Department of Health

Proposed Permanent Rules Relating to Health Care Homes

4764.0010 APPLICABILITY AND PURPOSE.

Subpart 1. **Applicability.** ~~Parts 4764.0010 to 4764.0070 apply~~ This chapter applies to an eligible provider ~~that is an applicant~~ seeking health care home certification or ~~is~~ a certified ~~as a~~ health care home.

Subp. 2. **Purpose.** ~~Parts 4764.0010 to 4764.0070 establish~~ This chapter establishes the foundational level standards and procedures for certification of health care homes. This chapter also establishes the level 2 and level 3 standards and procedures for certifying health care homes that meet requirements for advanced primary care functions beyond the foundational level.

A. The purpose of the foundational level standards is to require health care homes to deliver services that:

~~A.~~ (1) facilitate consistent and ongoing communication among the health care home and the patient and family, and provide the patient with continuous access to the patient's health care home;

~~B.~~ (2) use an electronic, searchable patient registry that enables the health care home to manage health care services, provide appropriate follow-up, and identify gaps in patient care;

~~C.~~ (3) include care coordination that focuses on patient and family-centered care;

~~D.~~ (4) include ~~a~~ care plan strategies for ~~selected~~ patients ~~with a chronic or complex condition,~~ and involve the patient and, if appropriate, the patient's family in the care planning process; and

~~E.~~ (5) reflect continuous improvement in the quality of the patient's experience, the patient's health outcomes, and the cost-effectiveness of services.

B. The purpose of the level 2 standard is to establish requirements for certified health care homes that choose to achieve certification for performance beyond the foundational level standards. Level 2 standards recognize a health care home's increasing capacity to:

(1) improve population health management processes that affect whole person care including health equity;

(2) improve wellness and early prevention; and

(3) strengthen partnerships across the medical provider network and community support system.

C. The purpose of the level 3 standard is to establish requirements for certified health care homes that choose to achieve certification for performance beyond the foundational and level 2 standards. Level 3 standards recognize a health care home's increasing capacity to:

(1) broaden the focus of a health care home to include community efforts toward population health improvement including health equity; and

(2) develop shared responsibility for population health improvement including use of health data.

4764.0020 DEFINITIONS.

Subpart 1. **Scope.** The terms used in ~~parts 4764.0010 to 4764.0070~~ this chapter have the meanings given them in this part.

Subp. 2. [See repealer.]

Subp. 3. **Care coordination.** "Care coordination" means a team approach that engages the ~~participant~~ patient, the personal clinician or local trade area clinician, and other members of the health care home team to enhance the ~~participant's~~ patient's well-being by organizing

timely access to resources and necessary care that results in continuity of care and builds trust.

Subp. 4. [See repealer.]

Subp. 5. **Care coordinator.** "Care coordinator" means a person who has primary responsibility to organize and coordinate care with the ~~participant~~ patient and family in a health care home.

Subp. 6. **Care plan.** "Care plan" means an individualized written document, including an electronic document, to guide a ~~participant's~~ patient's care.

Subp. 7. [See repealer.]

[For text of subparts 8 to 11, see Minnesota Rules]

Subp. 12. [See repealer.]

[For text of subparts 13 to 17, see Minnesota Rules]

Subp. 18. **Evidence-based ~~guidelines~~ practice.** "Evidence-based ~~guidelines~~ practice" means ~~clinical practice guidelines that are recognized by the medical community for achieving positive health outcomes and are based on scientific evidence and other authoritative sources, such as clinical literature~~ the integration of best research evidence with clinical expertise and patient values.

Subp. 19. **External care plan.** "External care plan" means a care plan created for a ~~participant~~ patient by an entity outside of the health care home such as a school-based individualized education program, a case management plan, a behavioral health plan, or a hospice plan.

[For text of subpart 20, see Minnesota Rules]

Subp. 21. **Health care home.** "Health care home" means a clinic, personal clinician, or local trade area clinician that is certified under ~~parts 4764.0010 to 4764.0070~~ this chapter.

Subp. 22. **Health care home learning collaborative or collaborative.** A "health care home learning collaborative" or "collaborative" means an organization established under Minnesota Statutes, section 256B.0751, subdivision 5, in which health care home team members and ~~participants from different health care~~ patients and other organizations that provide health care and community-based services to work together in a structured way to improve the quality of their services by learning ~~about best practices and quality methods,~~ and sharing experiences.

Subp. 22a. **Health care home services.** "Health care home services" means accessible, continuous, comprehensive, and coordinated care that is delivered in the context of family and community, and furthers patient-centered care.

Subp. 23. **Health care home team or care team.** "Health care home team" or "care team" means a group of health care professionals who plan and deliver patient care in a coordinated way through a health care home in collaboration with a ~~participant~~ patient. The care team includes at least a personal clinician or local trade area clinician and the care coordinator and may include other members and health professionals based on the ~~participant's~~ patient's needs.

Subp. 23a. **Health disparities.** "Health disparities" means preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

Subp. 23b. **Health equity.** "Health equity" means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

Subp. 23c. **Health inequities.** "Health inequities" are avoidable inequalities in health between groups of people within countries and between countries.

Subp. 23d. **Health literacy.** "Health literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Subp. 23e. **Integrated care.** "Integrated care" means a team-based model of care, based on the representatives of different disciplines and their expertise, to care for a shared population. The team collaborates with the patient and the patient's family to develop a shared plan of care that reflects patient-centered health outcomes and preferences.

[For text of subpart 24, see Minnesota Rules]

Subp. 24a. **Minnesota statewide quality reporting and measurement system.** "Minnesota statewide quality reporting and measurement system" means a system created through chapter 4654 that requires physician clinics and hospitals to submit data on a set of quality measures and establishes a standardized set of quality measures for health care providers across the state.

[For text of subpart 25, see Minnesota Rules]

Subp. 26. ~~**Participant**~~ **Patient.** ~~"Participant"~~ "Patient" means ~~the patient~~ a person and, where applicable, the ~~patient's~~ person's family, who has elected to receive care through a health care home.

Subp. 27. **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~~ patient perspectives and choices. It also incorporates the ~~participant's~~ patient's knowledge, values, beliefs, and cultural background into care planning and delivery. Patient and family-centered care applies to patients of all ages.

Subp. 27a. **Patient engagement.** "Patient engagement" means a concept that combines a patient's knowledge, skills, ability, and willingness to manage the patient's care with interventions and strategies designed to promote active and competent participation.

[For text of subpart 28, see Minnesota Rules]

Subp. 28a. **Population health.** "Population health" means the health outcomes of a group of individuals, including the distribution of health outcomes within the group.

Subp. 28b. **Population health improvement.** "Population health improvement" means efforts to improve health, well-being, and equity for a defined population or a group of people who live in a geographically defined area such as a neighborhood, city, or county.

[For text of subpart 29, see Minnesota Rules]

Subp. 30. [See repealer.]

[For text of subpart 31, see Minnesota Rules]

Subp. 32. **Primary care services patient population.** "Primary care services patient population" means all of the patients who are receiving primary care services from the health care home~~, regardless of whether a patient has chosen to participate in the health care home~~.

Subp. 33. [See repealer.]

Subp. 34. **Shared decision making.** "Shared decision making" means the mutual exchange of information between the ~~participant~~ patient and the provider or delegated care team member to assist with understanding the risks, benefits, and likely outcomes of available health care options so the patient and family or primary caregiver are able to actively participate in decision making.

Subp. 34a. **Social determinants of health.** "Social determinants of health" are the conditions in which people are born, grow, live, work, and age. The distribution of money, power, and resources at global, national, and local levels shapes these circumstances. The

social determinants of health are mostly responsible for health inequities, which are the unfair and avoidable differences in health status seen within and between countries.

Subp. 35. **Specialist.** "Specialist" means a health care provider or other person with specialized health training ~~not available within~~ who may be available on-site as part of the health care home care team or outside of the health care home. This includes traditional medical specialties and subspecialties. It also means individuals with special training such as chiropractic, mental health, nutrition, pharmacy, social work, health education, or other community-based services.

[For text of subpart 36, see Minnesota Rules]

Subp. 37. [See repealer.]

Subp. 38. **Variance.** "Variance" means a specified alternative or an exemption from compliance to a requirement in ~~parts 4764.0010 to 4764.0070~~ this chapter granted by the commissioner according to the requirements of part 4764.0050.

Subp. 39. **Whole person care.** "Whole person care" means primary care focused on the patient's physical, emotional, psychological, and spiritual well-being, as well as cultural, linguistic, and social needs, including needs related to communities in which patients self-identify.

4764.0030 CERTIFICATION AND RECERTIFICATION PROCEDURES.

Subpart 1. **Eligibility for certification.**

[For text of item A, see Minnesota Rules]

B. A clinic will be certified only if all of the clinic's personal clinicians and local trade area clinicians meet the requirements for participation in the health care home. It is the clinic's responsibility to ~~notify the department when a new clinician joins a certified clinic and intends to become a certified clinician~~ orient new clinicians and staff to the health

care home's care delivery approach. ~~The clinic has 90 days from the date of hiring the new clinician or until its next annual anniversary date to apply for recertification, whichever is sooner. A clinic may operate as a certified clinic with the new clinician acting as though certified until the new clinician is certified. If the clinician chooses not to be certified, the clinic will no longer be certified, but the clinicians who were previously certified as part of the clinic will automatically hold an individual certification only.~~

Subp. 2. **Contents of application.** The ~~applicant~~ eligible provider must submit the following to the commissioner:

A. a completed self-assessment ~~in a form~~ prescribed by the commissioner ~~which~~ and made available on the Department of Health website that describes how the ~~applicant~~ eligible provider meets the requirements in part 4764.0040;

B. a completed ~~and signed~~ application ~~form~~ prescribed by the commissioner and made available on the Department of Health website; and

C. any other information required by the commissioner to show that the ~~applicant~~ eligible provider meets the standards for certification or recertification.

Subp. 3. **On-site review and additional documentation.** The commissioner may conduct an on-site review and may request additional documentation to determine whether the ~~applicant~~ eligible provider or health care home complies with certification or recertification requirements.

[For text of subpart 4, see Minnesota Rules]

Subp. 5. **How to seek recertification.** To retain certification, a health care home must ~~submit a letter of~~ indicate its intent ~~stating its desire~~ to be recertified no later than 60 days before the ~~one-year~~ three-year anniversary of its last certification or recertification and do the following:

~~A. At the end of year one, an applicant must demonstrate:~~

A. ~~(1)~~ continue to meet the requirements for initial certification ~~continue to be met~~; ~~and~~

B. ~~(2)~~ meet the recertification requirements for ~~the end of year one for~~ each health care home standard in part 4764.0040 ~~are met.~~, and the requirement that the health care home achieves outcomes in its primary care services patient population for patient health, patient experience, and cost-effectiveness as established by the commissioner under subpart 6; and

C. continue to meet the requirements for level 2 and level 3 certification, if applicable.

~~B. At the end of year two and all subsequent years, unless the applicant obtains a variance for superior outcomes and continued progress on standards as provided in part 4764.0050, subpart 3, an applicant must demonstrate:~~

~~(1) the requirements for initial certification and recertification at the end of year one continue to be met; and~~

~~(2) the requirements for recertification at the end of year two in part 4764.0040, subpart 11, are met, including the requirement that the applicant's outcomes in its primary care services patient population achieve the benchmarks for patient health, patient experience, and cost-effectiveness established by the commissioner under subpart 6.~~

Subp. 5a. **How to seek certification as a level 2 or level 3 health care home.** The eligible provider or health care home may indicate its intent to seek level 2 or level 3 certification at the time of certification or at any time following certification as a health care home. The eligible provider or health care home must demonstrate how they have met the level 2 or level 3 requirements according to part 4764.0040 and do the following:

A. meet all foundational level certification and recertification requirements;

B. address how the health care home is working to resolve any outstanding requirements and corrective action plans, if applicable; and

C. if requested, participate in an on-site review and provide additional information or documentation necessary for the commissioner to make the determination that the health care home should be certified at level 2 or level 3.

[For text of subpart 6, see Minnesota Rules]

Subp. 7. **Notice of decision and timelines.**

A. The commissioner must notify an ~~applicant~~ eligible provider or health care home in writing regarding whether the ~~applicant~~ eligible provider or health care home is certified or recertified as a health care home or certified at level 2 or level 3 within 90 days after receiving a completed application.

~~B. If the commissioner certifies or recertifies the applicant as a health care home, the health care home is eligible for per-person care coordination payments under the care coordination payment system.~~

~~C.~~ B. If the commissioner denies the application for certification or recertification, the commissioner must notify the ~~applicant~~ eligible provider or health care home in writing of the reasons for the denial. The ~~applicant~~ eligible provider or health care home may file an appeal under part 4764.0060.

4764.0040 HEALTH CARE HOME STANDARDS.

Subpart 1. **Access and communication standard; certification requirements.** The ~~applicant for certification~~ health care home must have a system in place to support effective communication among the members of the health care home team, the ~~participant~~ patient and family, ~~and~~ other providers, and care team members. The ~~applicant~~ health care home must do the following:

A. offer ~~the applicant's~~ health care home services to all of the ~~applicant's patients who~~ primary care services population that includes:

(1) identifying patients who have or are at risk of developing complex or chronic conditions; ~~and~~

(2) ~~are interested in participation~~ offering varying levels of coordinated care to meet the needs of the patient; and

(3) offering more intensive care coordination for patients with complex needs;

B. establish a system designed to ensure that:

(1) ~~participants are informed~~ the health care home informs the patient that they have continuous access to designated clinic staff, an on-call provider, or a phone triage system;

(2) the designated clinic staff, on-call provider, or phone triage system representative has continuous access to ~~participants'~~ patients' medical record information, which must include the following for each ~~participant~~ patient:

(a) the ~~participant's~~ patient's contact information, personal clinician's or local trade area clinician's name and contact information, and designated enrollment in ~~a health care home~~ intensive care coordination services;

(b) the ~~participant's~~ patient's racial or ethnic background, primary language, and preferred means of communication;

(c) the ~~participant's~~ patient's consents and restrictions for releasing medical information; and

(d) the ~~participant's~~ patient's diagnoses, allergies, medications ~~related to chronic and complex conditions~~, and whether a care plan has been created for the ~~participant~~ patient; and

(3) the designated clinic staff, on-call provider, or phone triage system representative who has continuous access to the ~~participant's~~ patient's medical record information will determine when scheduling an appointment for the ~~participant~~ patient is appropriate based on:

(a) the acuity of the ~~participant's~~ patient's condition; and

(b) application of a protocol that addresses whether to schedule an appointment within one business day to avoid unnecessary emergency room visits and hospitalizations;

C. collect information about ~~participants'~~ patients' cultural background, racial heritage, and primary language and describe how the ~~applicant~~ health care home will apply this information to improve care;

D. document that the ~~applicant~~ health care home is using ~~participants'~~ the patient's preferred means of communication, if that means of communication is available within the health care home's ~~technological~~ capability;

E. inform ~~participants~~ patients that the ~~participant~~ patient may choose a specialty care resource without regard to whether a specialist is a member of the same provider group or network as the ~~participant's~~ patient's health care home, and that the ~~participant~~ patient is then responsible for determining whether specialty care resources are covered by the ~~participant's~~ patient's insurance; and

F. ~~establish adequate information and privacy security measures to comply with applicable privacy and confidentiality laws, including the requirements of the Health Insurance Portability and Accountability Act, Code of Federal Regulations, title 45, parts 160.101 to 164.534, and the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13~~ maintain policies and procedures that establish privacy and security protections of health information and comply with applicable privacy and confidentiality laws.

Subp. 2. **Access and communication standard; recertification ~~at the end of year one~~ requirements.** ~~By the end of the first year of~~ The health care home ~~certification, the applicant for recertification~~ must demonstrate that ~~the applicant~~ the health care home encourages ~~participants~~ patients to take an active role in managing ~~the participant's~~ their health care, and ~~that the applicant has demonstrated participant~~ must demonstrate patient involvement and communication by identifying and responding to one of the following: ~~participants'~~ the patient's readiness for change, literacy level, or other barriers to learning.

Subp. 2a. **Access and communication standard; level 2 certification requirements.** The health care home must demonstrate:

A. incorporating screening processes to assess whole person care needs and use this information to determine risk and manage patient care;

B. offering options beyond the traditional in-person office visit such as expanded hours of operation, electronic virtual visits, delivery of services in locations other than the clinic setting, and other efforts that increase patient access to the health care home team and that enhance the health care home's ability to meet the patient's preventative, acute, and chronic care needs;

C. implementing care delivery strategies responsive to the patient's social, cultural, and linguistic needs; and

D. implementing enhanced strategies to encourage patient engagement through interventions that support health literacy and help the patient manage chronic diseases, reduce risk factors, and address overall health and wellness.

Subp. 3. **~~Participant~~ Patient registry and tracking ~~participant~~ patient care activity standard; certification requirements.** The ~~applicant for certification~~ health care home must use a searchable, electronic registry to record ~~participant~~ patient information and track ~~participant~~ patient care.

A. The registry must enable the health care home team to conduct systematic reviews of the health care home's ~~participant~~ patient population to manage health care services, provide appropriate follow-up, and identify any gaps in care.

B. The registry must contain:

(1) for each ~~participant~~ patient, the name, age, gender identity, contact information, and identification number assigned by the health care provider, if any; and

(2) sufficient data elements to issue a report that shows any gaps in care ~~for groups of participants with a chronic or complex condition~~.

C. The health care home must use the registry to identify gaps in care and implement remedies to prevent gaps in care.

Subp. 3a. **Registry and tracking standard; level 2 certification requirements.** The health care home must demonstrate:

A. expanding registry criteria to identify needs related to social determinants of health and other whole person care data elements in the clinic population; and

B. planning and implementing interventions to address unmet needs identified by the expanded registry.

Subp. 4. [See repealer.]

Subp. 5. **Care coordination standard; certification requirements.** The ~~applicant for certification~~ health care home must adopt a system of care coordination that promotes patient and family-centered care through the following steps:

A. collaboration within the health care home, including the ~~participant~~ patient, care coordinator, and personal clinician or local trade area clinician as follows:

(1) one or more members of the health care home team, usually including the care coordinator, and the ~~participant~~ patient set goals and identify resources to achieve the goals;

[For text of subitem (2), see Minnesota Rules]

(3) the health care home team and ~~participant~~ patient determine whether and how often the ~~participant~~ patient will have contact with the care team, other providers involved in the ~~participant's~~ patient's care, or other community resources involved in the ~~participant's~~ patient's care;

B. uses health care home teams to provide and coordinate ~~participant~~ patient care, including communication and collaboration with specialists. If a health care home team includes more than one personal clinician or local trade area clinician, or more than one care coordinator, the ~~applicant~~ health care home must identify one personal clinician or local trade area clinician and one care coordinator as the primary contact for each ~~participant~~ patient and inform the ~~participant~~ patient of this designation;

[For text of items C and D, see Minnesota Rules]

E. documents the following elements of care coordination in the ~~participant's~~ patient's chart or care plan:

(1) referrals for specialty care, whether and when the ~~participant~~ patient has been seen by a provider to whom a referral was made, and the result of the referral;

(2) tests ordered, and when test results have been received and communicated to the ~~participant~~ patient;

[For text of subitem (3), see Minnesota Rules]

(4) timely postdischarge planning according to a protocol for ~~participants~~ patients discharged from hospitals, skilled nursing facilities, or other health care institutions;

(5) communication with ~~participant's~~ the patient's pharmacy regarding use of medication and medication reconciliation; and

(6) other information, such as links to external care plans, as determined by the care team to be beneficial to coordination of the ~~participant's~~ patient's care.

Subp. 6. **Care coordination standard; recertification ~~at the end of year one~~ requirements.** ~~By the end of the first year of~~ The health care home ~~certification, the applicant for recertification~~ must enhance the ~~applicant's~~ health care home's care coordination system by adopting and implementing the following additional patient and family-centered principles:

A. ensure that ~~participants~~ patients are given the opportunity to fully engage in care planning and shared decision-making regarding the ~~participant's~~ patient's care, and that the health care home solicits and documents the ~~participant's~~ patient's feedback regarding the ~~participant's~~ patient's role in the ~~participant's~~ patient's care;

B. identify and work with community-based organizations and public health resources such as disability and aging services, social services, transportation services, school-based services, and home health care services to facilitate the availability of appropriate resources for ~~participants~~ patients;

[For text of item C, see Minnesota Rules]

D. engage ~~participants~~ patients in planning for transitions among providers, and between life stages such as the transition from childhood to adulthood.

Subp. 6a. **Care coordination standard; level 2 certification requirements.** For the primary care services patient population, the health care home must demonstrate:

A. providing and coordinating care using an integrated care team;

B. supporting ongoing coordination of care and follow-up with partners by sharing information; and

C. implementing processes to improve care transitions that reduce readmission, adverse events, and unnecessary emergency department utilization.

Subp. 7. **Care plan standard; certification requirements.** The ~~applicant for certification~~ health care home must ~~meet the following requirements:~~ establish and implement policies and procedures to guide the health care home in the identification and use of care plan strategies to engage patients in their care and to support self-management. These strategies must include:

~~A. establish and implement policies and procedures to guide the health care home in assessing whether a care plan will benefit participants with complex or chronic conditions. The applicant must do the following in creating and developing a care plan:~~

~~(1) actively engage the participant and verify joint understanding of the care plan;~~

~~(2) engage all appropriate members of the health care team, such as nurses, pharmacists, dieticians, and social workers;~~

~~(3) incorporate pertinent elements of the assessment that a qualified member of the care team performed about the patient's health risks and chronic conditions;~~

~~(4) review, evaluate, and, if appropriate, amend the care plan, jointly with the participant, at specified intervals appropriate to manage the participant's health and measure progress toward goals;~~

~~(5) provide a copy of the care plan to the participant upon completion of creating or amending the plan; and~~

~~(6) use and document the use of evidence-based guidelines for medical services and procedures, if those guidelines and methods are available;~~

~~B. a participant's care plan must include goals and an action plan for the following:~~

~~(1) preventive care, including reasons for deviating from standard protocols;~~

~~(2) care of chronic illnesses;~~

~~(3) exacerbation of a known chronic condition, including plans for the participant's early contact with the health care home team during an acute episode; and~~

~~(4) end-of-life care and health care directives, when appropriate; and~~

~~C. the applicant must update the goals in the care plan with the participant as frequently as is warranted by the participant's condition.~~

A. providing patients with information from their personal clinician or local trade area clinician visit that includes relevant clinical details, health maintenance and preventative care instructions, and chronic condition monitoring instructions, including indicated early intervention steps and plans for managing exacerbations, as applicable;

B. offering documentation of any collaboratively developed patient-centered goals and action steps, including resources and supports needed to achieve these goals, when applicable. Include pertinent information related to whole person care needs or other determinants of health;

C. using advanced care planning processes to discuss palliative care, end-of-life care, and complete health care directives, when applicable. This includes providing the care team with information about the presence of a health care directive and providing a copy for the patient and family; and

D. informing strategies with evidence-based practice guidelines when available.

Subp. 8. **Care plan standard; recertification ~~at the end of year one~~ requirements.** ~~By the end of the first year of health care home certification, the applicant must ask each participant with a care plan whether the participant has any external care plans and, if so, create a comprehensive care plan by consolidating appropriate information from the external plans into the participant's care plan.~~ The health care home must integrate pertinent medical, medical specialty, quality of life, behavioral health, social services, community-based services, and other external care plans into care planning strategies to meet unique needs and circumstances of the patient.

Subp. 9. **Performance reporting and quality improvement standard; certification requirements.** The ~~applicant for certification~~ health care home must measure the ~~applicant's~~ health care home's performance and engage in a quality improvement process, focusing on patient experience, patient health, and measuring the cost-effectiveness of services, by doing the following:

A. establishing a health care home quality improvement team that reflects the structure of the clinic and includes, at a minimum, the following persons at the clinic level:

[For text of subitems (1) and (2), see Minnesota Rules]

(3) two or more ~~participant~~ patient representatives who were provided the opportunity and encouraged to participate; and

[For text of subitem (4), see Minnesota Rules]

[For text of item B, see Minnesota Rules]

C. demonstrating capability in performance measurement by showing that the ~~applicant~~ health care home has measured, analyzed, and tracked changes in at least one quality indicator selected by the ~~applicant~~ health care home based upon the opportunity for improvement;

D. participating in ~~a~~ the health care home learning collaborative through ~~representatives~~ care team members that reflect the structure of the clinic and ~~includes the following persons at the clinic level~~ may include the following:

(1) ~~one or more personal~~ clinicians or local trade area clinicians who deliver services in the health care home;

(2) ~~one or more~~ care coordinators;

(3) other care team members;

~~(3)~~ (4) ~~if the health care home is a clinic, one or more~~ representatives from clinic administration or management; and

~~(4)~~ (5) ~~two or more participant~~ patient representatives who were provided the opportunity and encouraged to participate with the goal of having ~~two participants~~ patients of the health care home take part; and

[For text of item E, see Minnesota Rules]

Subp. 10. **Performance reporting and quality improvement standard; recertification ~~at the end of year one~~ requirements.** ~~By~~ The ~~end of year one of~~ health care home ~~certification, the applicant for recertification~~ must:

A. participate in the Minnesota statewide quality reporting and measurement system by submitting outcomes for the quality indicators identified and in the manner prescribed by the commissioner;

B. show that the ~~applicant~~ health care home has selected at least one quality indicator from each of the following categories and has measured, analyzed, and tracked those indicators during the previous year:

[For text of subitems (1) and (2), see Minnesota Rules]

(3) measures related to cost-effectiveness of services; ~~and~~

C. submit health care homes data in the manner prescribed by the commissioner to fulfill the health care homes evaluation requirements in Minnesota Statutes, section 256B.0752, subdivision 2.; and

D. achieve the benchmarks for patient health, patient experience, and cost-effectiveness established under part 4764.0030, subpart 6, for the health care home's outcomes in its primary care services patient population.

Subp. 11. [See repealer.]

Subp. 12. **Performance reporting and quality improvement standard; level 2 certification requirements.** The health care home must demonstrate:

A. using information and population health data about the community served to inform organizational strategies and quality improvement plans;

B. measuring, analyzing, tracking, and addressing health disparities within the clinic population through continuous improvement processes;

C. establishing procedures for sharing work on health equity and eliciting feedback from the health care home team and other staff regarding these activities; and

D. recruiting, promoting, and supporting patient representation to the health care home quality improvement team that reflects the diversity of the patient population.

Subp. 13. **Performance reporting and quality improvement standard; level 3 certification requirements.** The health care home must contribute to a coordinated community health needs assessment and population health improvement planning process by:

A. sharing aggregated information or de-identified data that describes health issues and inequities;

B. prioritizing population health issues in the community and planning for population health improvement, in collaboration with community stakeholders;

C. implementing and monitoring progress of the population health improvement plan using shared goals and responsibility; and

D. sharing in the communication and dissemination of work on population health improvement and eliciting feedback from the community members and health care home staff regarding these activities.

4764.0050 VARIANCE.

Subpart 1. **Criteria for variance.** At certification or recertification, the ~~applicant~~ health care home may request a variance or the renewal of a variance from a requirement in parts 4764.0010 to 4764.0040. To request a variance, ~~an applicant~~ a health care home must submit a petition, according to the requirements of Minnesota Statutes, section 14.056, and demonstrate that the ~~applicant~~ health care home meets the criteria in item A or B.

A. If the commissioner finds that the application of the requirements, as applied to the circumstances of the ~~applicant~~ health care home, would not serve any of the rule's purposes, the commissioner must grant a variance.

B. If the commissioner finds that failure to grant the variance would result in hardship or injustice to the ~~applicant~~ health care home, the variance would be consistent with the public interest, and the variance would not prejudice the substantial legal or economic rights of any person or entity, the commissioner may grant a variance.

[For text of subpart 2, see Minnesota Rules]

Subp. 3. [See repealer.]

Subp. 4. ~~**Experimental**~~ **Variance for seeking better solutions and testing new methods.** The commissioner may grant a variance from one or more requirements to permit

~~an applicant~~ a health care home to offer health care home services of a type or in a manner that is innovative or to participate in a health care home research project that contributes to innovation and improvement of care if the commissioner finds that the variance does not impede the achievement of the criteria in Minnesota Statutes, section 256B.0751, subdivision 2, paragraph (a), and may improve the health care home services ~~provided by the applicant~~.

Subp. 5. **Variance for justifiable failure to show measurable improvement.** The commissioner may grant a variance to a health care home seeking recertification that fails to show measurable improvement as required by parts 4764.0030, subpart 5, item B, ~~subitem (3),~~ and 4764.0040, subpart ~~11~~ 10, if the ~~applicant~~ health care home demonstrates the following:

A. a reasonable justification for the ~~applicant's~~ health care home's inability to show required measurable improvement; and

[For text of item B, see Minnesota Rules]

4764.0060 APPEALS.

Subpart 1. **Denial of certification or recertification and time for appeal.** The commissioner must notify an ~~applicant~~ eligible provider or health care home in writing of the reasons for denial of an application for certification or recertification. An ~~applicant~~ eligible provider or health care home has 30 days from the date of receiving notice of the decision to appeal the decision.

Subp. 2. **How to appeal.** The ~~applicant~~ eligible provider or health care home may appeal by submitting either item A or B, or both:

A. a written statement of the ~~applicant's~~ eligible provider's or health care home's grounds for disputing the commissioner's decision; or

B. a corrective action plan that describes the following specific actions for improvement:

(1) the corrective steps that have been taken by the ~~applicant~~ eligible provider or health care home;

[For text of subitem (2), see Minnesota Rules]

(3) if applicable, any reasons that the ~~applicant~~ eligible provider or health care home is unable to comply.

Subp. 3. ~~**Optional**~~ **Request for meeting.** Upon request, an ~~applicant~~ eligible provider or health care home is entitled to a meeting with the commissioner's designee to discuss disputed facts and findings, present the ~~applicant's~~ eligible provider's or health care home's corrective action plan, or both.

Subp. 4. **Notice of decision and timeline.** The commissioner must grant or deny the appeal and notify the ~~applicant~~ eligible provider or health care home of the decision within 60 days after receipt of a completed appeal, or, if the ~~applicant~~ eligible provider or health care home meets with the commissioner's designee, within 60 days after the meeting.

4764.0070 REVOCATION, REINSTATEMENT, ~~AND~~ SURRENDER, RECOGNITION OF EXTERNAL ACCREDITING BODIES AND PATIENT-CENTERED MEDICAL HOME PROGRAMS, AND PROVISIONAL CERTIFICATION AND RECERTIFICATION.

Subpart 1. **Revocation.** If the commissioner denies an appeal or a health care home fails to appeal the commissioner's decision to deny recertification, the provider will no longer be certified as a health care home ~~or be eligible to receive per-person care coordination payments~~.

Subp. 2. **Reinstatement of revocation.** A provider whose certification as a health care home has been revoked may apply for reinstatement. If the provider was previously certified for ~~one year~~ three years or longer at the time of revocation, it must meet the recertification requirements to be reinstated. ~~During the 12 months following revocation of certification,~~ The provider may obtain technical or program assistance from the Minnesota

Department of Health and through a health care home learning collaborative to assist the provider to regain certification. The provider also may choose to provisionally reinstate their certification as outlined in subpart 7.

Subp. 3. **Surrender.** A health care home ~~may voluntarily surrender~~ that surrenders the health care home certification ~~by providing~~ must provide the commissioner and the health care home ~~participants~~ patients with ~~90 days'~~ written notice. After the ~~expiration of the 90-day~~ written notice ~~period~~ is provided, a provider that has surrendered health care home certification is no longer ~~eligible for per-person care coordination payments based on certification~~ certified as a health care home.

Subp. 4. **Reinstatement of surrendered certification.** A provider whose certification as a health care home has been surrendered may apply for reinstatement. Health care home certification can be reinstated upon receipt of the application and will be held in a provisional status until the health care home's recertification. The provider may choose to complete this recertification at any time within the recertification cycle to have their provisional status removed.

Subp. 5. **Recognition of other certification programs or accrediting bodies.** The commissioner may choose to grant health care home certification to providers who have achieved certification or accreditation from other state or national bodies if doing so is in alignment with health care home standards and program goals.

Subp. 6. **Provisional certification.** Clinics that are experiencing barriers or challenges to certification at the foundational level may request provisional certification. During the time of provisional certification, that must not last longer than three years, the provider must work with the Department of Health to develop an action plan outlining a modified or "stepped" certification process. Upon completion of the modified or stepped certification process, the provisional status will be removed. The provider may obtain technical or

program assistance from the Department of Health and through a health care home learning collaborative to assist the provider in gaining certification.

Subp. 7. **Provisional recertification.** Clinics that are experiencing barriers or challenges to recertification may request provisional recertification. During the time of provisional recertification that must not last longer than three years, the provider must work with the Department of Health to develop an action plan outlining a modified or "stepped" recertification process. Upon completion of the modified or stepped recertification process, the provisional status shall be removed. The provider may obtain technical or program assistance from the Department of Health and through a health care home learning collaborative to assist the provider in gaining recertification.

REPEALER. Minnesota Rules, parts 4764.0020, subparts 2, 4, 7, 12, 30, 33, and 37; 4764.0040, subparts 4 and 11; and 4764.0050, subpart 3, are repealed.