

CHAPTER 4764
DEPARTMENT OF HEALTH
HEALTH CARE HOMES

4764.0010	APPLICABILITY AND PURPOSE.
4764.0020	DEFINITIONS.
4764.0030	CERTIFICATION AND RECERTIFICATION PROCEDURES.
4764.0040	HEALTH CARE HOME STANDARDS.
4764.0050	VARIANCE.
4764.0060	APPEALS.
4764.0070	REVOCATION, REINSTATEMENT, AND SURRENDER.

4764.0010 APPLICABILITY AND PURPOSE.

Subpart 1. **Applicability.** Parts 4764.0010 to 4764.0070 apply to an eligible provider that is an applicant or is certified as a health care home.

Subp. 2. **Purpose.** Parts 4764.0010 to 4764.0070 establish the standards and procedures for certification of health care homes. The purpose of the standards is to require health care homes to deliver services that:

A. 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. 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. include care coordination that focuses on patient and family-centered care;

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

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

Statutory Authority: *MS s 256B.0751; 256B.0752; 256B.0753*

History: *34 SR 591*

Published Electronically: *January 13, 2010*

4764.0020 DEFINITIONS.

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

Subp. 2. [Repealed, 47 SR 338]

Subp. 3. **Care coordination.** "Care coordination" means a team approach that engages the participant, the personal clinician or local trade area clinician, and other members of the health care home team to enhance the participant's well-being by organizing timely access to resources and necessary care that results in continuity of care and builds trust.

Subp. 4. [Repealed, 47 SR 338]

Subp. 5. **Care coordinator.** "Care coordinator" means a person who has primary responsibility to organize and coordinate care with the participant 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 care.

Subp. 7. [Repealed, 47 SR 338]

Subp. 8. **Clinic.** "Clinic" means an operational entity through which personal clinicians or local trade area clinicians deliver health care services under a common set of operating policies and procedures using shared staff for administration and support. The operational entity may be a department or unit of a larger organization as long as it is a recognizable subgroup.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of health.

Subp. 10. **Commissioners.** "Commissioners" means the commissioners of health and human services.

Subp. 11. **Complex condition.** "Complex condition" means one or more medical conditions that require treatment or interventions across a broad scope of medical, social, or mental health services.

Subp. 12. [Repealed, 47 SR 338]

Subp. 13. **Continuous.** "Continuous" means 24 hours per day, seven days per week, 365 days per year.

Subp. 14. **Cost-effectiveness.** "Cost-effectiveness" means the measure of a service or medical treatment against a specified health care goal based on quality and cost, including use of resources.

Subp. 15. **Direct communication.** "Direct communication" means an exchange of information through the use of telephone, electronic mail, video conferencing, or face-to-face contact without the use of an intermediary. For purposes of this definition, an interpreter is not an intermediary.

Subp. 16. **Eligible provider.** "Eligible provider" means a personal clinician, local trade area clinician, or clinic that provides primary care services.

Subp. 17. **End-of-life care.** "End-of-life care" means palliative and supportive care and other services provided to terminally ill patients and their families to meet the physical, nutritional, emotional, social, spiritual, cultural, and special needs experienced during the final stages of illness, dying, and bereavement.

Subp. 18. **Evidence-based guidelines.** "Evidence-based guidelines" 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.

Subp. 19. **External care plan.** "External care plan" means a care plan created for a participant 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.

Subp. 20. **Family.**

A. For a patient who is 18 years of age or older, "family" means:

- (1) any person or persons identified by the patient as a family member;
- (2) legal guardian according to appointment or acceptance under Minnesota Statutes, sections 524.5-201 to 524.5-317;
- (3) a health care agent as defined in Minnesota Statutes, section 145C.01, subdivision 2; and
- (4) a spouse.

B. For a patient who is under the age of 18, "family" means:

- (1) the natural or adoptive parent or parents or a stepparent who live in the home with the patient;
- (2) a legal guardian according to appointment or acceptance under Minnesota Statutes, sections 260C.325 or 524.5-201 to 524.5-317;
- (3) any adult who lives with or provides care and support for the patient when the patient's natural or adoptive parents or stepparents do not reside in the same home as the patient; and
- (4) a spouse.

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.

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 62U.03, subdivision 6, in which health care home team members and participants from different health care organizations 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. 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. The care team includes at least a personal clinician or local trade area clinician and the care coordinator and may include other health professionals based on the participant's needs.

Subp. 24. **Local trade area clinician.** "Local trade area clinician" means a physician, physician assistant, or advanced practice registered nurse who provides primary care services outside of Minnesota in the local trade area of a state health care program recipient and maintains compliance with the licensing and certification requirements of the state where the clinician is located. For purposes of this subpart, "local trade area" has the meaning given in part 9505.0175, subpart 22.

Subp. 25. **Outcome.** "Outcome" means a measurement of improvement, maintenance, or decline as it relates to patient health, patient experience, or measures of cost-effectiveness in a health care home.

Subp. 26. **Participant.** "Participant" means the patient and, where applicable, the patient'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 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.

Subp. 28. **Personal clinician.** "Personal clinician" means a physician licensed under Minnesota Statutes, chapter 147, a physician assistant licensed and practicing under Minnesota Statutes, chapter 147A, or an advanced practice nurse licensed and registered to practice under Minnesota Statutes, chapter 148.

Subp. 29. **Preventive care.** "Preventive care" means disease prevention and health maintenance. It includes screening, early identification, counseling, treatment, and education to prevent health problems.

Subp. 30. [Repealed, 47 SR 338]

Subp. 31. **Primary care.** "Primary care" means overall and ongoing medical responsibility for a patient's comprehensive care for preventive care and a full range of acute and chronic conditions, including end-of-life care when appropriate.

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. [Repealed, 47 SR 338]

Subp. 34. **Shared decision making.** "Shared decision making" means the mutual exchange of information between the participant and the provider 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. 35. **Specialist.** "Specialist" means a health care provider or other person with specialized health training not available within 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.

Subp. 36. [Repealed, L 2022 c 55 art 1 s 187]

Subp. 37. [Repealed, 47 SR 338]

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

Statutory Authority: *MS s 256B.0751; 256B.0752; 256B.0753*

History: *34 SR 591; L 2011 ISp11 art 3 s 12*

Published Electronically: *November 16, 2022*

4764.0030 CERTIFICATION AND RECERTIFICATION PROCEDURES.

Subpart 1. Eligibility for certification.

A. An eligible provider, supported by a care team and systems according to the requirements in part 4764.0040, may apply for certification as a health care home.

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. 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 must submit the following to the commissioner:

A. a completed self-assessment in a form prescribed by the commissioner which describes how the applicant meets the requirements in part 4764.0040;

B. a completed and signed application form prescribed by the commissioner; and

C. any other information required by the commissioner to show that the applicant 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 complies with certification or recertification requirements.

Subp. 4. **Completed application for certification.** An application for certification or recertification is complete when the commissioner has received all information in subpart 2; the

on-site review, if any, has been completed; and the commissioner has received any additional documentation requested under subpart 3.

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

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

(1) the requirements for initial certification continue to be met; and

(2) the requirements for the end of year one for each health care home standard in part 4764.0040 are met.

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. 6. **Benchmarks.** The commissioner must announce benchmarks for patient health, patient experience, and cost-effectiveness annually. The benchmarks must be based on one or more of the following factors:

A. an improvement over time as reflected by a comparison of data measuring quality submitted by the health care home in the current year to data submitted in prior years;

B. a comparison of data measuring quality submitted by the health care home to data submitted by other health care homes;

C. standards established by state or federal law;

D. best practices recommended by a scientifically based outcomes development organization;

E. measures established by a national accrediting body or professional association; and

F. additional measures that improve the quality or enhance the use of data currently being collected.

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

A. The commissioner must notify an applicant in writing regarding whether the applicant is certified or recertified as a health care home 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. If the commissioner denies the application for certification or recertification, the commissioner must notify the applicant in writing of the reasons for the denial. The applicant may file an appeal under part 4764.0060.

Statutory Authority: *MS s 256B.0751; 256B.0752; 256B.0753*

History: *34 SR 591*

Published Electronically: *January 13, 2010*

4764.0040 HEALTH CARE HOME STANDARDS.

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

- A. offer the applicant's health care home services to all of the applicant's patients who:
 - (1) have or are at risk of developing complex or chronic conditions; and
 - (2) are interested in participation;
- B. establish a system designed to ensure that:
 - (1) participants are informed 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' medical record information, which must include the following for each participant:
 - (a) the participant's contact information, personal clinician's or local trade area clinician's name and contact information, and designated enrollment in a health care home;
 - (b) the participant's racial or ethnic background, primary language, and preferred means of communication;
 - (c) the participant's consents and restrictions for releasing medical information; and
 - (d) the participant's diagnoses, allergies, medications related to chronic and complex conditions, and whether a care plan has been created for the participant; and
 - (3) the designated clinic staff, on-call provider, or phone triage system representative who has continuous access to the participant's medical record information will determine when scheduling an appointment for the participant is appropriate based on:
 - (a) the acuity of the participant'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' cultural background, racial heritage, and primary language and describe how the applicant will apply this information to improve care;

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

E. inform participants that the participant 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 health care home, and that the participant is then responsible for determining whether specialty care resources are covered by the participant'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.

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

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

A. The registry must enable the health care home team to conduct systematic reviews of the health care home's participant 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, the name, age, gender, 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.

Subp. 4. [Repealed, 47 SR 338]

Subp. 5. **Care coordination standard; certification requirements.** The applicant for certification 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, 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 set goals and identify resources to achieve the goals;

(2) the personal clinician or local trade area clinician and the care coordinator ensure consistency and continuity of care; and

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

B. uses health care home teams to provide and coordinate participant 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 must identify one personal clinician or local trade area clinician and one care coordinator as the primary contact for each participant and inform the participant of this designation;

C. provides for direct communication in which routine, face-to-face discussions take place between the personal clinician or local trade area clinician and the care coordinator;

D. provides the care coordinator with dedicated time to perform care coordination responsibilities; and

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

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

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

(3) admissions to hospitals or skilled nursing facilities, and the result of the admission;

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

(5) communication with participant'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 care.

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

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

C. permit and encourage professionals within the health care home team to practice at a level that fully uses the professionals' training and skills; and

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

Subp. 7. **Care plan standard; certification requirements.** The applicant for certification must meet the following requirements:

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, dietitians, 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.

Subp. 8. **Care plan standard; recertification at the end of year one.** 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.

Subp. 9. **Performance reporting and quality improvement standard; certification requirements.** The applicant for certification must measure the applicant'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:

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

(2) one or more care coordinators;

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

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

B. establishing procedures for the health care home quality improvement team to share their work and elicit feedback from health care home team members and other staff regarding quality improvement activities;

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

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

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

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

E. establishing procedures for representatives of the health care home to share information learned through the collaborative and elicit feedback from health care home team members and other staff regarding information.

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

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

B. show that the applicant 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:

- (1) improvement in patient health;
- (2) quality of patient experience; and
- (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.

Subp. 11. [Repealed, 47 SR 338]

Statutory Authority: *MS s 256B.0751; 256B.0752; 256B.0753*

History: *34 SR 591*

Published Electronically: *November 16, 2022*

4764.0050 VARIANCE.

Subpart 1. **Criteria for variance.** At certification or recertification, the applicant 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 must submit a petition, according to the requirements of Minnesota Statutes, section 14.056, and demonstrate that the applicant 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, 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, 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.

Subp. 2. **Conditions and duration.** The commissioner may impose conditions on the granting of a variance according to Minnesota Statutes, section 14.055. The commissioner may limit the duration of a variance and may renew a variance.

Subp. 3. [Repealed, 47 SR 338]

Subp. 4. **Experimental variance.** The commissioner may grant a variance from one or more requirements to permit an applicant to offer health care home services of a type or in a manner that is innovative if the commissioner finds that the variance does not impede the achievement of the criteria in Minnesota Statutes, section 62U.03, subdivision 3, 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, if the applicant demonstrates the following:

A. reasonable justification for the applicant's inability to show required measurable improvement; and

B. a plan to achieve measurable improvement in the following year or a shorter time period identified by the commissioner.

Statutory Authority: *MS s 256B.0751; 256B.0752; 256B.0753*

History: *34 SR 591*

Published Electronically: *November 16, 2022*

4764.0060 APPEALS.

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

Subp. 2. **How to appeal.** The applicant may appeal by submitting either item A or B, or both:

A. a written statement of the applicant'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;

(2) a plan for continued improvement; and

(3) if applicable, any reasons that the applicant is unable to comply.

Subp. 3. **Optional request for meeting.** Upon request, an applicant is entitled to a meeting with the commissioner's designee to discuss disputed facts and findings, present the applicant'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 of the decision within 60 days after receipt of a completed appeal, or, if the applicant meets with the commissioner's designee, within 60 days after the meeting.

Statutory Authority: *MS s 256B.0751; 256B.0752; 256B.0753*

History: *34 SR 591*

Published Electronically: *January 13, 2010*

4764.0070 REVOCATION, REINSTATEMENT, AND SURRENDER.

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.** 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 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.

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

Statutory Authority: *MS s 256B.0751; 256B.0752; 256B.0753*

History: *34 SR 591*

Published Electronically: *January 13, 2010*