(1) **Immunizations**. By undertaking the following activity, the MCO will continue to work toward the goal that ninety percent (90%) of all infants should receive age-appropriate immunizations by age twenty-four (24) months:

(a) The MCO will work with the Minnesota Department of Health, the STATE, local public health agencies and other stakeholders to support the development of the northeastern Minnesota immunization registry through participation in the Community Health Information Collaborative (CHIC) immunization registry task force.

(C) **For other counties in the Non-Metro Area:** The MCO agrees to meet with the Local Agency to develop and discuss mutual objectives related to public health priorities.

Article. 7 Quality Assessment and Performance Improvement.

7.1 Quality Assessment and Performance Improvement Program. The MCO shall provide for a quality assessment and performance improvement program consistent with federal requirements under Title XIX of the Social Security Act, 42 CFR Part 438, and as required pursuant to Minnesota Statutes, Chapters 62D, 62M, 62N, 62Q and 256B and related rules, including Minnesota Rules, Part 4685.1105 to 4685.1130, and applicable NCQA "Standards and Guidelines for the Accreditation of Health Plans," as specified in this Contract.

The MCO shall have an ongoing quality assessment and performance improvement program for the services it furnishes to all Enrollees ensuring the delivery of quality health care.

7.1.1 Scope and Standards. The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR § 438, Subpart D, (access, structure and operations, and measurement and improvement). At least annually, the MCO must assess program standards to determine the quality and appropriateness of care and services furnished to all Enrollees. This assessment must include monitoring and evaluation of compliance with STATE and CMS standards and performance measurement.

7.1.2 Information System. The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement program. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data, and can achieve the following objectives:

(A) Collect data on Enrollee and Provider characteristics, and on services furnished to Enrollees;

(B) Ensure that data received from Providers is accurate and complete by:

(1) Verifying the accuracy and timeliness of reported data;

(2) Screening or editing the data for completeness, logic, and consistency; and

(3) Collecting service information in standardized formats to the extent feasible and appropriate.

(C) Make all collected data available to the STATE and CMS upon request.

7.1.3 Utilization Management. The MCO shall adopt a utilization management structure consistent with state regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans." Pursuant to 42 CFR § 438.240(b)(3), this structure must include an effective mechanism and written description to detect both under and over utilization of services.

(A) **Ensuring Appropriate Utilization**. The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO shall:

(1) Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.

(2) Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and over utilization.

(3) Examine possible explanations for all data not within thresholds.

(4) Analyze data not within threshold by medical group or practice.

(5) Take action to address identified problems of under and over utilization and measure the effectiveness of its interventions.

7.1.4 Special Health Care Needs. The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. If the MCO has in place an alternative mechanism(s), or is proposing a new mechanism(s) that meets or exceeds the requirements of section 7.1.4(A), the MCO must submit a written description to the STATE for approval. If the MCO's mechanism(s) have been approved by the STATE and there has been a material change, the MCO must timely submit a revised description to the STATE for approval.

(A) **Mechanism to Identify Persons with Special Health Care Needs.** The MCO must identify Enrollees that may need additional services through method(s) approved by the STATE.

(1) The MCO must analyze claim data for diagnoses and utilization (both under and over) patterns to identify Enrollees that may have special health care needs. At a minimum the MCO must quarterly analyze claim data to identify Enrollees eighteen (18) years and older for the following:

(a) Prevention Quality Indicators as described in the "Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions" by AHRQ for bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension and chronic pulmonary disease.

(b) Hospital emergency department utilization as determined by the MCO.

(c) Inpatient utilization stays for the MCO's identified key Minnesota Health Care Program diagnoses or diagnoses clusters.

(d) Hospital readmission for the same or similar diagnoses as defined by the MCO within a timeframe specified by the MCO.

(e) Individual Enrollee claims totaling more than one hundred thousand dollars ($100,000.00) per year.

(f) Home Care Services utilizations as determined by the MCO.

(2) In addition to claims data, the MCO may use other methods, such as: a) health risk assessment surveys; b) performance measures; c) medical record reviews; d) Enrollees receiving PCA services; e) requests for Service Authorizations; and/or f) other methods developed by the MCO or its Participating Providers.

(B) **Assessment of Enrollees Identified.** The MCO must implement mechanisms to assess Enrollees identified and monitor the treatment plan set forth by the MCO's treatment team, as applicable. The assessment must utilize appropriate Health Care Professionals to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.

(C) **Access to Specialists.** If the assessment determines the need for a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs.

(D) **Annual Reporting to the STATE.** The MCO shall incorporate into, or include as an addendum to, the MCO's Annual Quality Assessment and Performance Improvement Program Evaluation (as required in Contract section 7.1.8) a Special Health Care Needs summary describing efforts to identify Enrollees that may need additional services and the following items:

(1) The number of Adults identified in section 7.1.4(A) with special health care needs;

(2) Annual number of assessments completed by the MCO or referrals for assessments completed; and

(3) If the MCO adds the information in this section as an addendum, the addendum must include an evaluation of items 7.1.4(D).

7.1.5 Practice Guidelines. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for children, adolescents, prenatal care, young adults, and adult populations. The MCO must adopt, disseminate and apply practice guidelines consistent with the preventive care standards on child and adolescent immunization, well-child visits, chlamydia screening, breast cancer screening, and cervical cancer screening.

(A) **Adoption of practice guidelines**. The MCO shall: 1) adopt guidelines based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 2) consider the needs of the MCO Enrollees; 3) adopt in consultation with contracting Health Care Professionals; and 4) review and update them periodically, as appropriate.

(B) **Dissemination of guidelines**. The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to Enrollees and potential Enrollees.

(C) **Application of guidelines**. The MCO shall ensure that these guidelines are applied to decisions for utilization management, Enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.

(D) **Audit of Provider Compliance**. The MCO shall audit a reasonable sample of its Providers (by physician or clinic) to determine Provider compliance with the practice guidelines the MCO has chosen as priority to audit, using an appropriate data source. The MCO shall incorporate into, or include as an addendum to, the MCO's annual quality assessment and performance improvement program evaluation (as required in section 7.1.8) a written summary that shall include:

(1) How the MCO implemented section 7.1.5(A) through (C);

(2) All adopted guidelines, source of guidelines, date the guideline was reviewed and/or revised;

(3) Results of the audit; and

(4) Improvement strategies and/or necessary corrective action that will be undertaken.

(5) If the MCO adds the information in this section as an addendum, the addendum must include an evaluation of items 7.1.5(D), parts (1) through (4).

7.1.6 Credentialing and Recredentialing Process. The MCO shall adopt a uniform credentialing and recredentialing process and comply with that process consistent with state regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans." For organizational Providers, including hospitals, and Medicare certified home health care agencies, the MCO shall adopt a uniform credentialing and recredentialing process and comply with that process consistent with state regulations. Waiver service Providers and Personal Care Provider Organizations are exempt from this requirement.

(A) **Selection and Retention of Providers.** The MCO must implement written policies and procedures for the selection and retention of Providers.

(B) **Process for Credentialing and Recredentialing.** The MCO must follow a documented process for credentialing and recredentialing of those Providers who are subject to the credentialing and recredentialing process and have signed contracts or participation agreements with the MCO.

(C) **Discrimination Against Providers Serving High-Risk Populations.** The MCO is prohibited from discriminating against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

(D) **Sanction Review.** The MCO shall ensure prior to entering into or renewing an agreement with a Provider that the Provider: 1) has not been sanctioned for fraudulent use of federal or state funds by the U.S. Department of Health and Human Services, pursuant to 42 U.S.C. § 1320 a-7(a) or by the State of Minnesota; or 2) is not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines interpreting such order, or 3) is not an affiliate of such a Provider. The MCO shall not knowingly contract with such a Provider.

(E) **Restricting Financial Incentive.** The MCO may not give any financial incentive to a health care Provider based solely on the number of services denied or referrals not authorized by the Provider, pursuant to Minnesota Statutes, § 72A.20, subd. 33, and as required under 42 CFR § 417.479.

(F) **Provider Discrimination.** The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This section shall not be construed to prohibit the MCO from including Providers only to the extent necessary to meet the needs of the MCO's Enrollees or from establishing any measure designated to maintain quality and control costs consistent with the responsibilities of the MCO. If the MCO declines to include individuals or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision.

(G) **Affiliated Provider Access Standards.** The MCO shall require its Providers to meet the access standards required by section 6.16 of this Contract, and applicable state and federal laws. The MCO shall monitor, on a periodic or continuous basis, but no less than every twelve (12) months, the Providers' adherence to these standards.

7.1.7 Annual Quality Assurance Work Plan. On or before May 1st of the Contract Year, the MCO shall provide the STATE an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, Part 4685.1130, subpart 2, and current NCQA "Standards and Guidelines for the Accreditation of Health Plans". If the MCO chooses to substantively amend, modify or update its work plan at anytime during the year, it shall provide the STATE with material amendments, modifications or updates in a timely manner.

7.1.8 Annual Quality Assessment and Performance Improvement Program Evaluation. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations, and current NCQA "Standards and Guidelines for the Accreditation of Health Plans." This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standardized measures and MCO's performance improvement projects. The MCO must submit the written evaluation to the STATE by May 1st of the Contract Year.

7.2 Performance Improvement Projects (PIP). The MCO must conduct performance improvement projects designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Projects must comply with 42 CFR § 438.240(b)(1) and (d) and CMS protocol, entitled: "Conducting Performance Improvement Projects." The MCO is encouraged to participate in collaborative initiatives with the MCOs that coordinate PIP topics. The STATE will convene meetings with MCO representatives to discuss topics and options for collaborative PIPs.

7.2.1 New Performance Improvement Project Proposal. On or before September 1st of the Contract Year, the MCO must submit to the STATE for review and approval, a written description of the PIP MCO proposes to conduct beginning the first quarter of the next calendar year. The project proposal(s) must be consistent with CMS published protocol, entitled "Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects" and STATE requirements. The new PIP proposal(s) must include steps one through seven of the CMS protocol.

7.2.2 Performance Improvement Project Interim Progress Assessment. By December 1st of the Contract Year, the MCO must produce an interim performance improvement project report for each current project.

(A) The interim project report must include any changes to the project(s) protocol steps one through seven and steps eight through ten, as appropriate.

(B) If the MCO makes changes to the STATE-approved PIP success measure(s), the MCO shall submit changes to the STATE for approval.

(C) Upon the request of the STATE, the MCO shall make available to the STATE, or the STATE's designated review agency, a copy of the reports.

7.2.3 Final Performance Improvement Project Report. The MCO must submit to the STATE for review and approval, upon completion of each PIP, a final written report by September 1st of the Contract Year. The report must include any changes to protocol steps one through ten, as appropriate. Each completed project must have a separate report.

7.2.4 Performance Improvement Project Lifecycle. The project lifecycle must be based upon the project's measurement periodicity, such that, there are two measurement periods after the project has been demonstrated to have obtained a statistically significant improvement (p value of 0.05 or less). Implementation of the project must begin within the first quarter of the year following project approval.

7.2.5 Termination of a Performance Improvement Project. In the rare event that a project, after extensive MCO efforts to assess and correct barriers, fails to achieve statistical significance, the MCO may submit a written request to terminate the project. The request must demonstrate: 1) why the project was unable to result in significant improvement, sustained over time; 2) the MCO's efforts to resolve project barriers; and 3) an explanation of why these barriers were not addressed during the original proposal. The MCO is encouraged to provide information on how the project may have achieved "meaningful improvement" as defined by NCQA in the written termination request.

7.2.6 Performance Improvement Project Categories. The MCO shall propose a new PIP annually. PIP topics should address the full spectrum of clinical and nonclinical areas associated with the MCO and not consistently eliminate any particular subset of enrollees or topics when viewed over multiple years.

7.3 Disease Management Program. The MCO shall make available a Disease Management Program for its Enrollees with diabetes, asthma and heart disease.

7.3.1 Standards. The MCO's Disease Management Program shall be consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans" pursuant to the QI Standard Disease Management.

7.3.2 Waiver. If the MCO is able to demonstrate that a Disease Management Program: 1) is not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) will have a negative financial return on investment, the MCO may request that the STATE waive this requirement for the remainder of the Contract Year.

7.4 Enrollee Satisfaction Surveys. The STATE shall conduct an annual Enrollee satisfaction survey and, if necessary, the MCO shall cooperate with the entity arranged by the STATE to conduct the survey.

7.4.1 Enrollee Disenrollment Survey. Enrollee disenrollment, as measured by an ongoing survey conducted by the STATE or its designee in the manner required in Minnesota Statutes, Chapter 62J. The MCO shall cooperate with the STATE or its designee in collection activities as directed by the STATE.

7.5 External Quality Review Organization (EQRO). The MCO shall cooperate with the entity as arranged for by the STATE in an annual independent, external review of the quality of services furnished under this Contract, as required under 42 U.S.C. § 1396a(a)(30), and 42 CFR Part 438, Subpart E. Such cooperation shall include, but is not limited to: 1) meeting with the entity and responding to questions; 2) providing requested medical records and other data in the requested format; and 3) providing copies of MCO policies and procedures and other records, reports and/or data necessary for the external review.

7.5.1 Nonduplication of Mandatory External Quality Review (EQR) Activities. To avoid duplication, the STATE may use information collected from Medicare or private accreditation reviews in place of information collected by the EQRO, when the following required terms are met:

(A) Complies with federal requirements (42 CFR § 438.360);

(B) CMS or accrediting standards are comparable to standards established by the STATE and identified in the STATE's Quality Strategy;

(C) MCOs must have received an NCQA accreditation rating of excellent, commendable or accredited; and

(D) All Medicare or accrediting reports, findings and results, related to services provided under this Contract, are provided to the STATE.

7.5.2 Exemption from EQR. The MCO may request from the STATE an exemption to the EQR, if the MCO meets federal requirements (42 CFR § 438.362) and is approved by the STATE.

7.5.3 Review of EQRO Annual Technical Report Prior to Publication. The STATE shall allow the MCO to review a final draft copy of the EQRO Annual Technical Report prior to the date of publication. The MCO shall provide the STATE written comments about the report, including comments on its scientific soundness or statistical validity, within thirty (30) days of receipt of the final draft report. The STATE shall include a summary of the MCO's written comments in the final publication of the report, and may limit the MCO's comments to the report's scientific soundness and/or statistical validity.

7.5.4 EQRO Recommendation for Compliance. Pursuant to 42 CFR § 438.364(a)(5), the MCO shall effectively address recommendations for improving the quality of health care services made by the EQRO in the Annual Technical Report for obligations under this Contract.

7.6 Delegation of Quality Improvement Program Activities. The MCO shall meet the requirements for delegation as specified in section 9.3.6 for any delegated activities related to quality improvement.

7.7 Documentation of Care Management. The MCO shall maintain documentation sufficient to support its Care Management responsibilities set forth in section 6.1.3. Upon the reasonable request of the STATE, the MCO shall make available to the STATE, or the STATE's designated review agency, access to a sample of Enrollee Care Management plan documentation.

7.8 Inspection. The MCO shall provide that the STATE, CMS or their agents may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services or administrative procedures performed under this Contract.

7.9 Committee Participation. The MCO shall appoint a representative to participate in the STATE's advisory committees as follows:

(A) Quality Technical Committee covering EQR activities, surveys, Quality Strategy, and

(B) The collaborative quality improvement committee, covering measurement alignment, collaborative and priority initiatives.

7.10 Financial Performance Incentives.

7.10.1 Compliance. All incentives outlined in this section must comply with the federal managed care incentive arrangement requirements pursuant to 42 CFR § 438.6(c)(1)(iv); (2)(i); (4)(ii) and (iv); (5)(iii) and (iv) and the State Medicaid Manual (SMM) 2089.3.

7.10.2 Limit. The total of all payments paid to the MCO under this Contract shall not exceed 105% of the Capitation Payments pursuant to 42 CFR § 438.6(c)(5)(iii), as applicable to each group of rate cells covered under the incentive arrangement. If the incentive applies to the entire population covered under the Contract, the limit will apply in aggregate.

7.10.3 Method. Financial Performance Incentives for Well-Child Care Accessibility (section 7.10.6), Preventive Care (section 7.10.8) and Developmental and Mental Health Screenings (section 7.10.9) will be calculated from: (1) encounter data submitted by the MCO to the STATE no later than May 31st of the year subsequent to the Contract Year; (2) additional data sources approved by the STATE and in the STATE's possession; or (3) as otherwise stated below. A description of how Well-child, Lead Screening, Preventive Care and Developmental and Mental Health Screening incentives are calculated by the STATE are available on the DHS Managed Care website at: www.dhs.state.mn.us/dhs16_139763.

7.10.4 Collaboratives. MCOs are encouraged to join with other MCOs in collaborative initiatives to expand these preventive services.

7.10.5 Additional Incentive. When a MCO expands services ten (10) or more percentage points above the previous year's base rate for Well Child, Lead, or Preventive screenings, the State will pay one hundred and fifty percent (150%) of the unit incentive rate specified for each eligible incentive. This higher rate will apply to the full expansion of services. For example: the Breast Cancer Screening expansion incentive would be seventy-five dollars ($75) instead of fifty dollars ($50) if the expansion of services is ten percentage points or more over the previous year's base rate.

7.10.6 Well-Child Primary Care Accessibility Incentive.

(A) The MCO may be eligible for a financial performance incentive payment based on the MCO's well-child and lead screening services as reported in encounter data pursuant to section 3.5.1. The payment will depend on the MCO's access rate to well-child services among unduplicated Medical Assistance, MinnesotaCare and MinnesotaCare/Medical Assistance Enrollees age birth (0) through age twenty (20) under this Contract. For purposes of this section, "recipient" means an Enrollee who received any well-child service from the MCO during the Contract Year for sections 7.10.6(B)(1) and 7.10.6(B)(2); any "well-child service" means services which are billed using the codes determined to be well-child visits, provided by the STATE; well-child services "access rate", means the number of unduplicated Medical Assistance, MinnesotaCare and MinnesotaCare/MA recipients per one thousand (1,000) Enrollee months who received a well-child service during the Contract Year for sections 7.10.6(B)(1) and 7.10.6(B)(2).

(B) The MCO's incentive payment, if any, shall depend upon the increase in the access rate achieved by the MCO in the Contract Year. The STATE shall pay the MCO the incentive payment, if any, on the next available warrant sixty (60) days after the finalization of the encounter data submission.

(1) Well-Child Visits.

(a) If the MCO has an access rate for the Contract year equal to or below its access rate for the year preceding the Contract Year, the MCO shall not receive an incentive payment for that respective year.

(b) If, in the Contract Year, the MCO exceeds the well-child access rate for the year preceding the Contract Year, the MCO incentive payment will equal: the number of recipients per one thousand (1,000) Enrollee months in the Contract Year, minus the number of recipients per one thousand (1,000) Enrollee months in the year preceding the Contract Year, multiplied by the number of Enrollee months in the Contract Year, divided by one thousand (1,000), multiplied by ninety dollars ($90.00).

(c) Access rate calculations shall be computed as whole recipient numbers per one thousand (1,000) Enrollee months.

(2) Lead Screening.

(a) The MCO may receive an incentive payment if it provides a lead screening test (max of two (2) blood lead screening tests per child) to Children age nine (9) months through age thirty (30) months for the contract year. A lead screening blood test is defined by the STATE as a blood test submitted with a CPT code of 83655.

(b) The MCO may receive fifty dollars ($50.00) for each lead screening blood test performed, up to two (2) lead screening blood tests per unduplicated Child, in accordance with C&TC Screening Guidelines.

(c) The amount of the incentive payment, if any, will be equal to; the number of Enrollees for the Contract Year multiplied by the lead screening rate for the year preceding the Contract Year, subtracted from the number of tests provided during the Contract Year times fifty dollars ($50.00) per test.

(d) The lead screening incentive shall be computed from encounter data submitted by the MCO pursuant to and received by the STATE for lead screening blood tests with dates of services in the Contract Year. MDH lead data will be used in the calculation in addition to encounter data.

(e) The lead screening incentive calculations shall be computed as whole numbers.

(f) The STATE shall pay the MCO the incentive payment, if any, on the next available warrant sixty (60) days after the finalization of the encounter data submission.

7.10.7 Critical Access Dental Incentive Payment.

(A) The MCO shall participate in a dental access initiative whereby the MCO agrees to incent designated dentists to provide increased dental services for Medical Assistance and MinnesotaCare Enrollees in accordance with the following:

(1) **Designation of Critical Access Dental Providers**. The STATE shall provide to the MCO a list of dental Providers eligible for the critical access dental designation no later than December 1st of the year preceding the Contract Year. The list will also identify those Providers the STATE proposes to designate for the critical access dental payments. The MCO shall review the list and provide to the STATE information on those Providers the MCO recommends for critical access dental designation no later than ten (10) business days from the date of receipt of the list. The STATE will determine the final list of critical access dental designations and provide that list to the MCO no later than December 31st of the year preceding the Contract Year.

(2) **Quarterly Reporting of MCO's Dental Payments to Designated Critical Access Dental Providers.** The MCO shall provide for each quarter, no later than the 15th of the month following the end of the quarter, the total payment amount the MCO paid to the specific designated critical access dental Provider in a format specified by the STATE. Payments made under the major programs Non-citizen Medical Assistance (NM) and General Assistance Medical Care (GM) shall be excluded from the report. For each Provider listed, the MCO shall report payments for the major programs Medical Assistance and MinnesotaCare separately. The report must be certified in accordance with section 9.16.

(3) Critical Access Dental Payments to Designated Critical Access Dental Providers.

(a) The STATE shall calculate the critical access dental payment for each designated Provider identified in the MCO's quarterly report and provide to the MCO a payment schedule that will identify the amount of critical access dental payment to be paid to each designated Provider.

(b) For Medical Assistance covered services, this amount shall be thirty percent (30%) more than the amount that was reported by the MCO on its quarterly report. Effective April 1, 2010, the Medical Assistance critical access dental incentive payment will be suspended. No payments will be issued for the Medical Assistance critical access dental incentive payments for dates of service on and after April 1, 2010.

(c) For MinnesotaCare covered services, this amount shall be fifty percent (50%) more than the amount that was reported by the MCO on its quarterly report.

(d) The STATE will issue a gross payment adjustment to the MCO which will be the sum of the critical access dental payment amounts for the Providers identified in the quarterly report. The MCO shall distribute the critical access dental payments as specified in the STATE's payment schedule.

7.10.8 Preventive Care Incentives. The MCO may be eligible for a financial performance incentive payment based on the MCO's preventive care services as reported in the encounter data pursuant to section 3.5.1, for services with dates of service in the Contract Year. The incentive payment, if any, shall depend upon the increase in unduplicated preventive care services provided to Medical Assistance, MinnesotaCare and MinnesotaCare/Medical Assistance Enrollees in the Contract year. The STATE shall pay the MCO the incentive payment, if any, on the next available warrant sixty (60) days after the finalization of the encounter data submission.

If for any measure, the Contract year preventive care incentive rate is equal to or below the rate for the year preceding the Contract Year, the MCO shall not receive an

incentive payment for that measure. The rates shall be calculated as a whole number per one thousand (1,000) Enrollee months.

(A) **Chlamydia Screening of Women Sixteen (16) through Twenty-Four (24).** The rate of sexually active women age sixteen (16) through twenty-four (24) who had at least one test for Chlamydia during the Contract Year. If the rate for the Contract Year exceeds the rate for the year preceding the Contract Year, the MCO will receive an incentive payment equal to: the number of eligible women per one thousand (1000) Enrollee months in the Contract Year, minus the number of eligible women per one thousand (1000) Enrollee months in the year preceding the Contract Year, multiplied by the number of Enrollee months in the Contract Year, divided by one thousand (1000), multiplied by fifty dollars ($50.00).

(B) **Breast Cancer Screening.** The rate of women, age forty (40) through sixty-four (64) years, who had a mammogram during the Contract Year or prior measurement year. If the rate for the Contract Year exceeds the rate for the year preceding the Contract Year, the MCO will receive an incentive payment equal to: the number of eligible women per one thousand (1,000) Enrollee months in the Contract Year, minus the number of eligible women per one thousand (1,000) Enrollee months in year preceding the Contract Year, multiplied by the number of Enrollee months in the Contract Year, divided by one thousand (1,000), multiplied by fifty dollars ($50.00).

7.10.9 Developmental and Mental Health Screening Incentives. The MCO may be eligible for a financial performance incentive payment based on the MCO's developmental and mental health screenings as reported in the encounter data pursuant to section 3.5.1, no later than May 31st of the year subsequent to the Contract Year, for services with dates of service in the Contract Year. The incentive payment, if any, shall depend upon the increase in unduplicated developmental and mental health screening services provided to Medical Assistance, MinnesotaCare and MinnesotaCare/Medical Assistance Enrollees in the Contract Year. The STATE shall pay the MCO the incentive payment, if any, on the next available warrant sixty (60) days after the finalization of the encounter data submission.

(A) **Child Developmental Screening.** The rate of children age birth (0) through six (6) years of age, who received a standardized objective developmental screening during the Contract year and which is billed using CPT code 96110. If the Contract Year development screening incentive rate, is equal to or below its rate for the year preceding the Contract Year, the MCO shall not receive an incentive payment for that respective year. If the rate is greater then the rate for the year preceding the Contract Year, the amount of the incentive payment, if any, will be equal to: the number of Enrollees for the Contract Year's rate minus the rate of the year preceding the Contract Year, multiplied per one thousand (1,000) Enrollee months for the Contract Year, times twenty-five dollars ($25.00) per screening. The rates shall be calculated as a whole number per one thousand (1,000) Enrollee months.

(B) **Child Mental Health Screening.** The rate of children age birth (0) through twenty (20) years of age, who received a standardized mental health screening during the Contract Year and billed using CPT code 96110 with a UC modifier. If the Contract year mental health screening incentive rate, is equal to or below its rate for the year preceding the Contract Year, the MCO shall not receive an incentive payment for that respective year. If the rate is greater then the rate for the year preceding the Contract Year, the amount of the incentive payment, if any, will be equal to: the number of Enrollees for the Contract Year's rate minus the rate of the year preceding the Contract Year, multiplied per one thousand (1,000) Enrollee months for the Contract Year, multiplied by twenty-five dollars ($25.00) per screening. The rates shall be calculated as a whole number per one thousand (1,000) Enrollee months.

7.10.10 Pay for Performance. The MCO shall cooperate with the STATE to develop and implement a pay-for-performance model for rewarding Providers for chronic disease care.

(A) The STATE, as a member of the guiding coalition for the Minnesota Bridges to Excellence (BTE) health care quality initiative, has contracted with the Buyers Health Care Action Group (BHCAG) to implement the pay-for-performance BTE program. All private payers and the STATE participating in the pay-for-performance program contribute incentive payments based on the payer's proportionate share of Enrollees served by the clinics or medical groups.

(B) BHCAG calculates the incentive payment annually and provides a report to the MCOs and the State. As a participant in the program, the STATE pays the incentive reward payments to the MCO based on criteria established by BHCAG. The MCOs pay to BHCAG the same incentive reward payment. BHCAG then distributes the appropriate payment to the eligible clinics or medical groups based on their performance level of providing optimal chronic disease care.

(C) In order to receive the annual pay-for-performance reward, the MCO contracted clinic or medical group must have achieved optimal chronic disease care for a designated percentage of its patients, as determined by BHCAG. The pay-for-performance projects are limited to:

(1) Diabetes Care, and

(2) Coronary/Vascular Disease Care.

7.11 MN Community Measurement (MNCM). The STATE will work with MDH and the marketplace of purchasers and Providers on the development and application of the MN Community Measurement.