary) (http://www.healthit.gov/policy-researchers-implementers/glossary)

### **Integrated care**

Integrated care covers a complex and comprehensive field and there are many different approaches to and definitions of the concept. One overarching definition (Grone, O. and Garcia-Barbero, M. 2002) is integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.

### **Interoperability**

The ability of two or more information systems or components to exchange information and to use the information that has been exchanged accurately, securely, and verifiably, when and where needed.

Source: Office of the National Coordinator for HIT Glossary

## **Interprofessional Team**

Interprofessional Team, as defined in the Institute of Medicine's (IOM) Report, Health Professions Education: A Bridge to Quality, (2003) an interdisciplinary (Interprofessional) team is "composed of members from different professions and occupations with varied and specialized knowledge, skills, and methods." (p. 54) Members of an Interprofessional team communicate and work together, as colleagues, to provide quality, individualized care for patients.

## **Local Public Health**

In Minnesota, local public health services are provided through Community Health Boards, which have statutory responsibilities for public health (MN Stat. Chapter 145A), and by Tribal Governments, which are sovereign nations. Local public health responsibilities include prevention and control of communicable disease; protection from environmental health hazards; promoting healthy communities and healthy behaviors (including maternal and child health); preparing for and responding to public health emergencies; and assessing, and sometimes addressing gaps in health services. Local public health professionals carry out these activities in collaboration with multiple systems including schools, law enforcement, social services, municipalities, non-profits and private health care providers to coordinate high quality, non-duplicative programs.

Source: Adapted from [Minnesota Department of Health, Local Public Health Act](http://www.health.state.mn.us/divs/cfh/lph/) (http://www.health.state.mn.us/divs/cfh/lph/)

## **Long-Term and Post-Acute Care (LTPAC)**

Long Term and Post-Acute Care is characterized by a variety of settings, from complex care in long-term acute-care hospitals to supportive services in the community or home-based care. Typical services include rehabilitation, medical management, skilled nursing services, and assistance with activities of daily living due physical and/or cognitive impairments. Common types of LTPAC providers include but are not limited to: nursing facilities or skilled nursing facilities; home health agencies; hospice providers; inpatient rehabilitation facilities (IRFS); long-term acute care hospitals; assisted living facilities; continuing care retirement communities; home and community-based services; and adult day service providers.

Source: [U.S. Department of Health and Human Services, Opportunities For Engaging Long-Term and Post-Acute Care Providers in Health Information Exchange Activities](http://aspe.hhs.gov/daltcp/reports/2011/StratEng.pdf) (http://aspe.hhs.gov/daltcp/reports/2011/StratEng.pdf)

## **Minnesota e-Health Initiative**

The Minnesota e-Health Initiative is a public-private collaborative whose Vision is to accelerate the adoption and use of health information technology in order to improve health care quality, increase patient safety, reduce health care costs and improve public health.

Source: Minnesota Department of Health, [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/abouthome.html), (http://www.health.state.mn.us/e-health/abouthome.html)

## **Minnesota Model for EHR Adoption**

In 2008, the Minnesota e-Health Initiative developed the Minnesota Model for Adopting Interoperable EHRs that is applied to all aspects of the Initiative's work and policy development. The model has seven steps which are grouped into three major categories:

- Adopt, which includes the sequential steps of Assess, Plan and Select.
- Utilize, which involves implementing an EHR product and learning how to use it effectively.
- Exchange, including readiness to exchange information electronically with other partners, and implementing regular, ongoing exchange between interoperable EHR systems.

Source: [Minnesota e-Health Initiative: Report to the Minnesota Legislature 2013](http://www.health.state.mn.us/e-health/leg rpt2013.pdf), (www.health.state.mn.us/e-health/leg rpt2013.pdf)

### **Patient and Family Centered Care**

Patient and family centered care means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices. It also incorporates the participant's knowledge, values, beliefs, and cultural background into care planning and delivery. Patient and family-centered care applies to patients of all ages.

### **Population Health**

An aim to optimize the health and well-being of an entire community and reduce inequalities in health and well-being between population groups. A “community” may be either geographic regions and/or groups of people who share attributes (e.g., elderly, minorities, employees, disabled persons, students). Population health requires collaboration across all sectors of a community to address factors such as public infrastructure, the environment, education systems, social supports, and the health care system, in order to address all social determinants of health. Population health within an accountable care organization requires collaboration between all health care providers in the community, social support services within the community, and local public health.

Adapted from:

1. K Hacker, DK Walker. Achieving Population Health in Accountable Care Organizations, Am J Public Health. 2013; 103(7):1163-1167. <http://ajph.aphapublications.org/doi/ref/10.2105/AJPH.2013.301254>;
2. D Kindig, G Stoddart. What is population health? Am J Public Health. 2003;93(3):380–383; and
3. M Stoto. Population Health in the Affordable Care Act Era. AcademyHealth, February 2013. <http://www.academyhealth.org/files/AH2013pophealth.pdf>

### **Provider**

For purposes of SIM, the term “provider” is meant to include the broad notion of health care professionals within medicine, nursing, behavioral health, or allied health professions. Health care providers may also be a public/community health professional. Institutions include hospitals, clinics, primary care centers, long term care organizations, mental health centers, and other service delivery points.

Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models

### **Public Health**

Public health is the practice of preventing disease and promoting good health within groups of people, from small communities to entire countries. Public health also entails policy development and health surveillance. Public health professionals rely on policy and research strategies to understand issues such as infant mortality and chronic disease in particular populations. In Minnesota, Local public health

departments partner with multiple systems including schools, law enforcement, social services, municipalities, non-profits and private health care providers to coordinate programs.

Source:

1. American Public Health Association, [http://www.apha.org/NR/rdonlyres/C57478B8-8682-4347-8DDF-A1E24E82B919/0/what\\_is\\_PH\\_May1\\_Final.pdf](http://www.apha.org/NR/rdonlyres/C57478B8-8682-4347-8DDF-A1E24E82B919/0/what_is_PH_May1_Final.pdf);
2. Local Public Health Association of Minnesota, [http://www.lpha-mn.org/FactSheets/MN\\_Local%20Public%20Health%20System\\_LPHAfacts.pdf](http://www.lpha-mn.org/FactSheets/MN_Local%20Public%20Health%20System_LPHAfacts.pdf)

## **Social Services**

The system of programs, benefits and services made available by public, non-profit or private agencies that help people meet those social, economic, educational, and health needs that are fundamental to the well-being of individuals and families. Examples of social services, for the purposes of SIM, include but are not limited to organizations that provide housing, transportation, or nutritional services to individuals or families.

Source: Minnesota State Innovation Model Grant Request for Information on Health Information Technology and Data Analytics in Accountable Care Models

## **Summary of Care Record**

A summary of care record may include the following elements:

- Patient name
- Referring or transitioning provider's name and office contact information
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Reason for referral
- Current problem list (a list of current, active and historical diagnoses)
- Current medication list (a list of medications that a given patient is currently taking), and
- Current medication allergy list (a list of medications to which a given patient has known allergies)
- Diagnosis lists
- Advance directives
- Contact information; guardianship information
- Critical incident information relating to physical and/or mental/behavioral health.

**Transitions of Care**

The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Source: [CMS/EHR Incentive Program Menu Set Measures Measure 8 of 10-Transition of Care Summary](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/8_Transition_of_Care_Summary.pdf)  
([http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/8\\_Transition\\_of\\_Care\\_Summary.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/8_Transition_of_Care_Summary.pdf))

**Triple Aim**

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim": improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

Source: [Institute for Healthcare Improvement Triple Aim](http://www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx)  
([www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx](http://www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx))

# Appendix B: Cost Proposal Form

Request for Proposals

Minnesota Department of Health

Minnesota e-Health Roadmaps to Advance the Minnesota Accountable Health Model

Instructions: Complete the Cost Proposal Form by filling out Tables A - H and providing a narrative justification where requested. The narrative justification should include a description of the funds requested and how their use will support the proposal. Responder's may use/edit the provided form or create their own but must include all the information in a similar format.

<b>Table A. Personnel Budget and Justification</b>				
This should include all employees of the Responder whose work is tied to the proposal.				
Position	Name	Annual Salary/Rate	Level of Effort for Entire Length of the Contract	Cost
<b>Total</b>				
<b>Narrative Justification</b> <i>(enter a description of the personnel funds requested and how their use will support the purpose and goals of this proposal. Be sure to describe the role, responsibilities and unique qualifications of each position):</i>				

<b>Table B. Fringe Benefit Budget and Justification</b>			
List all components of fringe benefits rate including contributions for social security, employee insurance, pension plans, etc. Only those benefits not included in an organization's indirect cost pool may be shown as direct costs.			
Component	Rate	Wage	Cost
<b>Total</b>			
<b>Narrative Justification</b> <i>(enter a description of the Fringe funds requested, how the rate was determined, and how their use will support the purpose and goals of this proposal):</i>			

**Table C. Travel Budget and Justification**

Travel may include costs associated with travel for meetings, stakeholder engagement (reimbursement to stakeholder’s), and other items included in the work plan. The lowest available commercial fares for coach or equivalent accommodations must be used. Local travel policies prevail.

Purpose of Travel	Location	Item	Rate	Cost
<b>Total</b>				

**Narrative Justification** *(describe the purpose and need of travel and how costs were determined.):*

**Table D. Equipment Budget and Justification**

Permanent equipment is defined as nonexpendable personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more. If Responder defines “equipment” at lower rate, then follow the Responder’s policy.

Item(s)	Rate	Cost
<b>Total</b>		

**Narrative Justification** *(enter a description of the equipment and how its purchase will support the purpose and goals of this proposal):*

**Table E. Supplies Budget and Justification**

Materials costing less than \$5,000 per until and often having one-time use.

Item(s)	Rate	Cost
<b>Total</b>		

**Narrative Justification** *(enter a description of the supplies requested and how their purchase will support the purpose and goals of this proposal):*

**Table F. Contract Budget and Justification**

The costs of project activities to be undertaken by a third-party contractor should be included in this category as a single line item charge. A contract is generally the amount paid to non-employees for services or products. A consultant is a non-employee who provides advice and expertise in a specific program area. A complete itemization of the cost comprising the charge should be attached to the budget. If there is more than one contractor, each must be budgeted separately and must have an attached itemization.

Name	Role/Activity	Cost	Itemized Budget Included?
<b>Total</b>			

**Narrative Justification** (*explain the need for each agreement and how their use will support the purpose and goals of this proposal*):

**Table G. Other Budget and Justification**

Expenses not covered in any of the previous budget categories.

Item	Rate	Cost
<b>Total</b>		

**Narrative Justification** (*explain the need for each item and how their use will support the purpose and goals of this proposal. Be sure to break down costs into cost/unit: i.e. cost/square foot and explain the use of each item requested*):

**Table H. Total Costs**  
Include the total costs from Tables A – G.

<b>Category</b>	<b>Cost</b>
A. Personnel	
B. Fringe	
C. Travel	
D. Equipment	
E. Supplies	
F. Contractual	
G. Other	
H. Total Costs	