CHAPTER 4764
DEPARTMENT OF HEALTH
HEALTH CARE HOMES

4764.0010 APPLICABILITY AND PURPOSE.

Subpart 1. **Applicability.** This chapter applies to an eligible provider seeking health care home certification or a certified health care home.

Subp. 2. **Purpose.** 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:

(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;

(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;

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

(4) include care plan strategies for patients and involve the patient and, if appropriate, the patient's family in the care planning process; and

(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.

Statutory Authority: *MS s 62U.03; 256B.0751; 256B.0752; 256B.0753*

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4764.0020 DEFINITIONS.

Subpart 1. **Scope.** The terms used in this chapter 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 patient, the personal clinician or local trade area clinician, and other members of the health care home team to enhance the patient'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 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 patient'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 practice.** "Evidence-based practice " means 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 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.

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 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 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 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 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 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.

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. 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.

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. **Patient.** "Patient" means a person and, where applicable, the 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 patient perspectives and choices. It also incorporates the 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.

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. 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.

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.

Subp. 33. [Repealed, 47 SR 338]

Subp. 34. **Shared decision making.** "Shared decision making" means the mutual exchange of information between the 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 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.

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 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.

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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 orient new clinicians and staff to the health care home's care delivery approach.

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

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

B. a completed application 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 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 eligible provider or health care home 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 indicate its intent to be recertified in the manner prescribed by the commissioner no later than 60 days before the three-year anniversary of its last certification or recertification and do the following:

A. continue to meet the requirements for initial certification;

B. meet the recertification requirements for each health care home standard in part 4764.0040, 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.

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 in the manner prescribed by the commissioner. 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.

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

Statutory Authority: *MS s 62U.03; 256B.0751; 256B.0752; 256B.0753*

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4764.0040 HEALTH CARE HOME STANDARDS.

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

A. offer health care home services to all of the primary care services population that includes:

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

(2) 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) 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 patients' medical record information, which must include the following for each patient:

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

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

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

(d) the patient's diagnoses, allergies, medications, and whether a care plan has been created for the patient; and

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

(a) the acuity of the 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 patients' cultural background, racial heritage, and primary language and describe how the health care home will apply this information to improve care;

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

E. inform patients that the 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 patient's health care home, and that the patient is then responsible for determining whether specialty care resources are covered by the patient's insurance; and

F. 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 requirements.** The health care home must demonstrate that the health care home encourages patients to take an active role in managing their health care, and must demonstrate patient involvement and communication by identifying and responding to one of the following: 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. **Patient registry and tracking patient care activity standard; certification requirements.** The health care home must use a searchable, electronic registry to record patient information and track patient care.

A. The registry must enable the health care home team to conduct systematic reviews of the health care home's 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 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.

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. [Repealed, 47 SR 338]

Subp. 5. **Care coordination standard; certification requirements.** The 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 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 patient 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 patient determine whether and how often the patient will have contact with the care team, other providers involved in the patient's care, or other community resources involved in the patient's care;

B. uses health care home teams to provide and coordinate 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 health care home must identify one personal clinician or local trade area clinician and one care coordinator as the primary contact for each patient and inform the patient 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 patient's chart or care plan:

(1) referrals for specialty care, whether and when the 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 patient;

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

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

(5) communication with 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 patient's care.

Subp. 6. **Care coordination standard; recertification requirements.** The health care home must enhance the health care home's care coordination system by adopting and implementing the following additional patient- and family-centered principles:

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

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 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 health care home must 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. 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 requirements.** 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 health care home must measure the 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:

(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 patient 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 health care home has measured, analyzed, and tracked changes in at least one quality indicator selected by the health care home based upon the opportunity for improvement;

D. participating in the health care home learning collaborative through care team members that reflect the structure of the clinic and may include the following:

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

(2) care coordinators;

(3) other care team members;

(4) representatives from clinic administration or management; and

(5) patient representatives who were provided the opportunity and encouraged to participate with the goal of having patients 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 requirements.** The health care home 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 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:

(1) improvement in patient health;

(2) quality of patient experience; and

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

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. [Repealed, 47 SR 338]

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.

Statutory Authority: *MS s 62U.03; 256B.0751; 256B.0752; 256B.0753*

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4764.0050 VARIANCE.

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

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

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, and 4764.0040, subpart 10, if the health care home demonstrates the following:

A. a reasonable justification for the health care home'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.

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4764.0060 APPEALS.

Subpart 1. **Denial of certification or recertification and time for appeal.** The commissioner must notify an eligible provider or health care home in writing of the reasons for denial of an application for certification or recertification. An 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 eligible provider or health care home may appeal by submitting either item A or B, or both:

A. a written statement of the 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 eligible provider or health care home;

(2) a plan for continued improvement; and

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

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

Statutory Authority: *MS s 62U.03; 256B.0751; 256B.0752; 256B.0753*

History: *34 SR 591; 47 SR 338*
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4764.0070 REVOCATION, REINSTATEMENT, 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.

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 three years or longer at the time of revocation, it must meet the recertification requirements to be reinstated. 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 that surrenders the health care home certification must provide the commissioner and the health care home patients with written notice. After the written notice is provided, a provider that has surrendered health care home certification is no longer 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 must 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 shall grant health care home certification to providers who have achieved certification or accreditation from other state or national bodies that is consistent with the certification standards in part 4764.0040.

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.

Statutory Authority: *MS s 62U.03; 256B.0751; 256B.0752; 256B.0753*

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