From: LaPlante, Bonnie (MDH)
To: Jane Campbell
Subject: MDH Proposed Rules
Date: Wednesday, March 30, 2022 10:32:42 AM
Attachments: FINAL HCH SONAR.pdf
20200316 RD4548.pdf
FINAL Notice of intent.pdf

3/30/2022

Legislative Reference Library
645 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, Minnesota 55155

Re: In The Matter of the Proposed Rules of the Department of Health, Health Care Homes Program Rule Amendments, Revisor's ID Number RD 4548

Dear Librarian:

The Minnesota Department of Health intend to adopt amendments to rules governing the Health Care Homes program, which is overseen by the department's Health Policy Division. We plan to publish a Notice of Intent to Adopt Rules without a Public Hearing in the April 4, 2022 State Register.

The Department has prepared and attached a Statement of Need and Reasonableness. As required by Minnesota Statutes, sections 14.131 and 14.23, the Department is sending the Library an electronic copy of the Statement of Need and Reasonableness at the same time we are mailing our Notice of Intent to Adopt Rules.

If you have questions, please contact me at 218-770-3463.

Yours very truly,

Bonnie LaPlante

Director Health Care Homes Program

Attachments :
Statement of Need and Reasonableness
RD 4548
Notice of Intent to Adopt Rules Without a Hearing

Bonnie LaPlante
Director, Health Care Homes Program

Minnesota Department of Health
Office: 651-201-3744 | Mobile: 218-770-3463

MN DEPARTMENT OF HEALTH

Minnesota Department of Health

Division of Health Policy, Health Care Homes program

NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

Proposed Amendment to Rules Governing Health Care Homes, *Minnesota Rules*, Parts 4764.0010-4764.0070; Revisor's ID Number 4548; OAH Docket No. 82-9000-37454

Introduction. The Department of Health intends to adopt rules without a public hearing following the procedures in the rules of the Office of Administrative Hearings, *Minnesota Rules*, parts 1400.2300 to 1400.2310, and the Administrative Procedure Act, *Minnesota Statutes*, sections 14.22 to 14.28. You may submit written comments on the proposed rules and may also submit a written request that a hearing be held on the rules until May 4, 2022.

Agency Contact Person. You must submit questions on the rules and written requests for a public hearing to the agency contact person. The agency contact person is: Bonnie LaPlante at Minnesota Department of Health, Health Care Homes, phone 218-770-3463, *email* *bonnie.laplante@state.mn.us.*

Subject of Rules and Statutory Authority. The proposed rules are about the Health Care Homes program. The legislature authorized this rule as a health reform measure in 2008, and it was adopted in 2010. After ten years of administering this rule, the Minnesota Department of Health is considering amending the rule to bring it up to date and to expand the model from an emphasis on health care services for individuals to equitable health for populations and communities through screening for social determinants of health and developing community partnerships to address whole person health needs and population health.

The changes include:

- Establishing level 2 and level 3 Health Care Homes standards.
- Wording changes to 4764.0010 - 4764.0070 to clarify meaning.
- Updating recertification timeline to every three years to align with statute.

- 4764.0040 Health Care Homes Standards:
    - Subp. 2a. Access and communication standard; adding level 2 certification requirements.
    - Subp. 3a. Registry and tracking standard; adding level 2 certification requirements.
    - Subp. 6a. Care coordination standard; adding level 2 certification requirements.
    - Subp. 7. Care plan standard; Updating the foundational certification requirements.
    - Subp. 12. Performance reporting and quality improvement standard; adding level 2 certification requirements
    - Subp. 13. Performance reporting and quality improvement standard; adding level 3 certification requirements.

- 4764.0050 Variance:
  - Subp. 4. Changing the experimental variance to a variance for seeking better solutions and testing new methods.

- 4764.0070 Revocation, Reinstatement, and Surrender, Recognition of External Accrediting Bodies and Patient-Centered Medical Home Programs, and Provisional Certification and Recertification.
  - Subp. 4. Adding reinstatement of surrendered certification.
  - Subp. 5. Recognition of other certification programs or accrediting bodies.
  - Subp. 6. Adding provisional certification.
  - Subp. 7. Adding provisional recertification.

The statutory authority to adopt the rules comes from *Minnesota Statutes*, section 62U.03. A copy of the proposed rules is available at: https://www.health.state.mn.us/facilities/hchomes/rulerevision/index.html. In addition, a free copy of the rules is available upon request from the agency contact person listed above.

Comments. You have until 4:30 p.m. on Wednesday, May 4, 2022, to submit written comments in support of or in opposition to the proposed rules and any part or subpart of the rules. You must submit any comments in writing via the Office of Administrative Hearings Rulemaking eComments website ***https://minnesotaoah.granicusideas.com/discussions.*** If you have questions or issues with eComments please contact OAH. You may also review the proposed rule and Statement of Need and Reasonableness (SONAR) at this eComments website. Your comment must be submitted by the due date. The Department encourages comment. Your comment should identify the portion of the proposed rules addressed and the reason for the comment. You are encouraged to propose any change desired. Any comments that you have about the legality of the proposed rules must also be made during this comment period.

Request for a Hearing. In addition to submitting comments, you may also request that the Department hold a hearing on the rules. Your request must be in writing and the agency contact person must receive it by 4:30 p.m. on May 4, 2022. Please do not send your hearing request to OAH. Your written request for a public hearing must include your name and address. You must identify the portion of the proposed rules that you object to or state that you oppose the entire set of rules. Any request that does not comply with these requirements is not valid and the agency cannot count it when determining whether it must hold a public hearing. You are also encouraged to state the reason for the request and any changes you want made to the proposed rules.

Withdrawal of Requests. If 25 or more persons submit a valid written request for a hearing, the Department will hold a public hearing unless a sufficient number withdraw their requests in writing. If enough requests for hearing are withdrawn to reduce the number below 25, the agency must give written notice of this to all persons who requested a hearing, explain the actions the agency took to affect the withdrawal, and ask for written comments on this action. If a public hearing is required, the agency will follow the procedures in *Minnesota Statutes*, sections 14.131 to 14.20.

Alternative Format. Upon request, related documents can be made available in an alternative format, such as large print, braille, or audio. To make such a request, please contact the agency contact person at the address or telephone number listed above.

Modifications. The Department may modify the proposed rules as a result of public comment. The modifications must be supported by comments and information submitted to the agency, and the adopted rules may not be substantially different than these proposed rules, unless the agency follows the procedure under *Minnesota Rules*, part 1400.2110. If the proposed rules affect you in any way, the Department encourages you to participate in the rulemaking process.

Statement of Need and Reasonableness. The statement of need and reasonableness contains a summary of the justification for the proposed rules, including a description of who will be affected by the proposed rules and an estimate of the probable cost of the proposed rules. It is now available from the agency contact person or for review online at https://www.health.state.mn.us/facilities/hchomes/rulerevision/index.html. You may obtain copies for the cost of reproduction by contacting the agency contact person.

Lobbyist Registration. *Minnesota Statutes*, chapter 10A, requires each lobbyist to register with the State Campaign Finance and Public Disclosure Board. You should direct questions about this requirement to the Campaign Finance and Public Disclosure Board at: Suite 190, Centennial Building, 658 Cedar Street, St. Paul, Minnesota 55155, telephone (651) 539-1180 or 1-800-657-3889.

Adoption and Review of Rules. If no hearing is required, the agency may adopt the rules after the end of the comment period. The agency will then submit the rules and supporting documents to the Office of Administrative Hearings for review for legality. You may ask to be notified of the date the Department submits the rules to the office. If you want to be so notified, or want to receive a copy of the adopted rules, or want to register with the agency to receive notice of future rule proceedings, submit your request to the agency contact person listed above.

____________________	______________________________
Date	Jan Malcolm Commissioner of Health

STATEMENT OF NEED AND REASONABLENESS

In the Matter of Proposed Revisions of Minnesota Rules, 4764.0010-4764.0070; Revisor ID No. 4548; Docket No. 82-9000-37454

Health Policy Division

April 4, 2022

Minnesota Department of Health
Health Care Homes Program
PO Box 64882
St. Paul, MN 55164-0882
651-201-5421
Health.HealthCareHomes@state.mn.us
www.health.state.mn.us/facilities/hchomes/

General information:

1) Availability: The State Register notice, this Statement of Need and Reasonableness (SONAR), and the proposed rule will be available during the public comment period on the Health Care Homes Rulemaking webpage: https://www.health.state.mn.us/facilities/hchomes/rulerevision/.
2) View older rule records at: Minnesota Rule Statutes https://www.revisor.mn.gov/rules/status/.
3) Agency contact for information, documents, or alternative formats: Upon request, this Statement of Need and Reasonableness can be made available in an alternative format, such as large print, braille, or audio. To make a request, contact Bonnie LaPlante, Director, Health Care Homes, PO Box 64882, St. Paul, MN 55164-0882; telephone 651-201-3744; 1-888-345-0823; email; bonnie.laplante@state.mn.us.

CONTENTS

STATEMENT OF NEED AND REASONABLENESS 1

General information: 2
Acronyms 3
Introduction and program overview 4
Background 6
Notice Plan 7
Public Participation and Stakeholder Involvement 9
Statutory authority 11
Regulatory analysis 11
Statement of General Need of the Proposed Amendments 15
Reasonableness of the proposed amendments 17
General Reasonableness 17
Rule-by-Rule Analysis 17
Health Equity Policy 26
Performance-based rules 27
Consult with MMB on local government impact 27
Impact on local government ordinances and rules 27
Costs of complying for small business or city 27
Differences with federal and other state standards 28
SONAR appendices 28
Conclusion and MDH signature 28
Appendices 29
Appendix A: Glossary 29
Appendix B: Health Care Homes Advisory Committee members 31
Appendix C: Learning and Innovation Workgroup members 32
Appendix D: Rule Advisory Committee members 33
Appendix E: Health Care Home Advisory Committee meeting input on progression model 3/5/2019 34
Appendix F: Rule Advisory Committee Meeting Minutes 37
Appendix G: Letter to Minnesota Management and Budget 49
References 50

Acronyms

ACO	Accountable Care Organization
ACH	Accountable communities for health
APA	Administrative Procedures Act
ALJ	Administrative Law Judge
BHH	Behavioral Health Home Services
CMS	Centers for Medicare and Medicaid
CFR	Code of Federal Regulations
DHS	Minnesota Department of Human Services
HCH	Health Care Homes
IHP	Integrated Health Partnership
MAT	MN Association of Townships
MDH	Minnesota Department of Health
MHCP	Minnesota Health Care Program
Minn. R.	Minnesota Rules
Minn. Stat.	Minnesota Statutes
MMB	Minnesota Management and Budget
MN	Minnesota
MORS	MN Office of the Revisor of Statutes
NCQA	National Committee for Quality Assurance
OAH	Office of Administrative Hearings
PCMH	Patient-centered medical home
SDOH	Social determinants of health
SIM	State Innovation Model
SONAR	Statement of Need and Reasonableness

Introduction and program overview

The Minnesota Department of Health (the department or MDH) is proposing amendments to rules governing the Health Care Homes program, which is overseen by the department's Health Policy Division. These revisions are referred to in this SONAR as the proposed rule, proposed rule amendments, or proposed rule revisions. This introduction provides information on the current rule and program.

The Health Care Homes program is a medical home model of primary care delivery, also called a patient-centered medical home (PCMH). Participation in the program is completely voluntary. The goal of the program is to improve patient care and outcomes at primary care clinics. Other similar programs exist at the state and federal levels, but the Health Care Homes program is unique to Minnesota.

To avoid confusion between the Health Care Homes program and the participating clinics that are commonly referred to by department staff and stakeholders as health care homes, this SONAR uses the terms "HCH Program" or "Program" to refer to the Health Care Homes program and generally refers to the certified clinics, clinic organizations, and clinicians as "health care homes" or "certified clinics."

The HCH Program has two main functions that are defined in rule. One is to certify primary care clinics and clinicians as health care homes. The other purpose of the program is to provide learning opportunities for primary care clinic personnel and their partners.

The HCH Program certifies clinics that are part of large health care organizations, members of clinic groups, and independent clinics. One organization or health system may have 30 or more clinics certified as health care homes. It is common for an organization with several certified clinics to also have non-certified clinics. This may change over time with more clinics in the organization becoming certified, but it is a business decision on the part of the organization. Currently, 73 organizations with one or more certified clinics participate in the HCH Program for a total of 409 certified clinics.

Glossary (see Appendix A for sources)

Care coordination means a team approach that engages the patient, personal clinician, and other members of the health care home team to enhance the patient's wellbeing by organizing timely access to resources and necessary care that results in continuity of care and builds trust.

Health care home means a clinic, personal clinician, or local trade area clinician that is certified under parts 4764.0010 to .0070.

Medical home or patient-centered medical home is an approach to providing primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Primary care is overall and ongoing medical responsibility for a patient's care including preventive care and a full range of acute and chronic conditions, and end-of-life care when appropriate.

The HCH Program determines if a clinic or clinician is eligible for certification as a health care home. To be eligible to become certified as a health care home, a clinic or clinician must offer the full range of primary care services including preventive, acute, chronic, and end of life care. Certified clinicians defined as a physician, physician assistant, or advanced practice registered nurse are eligible to bill for HCH care coordination services authorized under Minnesota Statutes, sections 256B.0753 and 62U.03.

Statewide, health care homes serve approximately 3.5 million people. Three-fourths of the counties in Minnesota have at least one certified clinic within their borders. Border states have 20 certified clinics that are affiliated with certified organizations based in Minnesota. The vast majority of certified clinics are freestanding facilities, although some are connected to hospitals. At this time, three certified organizations have 'virtual' clinics that provide services for people residing in an assisted living or long-term care facility. There are other organizations providing primary care services outside of their

clinic walls. For example, school-based clinics and homeless shelters. The HCH Program also certifies clinicians that provide primary care within a larger practice that may offer additional types of care including specialty care.

Program staff work with non-certified eligible clinics and clinicians that are interested in HCH certification on an ongoing basis. The HCH Program certified 39 additional clinics in 2020. Clinics seek certification for a variety of reasons and rarely drop out of the Program. Reasons clinics give for pursuing and maintaining certification include showing commitment to best practices, improving patient health and quality of care, and better coordinating care. Clinics also report that the HCH Program aligns with their organization's missions, practices, or plans, and that they learn from and collaborate with peers around the State through Program-sponsored learning activities.

The Program operates a learning center that provides webinars, regional and statewide meetings and workshops, learning series, e-Learning courses, and other web-based instruction. These learning activities are open to non-certified clinics and organizations that collaborate or work with primary care clinics such as behavioral health providers, social services agencies, local public health agencies, hospitals, and home care agencies. The department collaborates with the Minnesota Department of Human Services (DHS) on these learning activities for health care homes and DHS Behavioral health home (BHH) services providers. The HCH Program does not charge health systems or clinics to apply for certification or to participate in learning activities other than an annual conference. This is in contrast to other states' PCMH programs that charge annual accreditation fees and fees for participation in learning events.

Health care homes use a team-based approach to providing patient care. The care team is made up of the primary care clinician, other clinic team members, and patients and their family members who work together to coordinate patient care. The patients and their needs are at the center of the team.

Health care homes offer services to patients that usually are not provided at non-certified clinics. One example is 24-hour access to the care team. The care team coordinates with specialists and other care providers for the patient and provides connections to community services to address patient needs outside of the clinic.

The HCH Program certifies clinics based on five standards. The standards align with the shared principles of primary care adopted by the national Primary Care Collaborative (Primary Care Collaborative, 2020). Program standards require clinics to perform in the following areas:

1. **Access and communication.** The clinic must have a system for consistent and ongoing communication with patients, and provide patients with continuous access to clinic staff, an on-call clinician, or phone triage.
2. **Participant registry and care tracking.** The clinic must have an electronic, searchable information system to monitor characteristics of its patient population and manage its needs for prevention, wellness, and acute and chronic care.
3. **Care coordination.** The clinic must have a system of managing care to meet patients' needs. This requires a care coordinator that works with patients with complex needs and communicates with the patients' other providers to ensure continuous, coordinated care.
4. **Care planning.** The clinic must provide patients with information on their care team, instructions for maintaining their health and monitoring health problems, and steps for taking action when necessary. Clinics must provide education and support for patients to help them set goals and manage their own car

5. **Performance reporting and quality improvement.** The clinic must carry out efforts or activities to improve its systems and processes. Clinic staff must participate in the Program's learning collaborative and submit patient care data to the Minnesota statewide quality reporting and measurement system at MDH.

The department conducts onsite visits to health care homes to verify that they meet these standards. Verification includes review of clinic policies, procedures, and other evidence. The department requires health care homes to apply for recertification every three years.

The HCH Program standards for certification and recertification provide an approach for clinic transformation and growth that allows clinics to meet requirements based on their specific circumstances and patient population needs. For example, the first recertification cycle adds new clinic-specific requirements in addition to the initial certification standards.

Glossary (see Appendix A for sources)

Learning collaborative – health care home team members, patients, and other organizations that provide health care and community-based services participate in learning activities together and share experiences.

Behavioral health home services – expanded concept of person-centered medical home providing whole person care for adults with serious mental illness and children with emotional disturbance who participate in MN Medical Assistance.

Background

The 2008 Minnesota Health Care Reform Act (Act)[1] initiated the HCH Program. The Act established foundational elements of health care delivery and payment models for Minnesota. It included statewide reporting of measures for health care quality, enhancements to the use of electronic health records and exchange of health information, and a medical home model, the current HCH Program.

The Act directed MDH and DHS to consider existing standards developed by national independent accrediting and medical home organizations in development of the HCH standards. The statute also required a HCH learning collaborative to provide opportunities for clinics and state agencies to exchange information on efforts to advance and improve primary care delivery and best practices. The department promulgated HCH rules through the expedited rulemaking process and certified the first clinics in 2010.

In 2013, the Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid (CMS) awarded Minnesota a State Innovation Model (SIM) grant. SIM was a national innovation model focused on the development and testing of multi-payer health care payment and service delivery. Minnesota's SIM goals were to achieve better care coordination, lower costs, and improve health outcomes.

DHS and MDH used SIM funds to implement the Minnesota Accountable Health Model framework. The HCH Program administered key features of the SIM grant, awarding grants to clinics and other providers for practice transformation, practice facilitation, and accountable communities for health (ACH) projects.

[1] Minn. Laws 2008, ch. 358, art. 2, § 1.

The department awarded $4.5 million to 15 ACH projects, 14 of which included one or more certified clinics. Funds enabled clinics to benefit from tools and resources to progress toward the ACH model of care. This model included behavioral health, public health, social services, and other community partners sharing responsibility for individual and population health. The ACH model highlighted the importance of addressing social determinants of health risk factors such as housing instability and food insecurity to improve overall health.

Toward the end of the SIM grant period in 2017, MDH awarded SIM funds to Morrison-Todd-Wadena Community Health Board and the CentraCare clinic in Long Prairie, MN, for a public health and primary care learning community. Project activities included sharing data from the primary care clinic and public health community needs assessment to better understand population health issues in the community. The project identified high tobacco use in a subset of the population and developed shared strategies and goals for the clinic and local public health to use in addressing the issue.

Glossary (see Appendix A for sources)

Accountable community for health – a structured, cross-sectoral alliance of health care, public health, and other organizations that plans and implements strategies to improve population health and health equity for all residents in a geographic area (Prevention Institute, 2020).

Population health improvement - efforts to improve health, wellbeing, 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.

In 2018, the HCH Program awarded three learning community partnership grants to certified clinics that had existing partnerships with community providers. The purpose of the grants was to increase and strengthen partnerships between primary care, local public health or a tribal health division, and behavioral health by using data and information to support shared population health goals. Each project developed a shared vision. Projects reviewed and used shared data to identify opportunities for development of action plans for improving population health.

Lessons learned from SIM and the 2018 learning community partnership projects, research into other PCMH program standards, and stakeholder input have informed the design of two additional levels of certification beyond the current foundational standards. As described in the section on public participation and stakeholder involvement, the department vetted the concepts for this new certification structure with the HCH advisory committee and its workgroups and a separate rule advisory committee before developing the proposed rule amendments.

Besides soliciting stakeholder input, HCH Program staff have conducted an extensive search of other state and national PCMH and accountable ACH models to identify best and emerging practices and to consider how the current HCH Program requirements align with other programs. This research confirmed that other PCMH programs are adding or have added requirements similar to proposed level 2 HCH requirements. Level 3 requirements more closely align with ACH models currently underway in several states.

HCH Program staff also completed a literature search to inform advancement of the standards to two additional levels of certification. The literature review focused on areas of practice transformation, health equity, population health, community partnerships, and care coordination.

Notice Plan

Our Notice Plan includes giving notice required by statute, in addition to the notice discussed below in this and the below *Public Participation and Stakeholder Involvement* and *Health Equity Policy* sections of this SONAR. We will mail the proposed revisions of Minnesota Rules, 4764.0010-4764.0070, and Notice

of Intent to Adopt to everyone who has registered to be on the department's rulemaking mailing list under Minnesota Statutes, section 14.14, subdivision 1a. We will also give notice to the Legislature per Minnesota Statutes, section 14.116.

Minnesota Statutes, section 14.131, requires that an agency include in its SONAR a description of its efforts to provide additional notification to persons or classes of persons who may be affected by the proposed rule or must explain why these efforts were not made.

The department emailed representatives of all of the health care homes (approximately 250 individuals) and members of the HCH rule advisory committee and workgroups a link to the Request for Comments published in the State Register on September 24, 2018. The HCH Program posted a link to the Request for Comments on the Program's rulemaking webpage and provided the link to the rulemaking webpage in the December 2018 HCH newsletter, *The Connection*.

The HCH Program prepared a four-page summary of the proposed rule amendments and shared it with the HCH advisory committee and workgroup members, HCH rule advisory committee members, and other stakeholders. Beginning in June 2018 through September 2021, the program has included updates in its quarterly newsletter on efforts to amend the rule.

Under Minnesota Statutes, section 14.14, subdivision 1a, MDH believes its regular means of notice, including publication in the *State Register* and the HCH newsletter as well as an email to the following HCH stakeholders will adequately provide notice of this rulemaking to persons interested in or regulated by these rules.

The HCH program intends to send an email notice with a hyperlink to electronic copies of the Notice and the proposed rule amendments on the Program rulemaking webpage to:

1. Four contacts (primary, clinic manager, clinical champion or medical director, finance) for each of the 68 HCH-certified organizations
2. Primary care clinics and organizations that do not have a certified clinic (82)
3. The HCH advisory committee, workgroup members, and interested parties (80)
4. HCH certification committee members (10)
5. HCH rule advisory committee members (see Appendix D)
6. HCH site visit evaluators (5)
7. Participants in the 2019 community engagement meetings
8. HCH quarterly newsletter distribution list (3,029 email addresses)
9. MDH primary care coalition contacts (40)
10. Other interested individuals including respondents to the Request for Comments, health professions organizations, and state boards

The department will post information on the notice at the following locations:

11. MDH Facebook page and Twitter feed
12. HCH rulemaking webpage: Health Care Homes - Rulemaking (state.mn.us)

Our Notice Plan did not include notifying the Commissioner of Agriculture because the rules do not affect farming operations per Minnesota Statutes, section 14.111.

Public Participation and Stakeholder Involvement

The process for amending the HCH rule began in 2016 with a request for information (RFI) and three public meetings that generated input from individuals and organizations across the state. The HCH advisory committee, described below, worked with MDH to develop the RFI. A total of 109 groups representing community organizations, clinics, hospitals, Integrated Health Partnerships (IHP) local public health, consumers, and payers responded to the RFI. Input supported the direction of proposed rule changes. This included the need for strong partnerships between community organizations and clinics, the importance of screening for social determinants of health risks, and cultural competency in clinic personnel (Health Care Homes, 2017).

MDH and DHS established the HCH advisory committee in 2014, pursuant to an amendment to section 256B.0751, which was renumbered as section 62U.03 pursuant to Minnesota Laws 2020, chapter 115, article 3, section 39. This statute requires the HCH advisory committee to advise MDH on ongoing statewide implementation of the Program including potential modifications of the HCH Rule or statutes. The HCH advisory committee has provided ongoing input to the HCH Program on rule revisions. Examples of feedback on rule revisions from the advisory committee are in Appendix E.

Health Care Home Advisory Committee

- 2014 legislative mandate
- Advises on program implementation
- Advice to include modification of the health care home rule
- See membership list at Appendix B

HCH advisory committee members represent the following:

- Primary care providers
- Mental health providers
- Nursing and care coordinators
- Health care homes
- Health plan companies
- Employers
- Academic researchers
- Consumers
- Minnesota organizations that work to improve health care quality
- State agencies

The HCH advisory committee meets three to four times a year. HCH Program staff consult with the advisory committee on proposed program improvements. Starting in 2018, HCH Program staff solicited committee input and provided updates on proposed rule amendments. The advisory committee is supportive of proposed rule revisions.

Also pursuant to legislative authority, the HCH advisory committee established workgroups to address specific topics. Workgroups include HCH advisory committee members and other representatives from certified clinics. The program innovation workgroup provided guidance and expertise to HCH Program staff on improving program processes and certification standards, including possible rule amendments. The workgroup was supportive of rule amendments including the addition of two levels of certification. In 2020, the HCH Program combined the program innovation and learning workgroups into the learning and innovation workgroup, to make more efficient use of workgroup and staff time since the two groups addressed similar topics and issues.

Learning and Innovation Workgroup

- HCH advisory committee workgroup
- Includes advisory committee members and others
- Advises HCH Program on specific topics including rule amendments
- See membership list at Appendix C

Rule Advisory Committee

- Separate body to advise HCH program only on rule amendments
- 30+ members represent HCH advisory committee and workgroups and other interested parties
- Met in 2018
- See membership list at Appendix D

In 2018, the HCH Program convened a separate freestanding rule advisory committee to advise solely on the proposed rule amendments. The committee met four times that year to review and make recommendations to the program on proposed rule amendments that affect the certification and recertification standards and processes. The agenda for each meeting included a HCH Program staff presentation to the committee on one or two of the five standards and proposed revisions and additions to the standard. Following the staff presentation, committee members formed small groups to discuss proposed amendments and provide recommendations. Members then reconvened to share results of the small group discussion. Examples of discussion and support for rule revisions are in the September 20, 2018, meeting minutes in Appendix F.

Besides ongoing input from the HCH advisory committee and its workgroups, and the rule advisory committee, proposed changes to the HCH rule build on other input from key stakeholders. The following additional groups have informed the development of proposed rule changes:

- Certified and non-certified clinics. HCH Program staff conducted phone and in-person meetings with several clinic representatives to discuss program improvements including the concept of additional levels of certification.
- Governor's Health Care Financing Task Force (Manatt Health, 2016). Recommendations included enhancing community partnerships by encouraging or incentivizing partnerships and care coordination activities with a broad range of community organizations within care coordination models.
- Minnesota's Olmstead Plan. Participation in meetings to further understand the needs of individuals with disabilities, provide resources for primary care providers to improve care and monitor the number of individuals with disabilities that are served by certified clinics.
- DHS IHP program staff.
- MDH programs including the Center for Public Health Practice (state and local public health system), Office of Rural Health and Primary Care, Center for Health Information Policy and Transformation.

In 2019, the HCH Program contracted with Minnesota Management and Budget to facilitate seven listening sessions throughout the State to receive input on proposed rule changes to the program. Meetings took place in Maplewood, Eagan, Minneapolis, Fergus Falls, St. Cloud, Duluth, and St. Paul. Participants at the meetings included:

- Advocates
- Local municipal fire departments and emergency responders
- Health professional associations
- Home care providers
- Mental health providers
- Area agencies on aging
- Hospitals and health systems
- Social service organizations
- Governor's Council on Developmental Disabilities

- DHS
- Consumer representatives
- Crisis centers
- Colleges and universities

The summary of findings (Minnesota Management and Budget, 2019) included many examples of "what works" according to session attendees. Examples in the summary include coordinating with partners and aligning efforts, focusing on whole-person health, using care teams and care coordination, integrating the community into the health care setting, and investing in promising approaches for populations with disparities. Overall, session participants supported the themes being put forward in proposed rule amendments.

Statutory authority

The department has the necessary statutory authority to adopt the proposed rule amendments. The department's statutory authority to adopt or amend the rules is stated in Minnesota Statutes section 62U.03.

This section directs MDH to develop and implement the HCH Program standards and to administer the HCH program.[2] It gives MDH discretion to use expedited rulemaking under section 14.389, and it provides that MDH may modify HCH rules with advice from the HCH advisory committee.[3] DHS reimburses HCH clinicians for HCH care coordination services they provide to Minnesota Health Care Program (MHCP) participants. The HCH rule does not regulate payment of HCH services.

Regulatory analysis

A. Description of the classes of persons who probably will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

1. Classes of persons affected by the proposed rule

The proposed rule applies to personal clinicians, clinics, and health systems that choose to seek certification as a health care home. The proposed rule amendments do not change the entities that provide information under this rule. Participation in the program remains voluntary and free.

Revisions affect the following classes of persons:

- Health care clinicians eligible for HCH certification (physicians, physician assistants, and advanced practice registered nurses including those meeting the definition of a local trade are clinician).
- Clinics that provide primary care services and are eligible for HCH certification including those already certified.
- The population of Minnesota and general public including persons from outside of the State of Minnesota who obtain services at a certified clinic.
- Local public health departments and other community organizations and service providers that collaborate with primary care clinics and clinicians certified as a health care home.

[2] § 62U.03, subd. 3.
[3] § 62U.03, subds. 3(c), 11(c)(4).

2. **Classes of persons that will bear the costs of the proposed rule**

   Proposed rule amendments do not require an outlay of funds from health care clinicians or clinics during the application process or at any other time. Eligible clinicians and clinics that choose to meet standards for certification may incur additional costs but may realize cost savings as well.

3. **Classes of person that will benefit from the proposed rule**

   - Certification at advanced levels beyond the foundational standards recognizes clinicians and clinics for providing services that improve patient health outcomes. This recognition better positions clinicians and clinics for value-based reimbursement and other financial incentives and improves care for individuals.
   - Some of the proposed rule revisions will reduce the burden for meeting specific certification requirements such as the proposed amendments to the care plan standard. This will potentially benefit clinics.
   - Many health care homes already perform at a level beyond the current foundational requirements. Proposed rule amendments will allow for an official form of recognition for these clinics and clinicians. The HCH program will acknowledge clinics and clinicians that achieve level 2 or level 3 certification in publications and include them in learning opportunities for advanced levels. Patients will have access to information about HCH clinic certification and recognition.
   - Patients and their families will benefit from clinic efforts to meet level 2 and level 3 standards that require increasing investments in health equity, identifying whole person care needs, and ensuring identified needs are met.
   - Communities will benefit when primary care clinics and clinicians attain advanced level certification through increased data sharing and combined population health improvement goals.
   - All Minnesotans will benefit from the proposed rule through advancing primary care models that address social determinants of health, health equity, population health, and value.

B. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

1. **Probable costs to the agency of implementation and enforcement**

   MDH probable costs for implementing the proposed rule amendments will be minimal. Existing agency staff will conduct the outreach, support, and monitoring needed to communicate with clinics and clinicians on the proposed rule amendments. MDH will incorporate new standards into existing certification requirements and processes, learning offerings, and other program activities.

   Probable costs to any other agency of implementation and enforcement

   No other state agency or local public health agency will have costs. This includes Medicaid expenditures at DHS for HCH care coordination reimbursement. The proposed rule amendments do not affect billing or reimbursement, including the degree to which clinics and clinicians bill for HCH care coordination services.

2. **Anticipated effect on state revenues.**

   Proposed rule amendments will not affect state revenues. Rule revisions will not result in additional claims to DHS for reimbursement of services. The department will not

require additional revenue to implement the rule revisions and will not assess fees or other costs on clinics and clinicians for participating in the program.

C. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Participation in the HCH program remains voluntary and free. The proposed rule is the least costly and least intrusive method for achieving the goals of the program.

1. Less costly methods for achieving the purpose of the proposed rule.

Certification at the current foundational level as well as new proposed level 2 and level 3 are voluntary and free. The department offers certification to clinics with the goal of improving patient care and lowering health care costs and does not charge for technical assistance or learning activities (besides the annual conference) and other supports. Similar programs at the national level require a fee for recognition as a patient centered medical home (PCMH) and for learning resources, making participation in HCH the least costly alternative to achieving recognition as a PCMH. Certification as a health care home positions clinics and organizations to participate more fully in value-based care arrangements that have the potential of providing financial and other incentives to the clinic and organization.

2. Less intrusive methods for achieving the purpose of the proposed rule.

The department will continue to recognize the unique attributes of primary care clinics and organizations in development of new level 2 and level 3 requirements. This approach allows the clinic and organization to meet standards in a way that works best for the organization and patient population. Proposed rule amendments allow the clinic to apply for certification at all three levels at any time and include an option for provisional certification for a clinic to transition into certification at a pace that best fits its needs.

D. A description of any alternative methods for achieving the purpose of the proposed rule that were seriously considered by the Agency and the reasons why they were rejected in favor of the proposed rule.

The only alternative method to the proposed rule would be to continue the program in its current state. The department rejected this alternative because of the importance of recognizing clinics for achieving advanced levels of primary care delivery, the importance of aligning the rule with requirements in the statute, and value of making the program relevant and up to date with changes in health care delivery and reimbursement. The proposed rule amendments have the potential of improving the quality of care patients receive from primary care clinics and clinicians.

E. The probable costs of complying with the proposed rule, including the portion of the total costs that will be borne by identifiable categories of affected parties, such as separate classes of governmental units, businesses, or individuals.

It is within the control of the eligible clinic or clinician to make a decision to participate in the HCH program. Many health care homes currently meet the level 2 and level 3 standards and would be eligible for certification at those levels without additional cost or effort.

<u>Costs of complying</u>

Primary care clinics and health care systems that choose to seek level 2 and 3 certification may incur additional costs in meeting requirements. The department estimates that costs of complying would be due primarily to additional staff time. Although the current foundational standards require staff resources for providing care coordination, the level 2 requirements may require additional staff time over that required for meeting foundational care coordination requirements. Level 3 requirements also could entail more staff resources for the clinic to coordinate efforts and share data with other organizations and agencies in the community.

It is not possible to estimate probable costs of complying with the rule since clinics vary considerably in size and other features and meet certification requirements in the way that works most effectively for the organization. Also, the department is not aware of any formula or methodology for estimating the costs of transforming a practice to a patient-centered medical home.

Possible savings from complying

The HCH clinic approach is to intervene early in patient care and keep patients out of the hospital and emergency department (ED), driving avoidable high costs out of the system and resulting in fewer claims, more effective care, and healthier individuals. While the up-front clinic costs may be higher, the total cost of care is generally reduced. More importantly, patients receive better care and have better health outcomes.

Certified clinics periodically compare the frequency of visits and charges for patients pre- and post-care coordination participation with findings demonstrating savings in the total cost of patient care. Many payers support and share in these savings with the clinic as part of the value-based reimbursement model. Level 2 and 3 certification could result in additional financial benefit for the clinic and organization due to an increased ability to participate in value-based reimbursement.

F. The probable costs or consequences of not adopting the proposed rule, including those costs or consequences borne by identifiable categories of affected parties, such as separate classes of government units, businesses, or individuals.

The department chose to propose rule amendments and add levels of certification to formally recognize health care homes that currently provide enhanced patient care beyond current foundational standards and to increase capacity to improve primary care across the State.

- By not adopting the proposed rule, MDH will be unable to certify clinics and clinicians and offer other incentives to health care homes for addressing social determinant of health (SDOH) risks and health equity and collaborating within the community to improve population health.
- A probable consequence for primary care clinic patients is that they may not have access to the enhanced services that result from level 2 and level 3 certification. This includes services such as identification and fulfillment of SDOH needs.
- The consequences of primary care clinics not meeting SDOH and whole person care needs, not addressing health equity, and not collaborating with other community services providers will have a negative effect on patient and population health.

G. An assessment of any differences between the proposed rule and existing federal regulations and a specific analysis of the need for and reasonableness of each difference.

There are no federal regulations for designating a primary care clinic or organization as a medical home or PCMH. However, several state and national programs recognize primary care clinics as PCMHs using their own criteria. Participation in other state and national PCMH programs is voluntary, but many programs require recognition as a condition of receiving enhanced reimbursement and other incentives.

National PCMH programs include Joint Commission Primary Care Medical Home, National Committee for Quality Assurance (NCQA), and Utilization Review Accreditation Commission. Several states, some large health care systems, and some companies that pay for health care services, such as Blue Cross Blue Shield Blue Care Network of Michigan, also operate PCMH programs. Several state programs include NCQA recognition as a qualification for meeting the state's PCMH program standards.

The HCH Program reviewed requirements in other state and national programs as it developed rule revisions. Minnesota's program is in keeping with criteria used by other states and national program recommendations, and does not create additional, unnecessary, or burdensome requirements.

H. An assessment of the cumulative effect of the rule with other federal and state regulations related to the specific purpose of the rule.

Proposed amendments to the HCH rule are consistent with the Agency for Healthcare Research and Quality shared principles of primary care (Primary Care Collaborative, 2020). These principles define a model of primary care that is person and family centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. Proposed rule amendments align with national PCMH models and promote transformation and progression of the primary care clinic practice to deliver high quality care. The proposed revisions include the option of granting certification to primary care clinics already certified or accredited by other state or national PCMH programs to reduce duplication or cumulative impact from requirements across programs.

Statement of General Need of the Proposed Amendments

The HCH rule has not been amended since it was adopted in 2010.

One of the reasons the HCH rule requires amendments is to update the rule to conform to changes in the HCH statute.[4] The rule is inconsistent with a 2016 revision to the HCH statute that changed the frequency of recertification from an annual requirement to once every three years.[5]

It is also necessary to amend the rule to align it with significant changes in health care delivery and payment. The initial HCH rule adopted in 2010 envisioned a one-size-fits-all model. Experience has shown that clinics and health systems with different levels of resources and capabilities progress through the standards in different ways and at different speeds. In recognition of the differences in clinic capacity and trends in health care services payment and delivery, proposed rule amendments include two additional standards and levels of certification beyond the original standards. The additional levels of certification will support clinics in their efforts to participate in the growing field of value-based purchasing. The Patient Protection and Affordable Care Act of 2010 promoted value-based purchasing in which government, health insurers, and other payers link payment for health care services to improvement in patient and population health. Many health care providers participate in value-based purchasing arrangements that pay based on performance and in some cases require the provider to assume risk. These arrangements include incentives to reward providers that prevent unnecessary utilization of services such as hospital admissions and emergency room visits.

Glossary (see Appendix A for sources)

Value-based purchasing – Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Value-based reimbursement models go by various names such as accountable care organization (ACO) or alternative payment model. The Minnesota Health Care Program (MHCP) at DHS has a value-based purchasing model for Medical Assistance participants called an Integrated Health Partnership (IHP). Combined, Minnesota's now 25 IHPs provide care to over 452 thousand Minnesotans enrolled in MHCP and have achieved an estimated savings of $276 million.

Value-based models emphasize population health improvement, care integration and coordination, and using information technology to improve patient care (National Academies of Sciences, Engineering, and Medicine, 2018). A health care provider like a certified clinic that provides accessible, team-based coordinated care already has the capacity to more successfully participate in a value-based system such as an accountable care organization (ACO). However, current HCH standards

[4] Minn. Laws 2016, ch. 163, art. 3, § 7.

[5] *Compare* Minn. Stat. § 62U.03, subd. 4(a), *with* Minn. R. 4764.0030, subp. 5.

do not fully address requirements for clinics to participate in value-based care arrangements. For clinics to successfully participate in value-based purchasing models that require high-quality, cost-efficient care, they must address all factors that influence patient health. Proposed HCH rule amendments include these factors in the additional levels of certification.

Research shows that clinical or medical care influences only 10 to 20 percent of an individual's health, and genetics another 10 percent. The remaining 70 to 80 percent is due to other life factors including the environment, health behaviors, and social and economic factors. (Kindig, Population health improvement: a community health business model that engages partners in all sectors, 2014) (Blue Cross Blue Shield of Minnesota, University of Minnesota, 2018).

A large portion of those remaining factors are often referred to as social determinants of health. Social determinants of health are estimated to influence 50 percent of health outcomes (National Institute for Health Care Management Foundation, 2019). For this reason, DHS requires IHPs to address social determinants of health (SDOH) in their plans.

SDOH risk factors that contribute to poorer health include low-quality or inadequate housing, lack of access to transportation, lower educational attainment, and food insecurity. Current HCH standards do not adequately address the need to screen and refer patients for SDOH risks and coordinate with community service providers to ensure needs are met.

Another major factor to address for improving health is health equity. Many health disparities are rooted in inequities, and the revisions to the HCH standards more directly address the need for clinics to identify health disparities and implement strategies for achieving health equity.

Glossary (see Appendix A for sources)

Accountable care organization – a group of health care providers who give coordinated care and chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

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

The standards also need a greater emphasis on population health. Addressing population health in the clinic population requires a systematic process for identifying and managing the total health needs of the patient population. This includes an increased emphasis on primary care integration with other care areas, such as behavioral health, to meet whole person health needs. Incorporating a broader focus on SDOH and community partnerships into HCH standards are important strategies for advancing population health, achieving health equity, and improving the quality of whole person care.

With the advent of value-based purchasing, clinics often seek certification due to the alignment of the HCH model with value-based arrangements. Current standards are out of step with the wholistic scope of patient needs clinics must address to transform their practices. Clinic representatives have encouraged the HCH program to develop gradient levels of certification to receive recognition for achievements in addressing needs beyond the current foundational requirements. Proposed additional levels of certification require addressing SDOH and health equity, meeting whole person care needs, expanding community partnerships, and working with other providers on population health improvement.

Reasonableness of the proposed amendments

General Reasonableness

Overall, the proposed revisions to these rules regarding voluntary participation in the HCH Program are reasonable because:

1) Proposed revisions will align with changes in the statute 62U.03.
2) Proposed amendments are consistent with trends in health care delivery and reimbursement.
3) Significant stakeholder review and input support the rule amendments.

Rule-by-Rule Analysis

4764.0010 Applicability and Purpose

Subp. 1. Applicability. MDH's proposed amendments to this subpart are needed for clarity and to retain the subpart's meaning despite the below-discussed revision deleting the rule's definition of applicant from Part 4764.0020, subpart 2.

Subp. 2. Purpose. This subpart introduces new language for a modified framework for the HCH Program, adding two levels of certification beyond current requirements, which are retained at the foundational level. Additional levels of certification are necessary to keep pace with changes in the health care delivery system. Changes in health care delivery include reimbursement in which payment models are increasingly value based. An infrastructure in a certified clinic that provides accessible, effective, team-based integrated care within a health care system is key to successful participation in these models. A broader focus on social determinants of health (SDOH) and community partnerships is an important strategy for advancing population health, achieving health equity, and improving the quality of whole person care.

Progressing levels of certification recognize an organization's increasing capacity to take on value-based care and successfully participate in value-based purchasing arrangements. Clinics choosing to seek certification as a HCH cite the benefits of certified status as a "seal of approval" in marketing their services. The opportunity for certification at additional levels adds to a perception of higher distinction and competency.

The addition of two levels of certification is reasonable because the proposed framework has broad support and builds on key stakeholder input. The HCH Program would support Minnesota primary care clinicians and community partners in seeking level 2 and 3 certification with clear standards, tools, and resources that align with other initiatives at the state and federal levels. All Minnesotans would have the potential to benefit from improved care coordination to meet whole person care needs.

Adding level 2 and level 3 certification is reasonable because it encourages clinics and clinicians to better meet whole person care needs by addressing SDOH. Levels 2 and 3 promote integration of care with local public health, social service organizations, and other health care providers such as mental health and specialists. The department designed level 2 and 3 standards to improve efficacy and coordination in the health care system, increase the ability to address SDOH and whole person care, and strengthen the role of clinics in sharing responsibility for the health of the community.

The addition of two certification levels recognizes clinics that are advancing their models beyond the existing foundational standards to further reduce health disparities, improve the value of health care investments, and address population health and health equity.

The proposed levels of certification fall into three distinct categories.

Foundational standards. Current standards with a focus on building team-based patient-centered care that helps individuals achieve coordinated care within the clinic and among specialty providers.
Level 2: accountable care for the clinic population. Foundational standards and additional activities with a broader focus on individual patients and the clinic population to improve processes that affect whole-person care. Includes addressing SDOH, wellness, and early prevention, and strengthening partnerships across the medical and community social support systems. Level 2 requires clinics to perform at a higher level for the clinic population.
Level 3: community integrated health care. Builds on foundational standards and level 2. Includes population health beyond managing only the clinic population with an emphasis on integrating community health efforts, developing shared responsibility for health, using community health data, and sharing care management. The clinic is in a partnership role with other community organizations to work on population health improvement. Level 3 is similar to the ACH model piloted during the SIM grant and other grants described above in the background section.

Under the system of three certification types, clinics would be free to enter at the level appropriate for them with no requirement to advance to a higher level. Clinics without the capacity to achieve a higher level can continue to be certified at the foundational program standards. Clinics can progress to level 2 and level 3 at their own pace. Certification would remain voluntary and free.

.0020 Definitions

In evaluating the definitions, the department chose to repeal definitions it determined were redundant and where the common dictionary definition for the term was adequate for the purposes of the rule.

Subp. 2. Applicant. The rule needs this amendment to eliminate redundancy because, by definition, applicants are eligible providers. The change is reasonable because the defined terms of eligible provider and health care home are adequate for the rule and dropping the definition of applicant lessens the possibility of confusion over terms.

Subp. 18. Evidence-based guidelines. The department changed the term "evidence-based guidelines" to "evidence-based practice" and defined it to more accurately reflect this type of activity in a clinical setting. The department adopted the proposed definition from the Institute of Medicine (Prendergast, 2010).

Subp. 22. Health care home learning collaborative. The department needed to modify the definition to recognize that health care home learning collaborative activities are available to community-based organizations and health care organizations. This is reasonable because it promotes the goals of the proposed level 2 and level 3 framework to strengthen partnerships across the medical provider network and community support system, address social and other whole person care needs, and move toward integrating community health efforts.

Subp. 22a. Health care home services. The department added a definition for health care home services as a necessary clarification. Clarification is needed since clinics and organizations have interpreted the phrase health care home services differently over time. Most often, clinics and clinicians and others assume the term health care home services refers only to more intensive care coordination services offered to those patients with more complex needs. The change is reasonable because the intent of the rule is for certified clinics to take a population-based approach and to offer services across

a continuum that meet a broad range of needs, not only the needs of those with the highest levels of medical complexity. The department clarifies this requirement in part 4764.0040, subpart 1.

Subp. 23. Health care home team or care team. The amendment is needed to expand the definition of the health care home team or care team to recognize other members involved in a person's care who may be outside of a traditional health professional role. This is reasonable because clinic care teams often include professions such as community health worker and community paramedic that do not fit the traditional definition of health professional.

Subp. 23a. Health disparities. The department added a definition for *health disparities* to support the increased emphasis on health disparities in rule language for level 2 requirements. The definition proposed is taken from the US Department of Health and Human Services Centers for Disease Control and Prevention (Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, 2017).

Subp. 23b. Health equity. The department added a definition for *health equity* because it is emphasized in for the proposed level 2 requirements. The department adopted this proposed definition from a Minnesota Department of Health report to the Legislature on health equity (Minnesota Department of Health, 2014).

Subp. 23c. Health inequities. The department added a definition for *health inequities* because it is necessary in the context of how the rule defines SDOH. The proposed definition is reasonable because it is a widely used definition from the World Health Organization (World Health Organization, 2008).

Subp. 23d. Health literacy. The department added a definition for *health literacy* because it is an important concept for understanding level 2 requirements for patient engagement. The proposed definition is reasonable because it comes from the US Department of Health and Human Services Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, 2019).

Subp. 23e. Integrated care. The department added a definition for *integrated care*. Under proposed revisions, integrated care is an important component of providing whole-person care in a level 2 HCH clinic. A definition of the term is needed to ensure a shared understanding of how to implement these level 2 requirements. The proposed definition is reasonable because it is adapted from the national SAMHSA-HRSA Center for Integrated Health Solutions (SAMHSA-HRSA, 2014).

Subp. 24a. Minnesota statewide quality reporting and measurement system. The rule used an incorrect term, *statewide quality reporting system*, to refer to Minnesota's statewide quality reporting and measurement system, created through Minnesota rules, chapter 4654.[6] This revision is necessary to avoid confusion on the name and to reference the applicable rule.

Subp. 26. Patient. The rule referred to certified clinic patients as *participants*. This change is needed and reasonable because *participant* is not a term normally used to refer to a patient and is confusing because the word *participant* can refer to other persons besides patients.

Subp. 27a. Patient engagement. The department added a definition for *patient engagement*. It is necessary to provide a definition as background for understanding of patient and family centered care principles emphasized in the level 2 requirements. The proposed definition is reasonable because it is adapted from the national Agency for Healthcare Research and Quality (AHRQ) (American Instiutes for Research, 2012).

---

[6] *See* Minn. R. 4764, subp. 37 ("Statewide quality reporting system" definition). The department also proposes deleting this subpart as part of this rule revision.

Subp. 28a. Population health. The department added a definition for *population health*. The definition is necessary because population health is a core component and overarching goal of level 3 requirements. The proposed definition is reasonable because it is from an article in a reputable public health journal, the American Journal of Public Health (Kindig, What is population health, 2003).

Subp. 28b. Population health improvement. The department added a definition *for population health improvement* that is necessary because population health improvement is a core component of level 3 certification. Population health improvement refers to a coordinated approach to improving health in a defined group that could be different from the clinic population. The proposed definition is from a national Pathways to Population Health report (Stout, 2017).

Subp. 32. Primary care services patient population. The current rule uses the term *primary care services patient population* to refer to all patients who receive primary care services from the health care home. It is necessary for the department to delete language at the end of the definition because it is confusing and misleading. The revision is reasonable because the current definition could incorrectly be read to mean that only a subgroup of patients are eligible for the benefits of being a health care home patient.

Subp. 34. Shared decision making. The department slightly modified the current definition in rule for *shared decision making* to acknowledge that a clinic may designate someone from the care team besides a clinician to complete this function. This change is reasonable because it clarifies and strengthens the ability of clinic personnel to practice at a level that fully uses their professional training and skills.

Subp. 34a. Social determinants of health. The department added a definition for *social determinants of health* because it is necessary for understanding the emphasis on SDOH in level 2 clinic certification. The proposed definition is adopted from Social Determinants of Health, The Canadian Facts (Mikkonen, 2010).

Subp. 35. Specialist. The department slightly modified the current definition of *specialist* to provide a necessary clarification that the specialist may either be available onsite as part of the health care home team or through a referral made to someone outside of the health care home. It is reasonable to assume that a specialist may also be practicing within a clinic.

Subp. 39. Whole person care. The department added a definition for *whole person care* because it is necessary for understanding this component in level 2 certification. The proposed definition is from the Primary Care Collaborative, Shared Principles of Primary Care (Epperly, 2019).

.0030 Certification and Recertification Procedures

Subp. 1. Eligibility for certification. It is necessary to delete the requirement that the clinic provide notification to the department within 90 days of a new clinician joining the clinic who intends to become certified because the notification is an unnecessary burden on the clinic. The department currently has access to this information from other sources. The department proposes adding language to this subpart to require the clinic to orient new staff, including clinicians, to the health care home approach to care delivery. This is a reasonable addition because it is important for quality patient care.

Subp. 2. Contents of application. It is necessary to amend the specific requirements of signing an application and completing a self-assessment form. Changes allow the department flexibility in offering the most efficient and least burdensome options for the eligible provider to complete the self-assessment and application. This change is reasonable because it allows for updating the application process to keep pace with technology and meet program needs.

Subp. 5. How to seek recertification. This change is necessary to align with legislative changes made to the HCH statute that changed the recertification cycle from every year to every three years. The department updated this subpart to reflect the statutory change in the recertification cycle. The change is reasonable because it makes the rule consistent with law.

Subp. 5a. How to seek certification as a level 2 or level 3 health care home. The addition of a new HCH proposed framework is necessary to update program standards so they are consistent with changes in the health care delivery system. The proposed framework builds on the current HCH certification framework and adds two levels of progression. The ways to seek certification are reasonable because clinics and organizations would choose to enter at the level appropriate for their organization. Certified clinics could choose to remain at their current level if they continued to meet required criteria. The rule does not require clinics to advance beyond the foundational standards and structure. A certified clinic could elect to change levels within the certification period of three years if they meet the requirements.

.0040 Health Care Homes Standards

Subp. 1. Access and communication standard; certification requirements. The health care home is responsible for the management of the entire clinic population. It is necessary for the department to clarify how health care homes are to implement effective population management. This includes using a systematic process for identifying patients with needs or risk factors that may require additional resources and supports. Changes in this subpart are reasonable because they acknowledge the clinic has a range of interventions and services the clinic could offer to patients based on patient needs and individual circumstances.

The department deleted specific references to patient privacy regulations to eliminate out-of-date citations. This is reasonable because the HCH program does not regulate data privacy and a general statement requiring the certified clinic to maintain policies and procedures for data privacy and security and comply with applicable laws is adequate.

Subp. 2a. Access and communication standard; level 2 certification requirements. The access and communication standard directs the certified clinic to deliver services that facilitate ongoing communication with the patient and the patient's family and provide care when patients need it. It is necessary for the department to add level 2 requirements to access and communication criteria to recognize and encourage clinics for doing the following:

- Support the patient in being engaged in their care. The clinic does this through the use of strategies that increase a patient's knowledge, skills, and willingness to manage their own health and care.
- Improve access to needed services by requiring clinics to identify patients who need services based on non-medical factors and other determinants of health.
- Increase options for how patients and their families can interact with their primary care clinic, clinician, and care team.
- Deliver health care services that meet the social, cultural, and linguistic needs of patients.

The addition of level 2 certification criteria is reasonable because primary care that focuses on the whole person enhances care delivery for the patient and improves patient outcomes. Many factors affect a person's health and wellbeing, including food security, housing, transportation, employment, income, education, lifestyle, social safety nets, and environmental and safety concerns. This change adds requirements for a Level 2 HCH clinic to incorporate a broader set of screening practices that identify patient needs, especially those related to SDOH, and use this information to better target interventions

and services. A November 2019 review of HCH certification and recertification reports found that 42 percent of certified clinics were assessing SDOH needs in their clinic patient population.

To ensure certified clinics can address challenges to accessing care for their patients, Level 2 HCH criteria will include requirements to increase options for how patients access preventive, acute, and chronic care. Level 2 criteria also outline requirements for certified clinics to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. A culturally competent health care system can help improve health outcomes and quality of care, and can contribute to the elimination of racial, ethnic, and other health disparities.

Patient engagement in health care helps to improve health outcomes, promote better care, and achieve lower costs. Certified clinics are using approaches to better engage patients through education, self-management strategies, and engagement of patients and their families in shared decision-making. Primary care that is able to meet patients where they are enables the development of trust, collaboration in goal setting and action steps, and promotes the development of patient and caregiver confidence. Level 2 criteria require certified clinics to implement more rigorous patient engagement strategies through interventions to increase health literacy and help patients manage chronic disease and reduce risk factors.

Subp. 3 Patient registry and tracking patient care activity standard; certification requirements. The current rule requires that certified clinics implement an electronic registry to manage patient care and identify gaps in care. It also requires clinics build upon this at recertification by implementing remedies to prevent the identified gaps in care. Proposed changes eliminate the recertification requirement by repealing subpart 4 and require clinics to meet this criterion as part of the foundational certification requirements via the proposed addition of item C to subpart 3. This change is needed and reasonable because ten years of experience in HCH certification and recertification has demonstrated that clinics normally implement these requirements at the same time. The certified clinic is unlikely to implement registries and identify gaps in care without simultaneously implementing remedies and processes that can address and prevent the identified gaps. The clinic is likely to progress in its level of sophistication in how this is done over time, but that at the most basic level, this is a requirement appropriately met at certification.

Subp. 3a. Patient registry and tracking patient care activity standard; level 2 certification requirements. The foundational patient registry and tracking patient care standard directs certified clinics to use an electronic, searchable registry for the clinic population. Certified clinics use this information to manage health care services, provide appropriate follow-up, and identify gaps in care for their patient population. Additionally, certified clinics use the information to provide and coordinate care for the current and emerging needs of the population they serve. The department is adding level 2 requirements to encourage clinics to add data elements to a patient registry that incorporate SDOH and to use this information to manage care and address unmet needs. This change is needed to address whole person health through broader criteria known to affect the health of a population.

Changes are reasonable because they will allow for the certified clinic to choose the specific SDOH registry elements. This provides flexibility for clinics to consider the unique needs of their patient populations and communities. Stakeholder feedback, including discussion among the rulemaking advisory committee, supported the use of patient registry requirements that encourage population health improvement through collection and use of actionable patient data inclusive of SDOH. Many clinics currently are using screening tools to assess needs related to SDOH but are at varying levels of capacity in applying this information to care delivery. For this reason, stakeholders felt it was important to allow flexibility and maintain a non-prescriptive approach to required elements thereby supporting varying capacity and technology, i.e., electronic health records. Flexibility is important for continued model progression in certified clinics of smaller size and fewer resources.

Subp. 6a. Care coordination standard; level 2 certification requirements. The care coordination standard directs clinics to have a system that delivers coordinated care focused on the patient and their family's needs. The department is adding level 2 HCH certification criteria that will advance coordinated care systems. Level 2 certification criteria require a certified clinic to have multidisciplinary care team to meet patient and family needs, ensure information exchange, and implement processes aimed at improving safety and reducing readmissions and unnecessary ED utilization. These changes are needed and reasonable because:

- The care team will need a broader set of disciplines and expertise to address whole person patient care needs identified through expanded screening processes. The changes are reasonable because they allow for clinic flexibility. Certified clinics can choose the make-up of the integrated care team based on the needs of their patient population and available resources.
- Health care home care team members and their health care partners need to share relevant medical information about shared patients. Access to accurate and up-to-date information about patients results in coordinated care, which can improve quality and enhance patient safety. Although stakeholders agree this is an important component to improving care, additional feedback from advisory committees and workgroups describe various challenges with sharing information among external partners, including technical limitations, concerns with patient data privacy and security, and lack of organizational processes. Proposed level 2 requirements are reasonable because they acknowledge these challenges and barriers. Changes require certified clinics to demonstrate they are working to improve information sharing processes but also consider what is within the clinic scope and locus of control.
- Effective care transitions are key to improved outcomes for patient populations with higher risk. Poorly coordinated care transitions result in higher costs, poor health outcomes, and adverse events such as medication errors and complications. The focus on reducing readmissions and unnecessary ED utilization is reasonable because it aligns with current alternative payment arrangements, such as in ACOs and efforts to reduce the cost of care.

Subp. 7. Care plan standard; certification requirements. The care plan standard requires certified clinics to develop a patient centered care plan with specific elements for selected patients with chronic or complex conditions. Current rule provides certified clinics with flexibility to develop policies and procedures that guide the development of a care plan for selected patients using self-determined criteria. Despite that flexibility, stakeholder feedback from advisory committees, workgroups, certified clinics, and uncertified primary care clinics reveals that the care plan standard is generally difficult to fully meet, burdensome, and not valuable as a key component of health improvement.

Review of HCH certification and recertification reports over time also confirms that the care plan results in a higher proportion of variances than other HCH standards. Furthermore, progress in development of technology, electronic health records, patient portals, online tools, and apps allows for multiple ways in which clinics may be sharing the elements of a care plan with patients, care team members, and external partners supporting the patient. The care plan standard remains a relevant and important component to the HCH care delivery model, but it requires changes to broaden the criteria and increase flexibility. The proposed changes are reasonable because they provide clarity to the care plan standard through the use of plain language, acknowledgement of care plan format variability, and inclusion of SDOH criteria.

Subp. 8. Care plan standard; recertification requirements. It is necessary for the department to clarify that HCH clinics are to integrate external care plans into the HCH patient care plan to the extent that information is useful to meeting patient needs and supporting patient goals. The certified clinic is to consider the expertise and role in supporting the patient's health of all care team members and community providers that serve a patient, including those external to the health care home team.

However, creating an exhaustive list of those members and providers is not the best use of clinic resources and staff time, nor is it of value to the patient. The change is reasonable because it is important that patients make connections and linkages with external care team members and community providers that are relevant to meeting their current needs.

Subp. 9. Performance reporting and quality improvement standard; certification requirements. The department is proposing that it no longer specify the exact makeup and number of certified clinic attendees who must participate in the HCH learning collaborative. The change will require certified clinic participation that reflects the structure of the clinic. This change is needed because clinics are in the best position to determine the number and type of personnel to assign to participation in HCH learning collaborative activities. This change is reasonable because it provides flexibility for the clinic to determine participation in the variety of learning offerings that the HCH program currently provides (including webinars, online learning, regional meetings, and an annual conference).

Subp. 12 Performance reporting and quality improvement standard; level 2 certification requirements. The performance reporting and quality improvement standard directs clinics to engage in continuous improvement processes that focus on the patient's assessment of their experience at the clinic, patient health, and the cost-effectiveness of services. The department is adding level 2 HCH certification criteria that will advance these processes through requirements to:

- use community health data to inform clinic strategies and improvement plans;
- address health disparities within the clinic population through quality improvement efforts; and
- recruit, promote, and support patient participation in clinic operations and quality improvement efforts that reflect the diversity of the patient population.

These additions are needed because community health data and information can identify key SDOH and wellbeing factors that influence the health of the patient population.

It is necessary for certified clinics to monitor and track disparities within their patient population to implement potential solutions to identified disparities. Addressing appropriate solutions requires authentic patient engagement and the use of patient feedback. As a key principle to patient and family centered care, current foundational HCH certification criteria require clinics to engage patients at the direct care and organizational levels, and to use patient feedback in their quality improvement teams and processes. Level 2 criteria will require clinics to ensure patient feedback reflects diversity of the patient population and includes underrepresented voices.

These changes are reasonable because it is important that clinics understand these factors and address them in strategic plans, operations, and quality improvement plans, as appropriate.

Subp. 13. Performance reporting and quality improvement standard; level 3 certification requirements. This subpart introduces the only Level 3 HCH certification requirements. Level 3 certification criteria broaden the focus from the clinic population to include population health. The emphasis is on:

- Integrating community health efforts
- Using data to collaboratively plan community-based health improvement efforts
- Developing shared responsibility for health among cross-sector partners, and
- Participating in processes that share in the communication and dissemination of this work.

Comprehensive data sources are essential to understanding community health needs and population health. Certified clinics have important information and data to contribute to a

comprehensive community health assessment. Because population health requires a multi-sector approach, the most effective, efficient, sustainable way to improve population health is for health care organizations to develop relationships and skills to work effectively with community partners and collaboratively approach community health needs. Achievement of improved health and cost savings requires shared responsibility across clinic and community partners. All partners, including clinic partners, have shared responsibility in addressing the health needs of the community and for the ongoing monitoring and tracking of data to determine the impact of efforts.

The HCH rule advisory committee recommended a requirement for certified clinics to promote community engagement and incorporate the community voice. In response, the department added the requirement for the certified clinic to share in the dissemination of community health information and communication of improvement planning efforts. The clinic and other community providers and agencies need to be engaged in this work, connected to, and aware of community level data and community-based health improvement efforts to improve population health.

Several pilots in which certified clinics and community partners shared data to inform quality improvement efforts have reinforced this concept and provided learnings that clinics can use to improve their capacity in this area. These pilots are further discussed in the background section of this SONAR.

.0050 Variance

Subp. 3 Variance for superior outcomes and continued progress on standards. The department proposes deleting this variance. Repeal is necessary because the requirement to meet all benchmarking criteria to get the variance has proven unattainable in practice. It is reasonable to repeal the subpart since there have been no instances since the inception of the HCH program in which a clinic has successfully applied for this variance.

Subp. 4 Variance for seeking better solutions and testing new methods. The department proposes broadening the scope of the experimental variance to include participation in a health care home research project as a valuable option for granting a variance. This is necessary because, as the department works to build the evidence for the HCH program and advance primary care through research, it will need the participation and partnership of HCH organizations and clinics. The department will use this variance to defer recertification for a certified clinic that is participating in research. The variance will provide an incentive for the clinic to participate in research that will contribute to the knowledge and advancement of the HCH program. The variance is reasonable because clinics are busy and have many priorities; the department does not want a health care home to have to choose between participating in a joint research project and completing recertification requirements.

.0070 Revocation, reinstatement, surrender, recognition of external accrediting bodies and patient-centered medical home programs, and provisional certification and recertification,

Subp. 1 Revocation. The department proposes deleting language referencing care coordination payments. This is necessary because it is not applicable to the implementation of the health care home care delivery model and the scope of this rule. It is reasonable to delete inapplicable and potentially confusing rule language.

Subp. 2 Reinstatement of revocation. This subpart's heading is being revised to make clear that it is specific to the reinstatement of revocation as outlined in 4764.0070, subpart 1. This subpart also was aligned with new provisional certification and provisional recertification processes proposed in part 4764.0070 subpart 7.

Subp. 3 Surrender. The department proposes deleting the 90-day timeline for the written notice. This is necessary and reasonable because specifying a timeframe is not pertinent to voluntary surrender of health care home certification. A clinic may choose to surrender certification at any time and the department considers the clinic to be certified until it chooses to not recertify according to procedures in part 4764.0030.

As in part 4764.0070 subpart 1, the department proposes deleting language referencing care coordination payments. Deletion is necessary as it is not applicable to the implementation of the health care home care delivery model and the scope of this rule. It is reasonable to delete inapplicable and potentially confusing rule language.

Subp. 4 Reinstatement of surrendered certification. The department proposes adding a process for reinstating certification of a clinic that has voluntarily surrendered their health care home certification. This is necessary because a small number of Minnesota clinics have surrendered their health care home certification in the past. Outlining a process for reinstatement, should a clinic choose to seek it, better serves the clinic and promotion of the program and is prudent and reasonable.

Subp. 5 Recognition of other certification programs or accrediting bodies. The addition of this subpart is necessary to allow the department to honor other PCMH recognition, certification processes, or accrediting bodies if the certification or accreditation requirements meet or exceed health care home standards and program goals. The health care environment has changed considerably since adoption of the HCH rule in 2010. Now there are numerous national and state programs recognizing or certifying clinics as a PCMH. Also, some health care systems have an internal program that follows PCMH principles and are well-aligned with HCH requirements. The HCH program constructed crosswalks to compare requirements in these other PCMH programs with HCH requirements to understand their alignment with HCH standards and goals. The addition of this subpart is reasonable because it is in the best interest of both the department and the clinic to streamline the HCH certification and recertification procedures where there is alignment across requirements and standards.

Subp. 6 Provisional certification. The department proposes to add processes for provisional certification to encourage clinics interested in certification but experiencing barriers to meeting the requirements. The new subpart is necessary and reasonable because it provides an incremental or stepped process allowing clinics to achieve a provisional certification while continuing to work with the department to build their capacity to gain certification.

Subp. 7 Provisional recertification. The department proposes adding a similar process for provisional recertification to encourage clinics interested in recertification and experiencing barriers to meeting the recertification requirements. The subpart is necessary and reasonable because it provides an incremental or stepped process, allowing clinics to achieve a provisional recertification while continuing to work with the department to build their capacity to achieve recertification.

Health Equity Policy

The department has intentionally sought to make changes to the HCH rule to recognize and support clinics in addressing SDOH and positively impacting health equity. Changes to the rule prioritize treatment of the whole person by including the SDOH as a factor contributing to better health outcomes. The department focused on increasing investments in health equity through identifying whole person care needs and ensuring identified needs are met.

The department engaged community stakeholders in the rule change process by recruiting rule advisory committee members who represent diverse populations and holding facilitated community engagement sessions across the State.

Performance-based rules

Minnesota Statutes, section 14.002, requires state agencies, whenever feasible, to develop rules that are not overly prescriptive and inflexible, and rules that emphasize achievement of the department's regulatory objectives while allowing maximum flexibility to regulated parties and to the department in meeting those objectives.

The HCH program will continue to operate under performance-based standards that emphasize superior care delivery. The rule-by-rule analysis describes the outcomes that standards are designed to achieve and emphasizes one of the main program goals of incorporating maximum flexibility into how the clinic best achieves improved care delivery and health outcomes in the population.

HCH rules include reporting of measurable quality indicators, and this requirement remains in effect in the proposed rules. This includes a requirement to submit data and implement quality improvement activities for quality indicators.

The HCH program will remain voluntary. The proposed rules provide additional flexibility for clinics to be granted variances for participation in a research project that is intended to contribute to innovation and improvement of care delivery and allow for certification to a clinic or clinician who has certification from another PCMH program if certification meet or exceed health care home standards and program goals. Proposed amendments also allow an eligible provider to request provisional certification if it is experiencing barriers or challenges to certification or recertification and clarify the process for reinstating a surrendered certification.

MDH asserts that it has met its requirements for establishing performance-based standards and maximum flexibility.

Consult with MMB on local government impact

As required by Minnesota Statutes, section 14.131, MDH has consulted with Minnesota Management and Budget (MMB). We did this by sending MMB copies of the proposed rules and SONAR on November 17, 2021. A copy of this letter is attached as Appendix G. MDH has not received responsive feedback from MMB.

Impact on local government ordinances and rules

Minnesota Statutes, section, subdivision 1, requires an agency to determine whether a proposed rule will require a local government to adopt or amend any ordinances or other regulation in order to comply with the rule. MDH has determined that the proposed amendments will not have any effect on local ordinances or regulations.

Costs of complying for small business or city

Minnesota Statutes, section 14.127, subdivisions 1 and 2, require an agency to "determine if the cost of complying with a proposed rule in the first year after the rule takes effect will exceed $25,000 for any one business that has less than 50 full-time employees, or any one statutory or home rule charter city that has less than ten full-time employees."

Participation in the HCH program is at the option of the organization and any potential costs of complying with the standards are voluntarily assumed by the health system and clinic organization. Some clinics may qualify as small businesses, but participation is voluntary. Costs of meeting the requirements in the standards depend upon decisions and choices of the organization that is applying for certification. Cities are not eligible for HCH certification and this rule does not apply to cities.

Differences with federal and other state standards

Federal regulations do not exist for designating a primary care clinic or organization as a PCMH. However, other state and national programs recognize primary care clinics as a PCMH using their own specific criteria. The HCH program reviewed requirements in these state and national programs as it developed rule revisions and found that the standards and requirements in the proposed rule align closely with those in other PCMH programs and models.

SONAR appendices

Appendix A. Glossary
Appendix B. Health Care Homes Advisory Committee members
Appendix C. HCH Learning and Innovation Workgroup members
Appendix D. Rule Advisory Committee members
Appendix E. Health Care Homes Advisory Committee meeting input on progression model 3/5/2109
Appendix F. Rule Advisory Committee meeting minutes
Appendix G. Letter to MMB

Conclusion and MDH signature

In this SONAR, the agency has established the need for and the reasonableness of each of the proposed amendments to Minnesota Rules, chapter 4764. The agency has provided the necessary notice and, in this SONAR, documented its compliance with all applicable administrative rulemaking requirements of Minnesota statute and rules.

Based on the forgoing, the proposed amendments are both needed and reasonable.

____
Jan K. Malcolm, Commissioner
Minnesota Department of Health

____
Date

Appendices

Appendix A: Glossary

2008 Health Care Reform Act – Requires the commissioners of health and human services to develop and implement certification standards for health care homes, and to develop a payment system to provide health care homes with per-person care coordination fees (Chun, 2008).

Accountable care organization – a group of health care providers who give coordinated care and chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings (US Centers for Medicare & Medicaid Services, 2020).

Accountable community for health – a structured, cross-sectoral alliance of health care, public health, and other organizations that plans and implements strategies to improve population health and health equity for all residents in a geographic area (Prevention Institute, 2020).

Care coordination – a team approach that engages the patient, personal clinician, and other members of the health care home team to enhance the patient's wellbeing by organizing timely access to resources and necessary care that results in continuity of care and builds trust.[7]

Fee for service – a method in which doctors and other health care providers are paid for each service performed such as tests and office visits (US Centers for Medicare & Medicaid Services, 2020).

Health care home – a clinic, personal clinician, or local trade area clinician that is certified under parts 4764.0010 to 0070.[8]

Health equity – achieving the conditions in which all people have the opportunity to attain their highest possible level of health (Minnesota Department of Health, 2014).

Learning collaborative – health care home team members, patients, and other organizations that provide health care and community-based services participate in learning activities together and share experiences.[9]

Medical home or patient-centered medical home – an approach to providing primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs (Primary Care Collaborative, 2020).

Minnesota statewide quality reporting and measurement system – a system at MDH to collect data necessary for monitoring compliance with certification standards and for evaluating the impact of health care homes on outcomes.[10]

Patient-centered medical home or medical home – an approach to providing primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs (Primary Care Collaborative, 2020).

Primary care – overall and ongoing medical responsibility for a patient's care, including preventive care and a full range of acute and chronic conditions, and end-of-life care when appropriate.[11]

Population health – the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

---

[7] *See* Minn. R. 4764.0020, subp. 3
[8] *See* Minn. R. 4764.0020, subp. 21
[9] *See* Minn. R. 4764.0020, subp. 22
[10] *See* Proposed Minn. R. 4764.0020, subp. 24a
[11] *See* Minn. R. 4764.0020, subp. 31

Population health improvement – efforts to improve health, wellbeing, 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.

Social determinants of health – 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. Social determinants of health are mostly responsible for health inequities that are the unfair and avoidable differences in health status seen within and between countries (Mikkonen, 2010).

Value-based purchasing – linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers (US Centers for Medicare & Medicaid Services, 2020).

Appendix B: Health Care Homes Advisory Committee members

(Bold text indicates members involved during the rulemaking process: Italic text in parenthesis notes change, if any in membership since that time)

ACADEMIC RESEARCHER IN MINNESOTA

- **Rhonda Cady** *(Steve Dehmer)*
  Gillette Children's Specialty Healthcare *(HealthPartners)*

CERTIFIED HEALTH CARE HOME REPRESENTATIVE

- **Monica Aidoo-Abrahams** *(Jennifer Jerde)*
  Hennepin Healthcare (Ridgeview)
- **Dale Dobrin** *(Wendy Borth)*
  South Lake Pediatric Clinic *(Sleepy Eye Medical center)*
- **Rebecca Nixon**
  North Memorial
- **Tracy Telander**
  HealthEast

CONSUMER OR PATIENT

- **Philip Deering** *(Hanna Barr)*
- **Robert C. Jones** *(Arjun Kataria)*
- **Samuel Mwangi Sr.** *(Anna Pederson)*
- **Melissa Winger**

EMPLOYER

- **Shawna Gisch** *(Philip Deering)*
  UnitedHealth Group

HEALTH CARE PROFESSIONAL

- **Dana Brandenburg**
  U of MN Department of Family Medicine and Community Health
- **Thomas Kottke** (Dale Dobrin)
  HealthPartners (South Lake Pediatrics)
- **Christine Singer** (*Tatiana Keretesh)*
  West Side Community Health Services *(Ramsey County Public Health)*
- **David Thorson** *(Andrea Voss)*
  Primary Care Provider *(Genevive)*

STATE AGENCY REPRESENTATIVE

- **Lorna K. Smith**
  State Member, State Employee Group Insurance Program

QUALITY IMPROVEMENT ORGANIZATION REPRESENTATIVE

- **Sarah Horst** *(Jerri Hiniker)*
  Institute for Clinical Systems Improvement *(Stratis Health)*

Appendix C: Learning and Innovation Workgroup members

- **Al Strauss, Training and Development Specialist**
  MDH
- **Alex Dahlquist, Office of Statewide Health Improvement**
  MDH
- **Ben C. Bengtson, Clinic Manager and HCH Lead**
  St. Luke's Health System
- **Brittney Dahlin, Quality Improvement Director**
  Minnesota Association of Community Health Centers
- **Caryn McGeary, Quality and Patient Safety Coordinator**
  Affiliated Community Medical Center
- **Charlie Mandile, Executive Director**
  HealthFinders Collaborative
- **Claire Neely, MD, Medical Director**
  Institute for Clinical Systems Improvement (ICSI)
- **Daniel Backes**
  CentraCare Health
- **Deb McKinley, HCH Educational Partner**
  Stratis Health
- **Eileen Weber, Clinical Assistant Professor**
  University of Minnesota School of Nursing
- **Jenny Kolb, Care Coordination Manager**
  Fairview Health Services
- **Jill Swenson, Care Management Lead RN**
  Sanford Health
- **John Halfen, MD, Chief Medical Officer**
  Lakewood Health System
- **John Hobday, Owner**
  Healthcare Interactive
- **Joy May, Team Based Care Delivery Lead**
  Hutchinson Health
- **Kris Monson, Clinic Manager**
  Lac Qui Parle Clinic
- **Kristen Godfrey Walters, Community Care Coordination Manager**
  Hennepin County Medical Center
- **Kristi Van Riper**
  University of Minnesota Physicians
- **Maggie Wacker**
  HealthPartners
- **Melissa Winger**
  Consumer
- **Miranda Cantine**
  Ortonville Area Health Services
- **Nancy Miller, Quality Improvement Program Manager**
  Stratis Health
- **Nicky Mack, Program Manager**
  North Memorial Health
- **Rachel Finley, Operations Supervisor**
  Fairview Health Services
- **Rhonda Buckallew, Clinic Administrator**
  Unity Family Healthcare
- **Sarah Horst**
  ICSI
- **Savannah Altman, HCH Coordinator**
  Alexandria Clinic
- **Vimbai Madzura, Integration Reform Manager**
  DHS

Appendix D: Rule Advisory Committee members

- **Anne Schloegel, Planner Principal**
  Center for Health Information Policy and Transformation, MDH
- **Beth Gyllstrom, Research Scientist**
  Performance Improvement and Research, MDH
- **Bev Annis, RN, BA, CHES**
  HCH Site Visit Evaluator
- **Brittney Dahlin, Quality Improvement Director**
  Minnesota Association of Community Health Centers
- **Carolyn Allshouse, Executive Director**
  Family Voices of Minnesota
- **Cherylee Sherry, Supervisor**
  Statewide Health Improvement Partnership, MDH
- **Clarence Jones**
  Consumer representative
- **Daisey Sanchez**
  Health Finders Collaborative
- **Dale Dobrin, MD**
  South Lake Pediatrics
- **Dawn Simonson, Executive Director**
  Metropolitan Area Agency on Aging
- **Deborah Cushman, Associate Director**
  Minnesota Literacy Council
- **Eileen Weber, Clinical Assistant Professor**
  University of Minnesota School of Nursing
- **George Klauser, Executive Director**
  Altair ACO
- **Gena Graves**
  Park Nicollet
- **Isolina Soto, Lead Mental Health Case Manager**
  West Side Community Health Center
- **Jane Kluge, Ambulatory Care Management Coordinator**
  CentraCare Health
- **Jenny Kolb, Care Management Services Coordinator**
  Fairview Health Services
- **Jill Swenson, Care Management Lead RN**
  Sanford Health
- **Jodi Painschab, Clinic Administrator**
  Stellis Health
- **John Halfen, MD, Medical Director**
  Lakewood Health Systems
- **Kristen Godfrey Walters, Community Care Coordination Manager**
  Hennepin County Medical Center
- **Mary Benbenek, Certified Family Medicine and Pediatric NP**
  Minnesota Nurse Practitioners
- **Miranda Cantine, RN Health Coach**
  Ortonville Area Health Services
- **Naomi Samuelson, Health Care Home Coordinator**
  Murray County Medical Center
- **Nicky Mack**
  North Memorial Health
- **Rhonda Cady**
  Gillette Children's Hospital
- **Sandy Anderson**
  Sleepy Eye Medical Center
- **Sara Bonneville**
  Integrated Health Partnerships, DHS
- **Sarah Horst**
  Institute for Clinical Systems Improvement

Appendix E: Health Care Home Advisory Committee meeting input on progression model 3/5/2019

Burden

- How much time is this going to take?
- How does a clinic staff for this?
- Can individual clinics afford the investment to do this? (SDOH, partnerships). Could this result in a net loss?
- How does a small clinic access QI data? They do not have access now and need tools to do so.
- How can this be accomplished at the clinic level? (SDOH, food access, education)
- Developing partnerships creates barriers with data privacy and funding.
- Important that we select metrics that **align with HEDIS** – no new measures, no new burden; Health Plans would be more likely to support this – it's a win/win
- Let's not lay on MORE work/metrics – **no more burden** – blend, align with other metrics

Need for Clarification

- Care coordination: what does community-based model mean? Provide examples.
- Are outcomes presented in this model actually related to cost of care or is this just a hypothesis?
- What do the distinct levels actually mean?
- Are screening requirements just for patients receiving high levels of care coordination, or the whole clinic? **Answer:** Both. All patients may receive certain general screenings (a PHQ, for example). But only those scoring in a certain way would need to be screened with other risk assessments and such
- **Comment:** I like the changes, in particular adding the social determinants to screening. Where would this data be kept; for example, information on transportation issues? Patients want this kind of thing to remain private
- **Comment:** Most clinics are already doing many of the things specified in the proposed changes. It does not seem like the Level 2 requirements are a major stretch. Though, more thought is required. Maybe some clinics will have more work to do than others
- Some kind of additional guidance would be helpful when it comes to how to implement changes. The operational aspects could be a bigger lift for some clinics

Incentives for Clinic, Patient, Payer; Clinic Recognition

- Why would a clinic want to do this?
- How does this model fit with payers? Payments are tied to delivery of health services only.
- What is the value we are getting from this? (payer perspective)
- What is the value to the clinic at a level 2 or 3 other than civic engagement? Why? Is there any association with revenue?
- Tie recognition to financial rewards and or best practice. And give transparency to patients in order to attract patients. From a patient perspective why is this clinic better at a level 2 or 3?
- Recognition must have meaning to the purchasers, what is the value to them? Tie the impact of the HCH to SDOH from the purchaser's perspective.
- How do other PCMH programs recognize clinics? How can HCH tie its recognition to other model recognition? (see handout)
- Consider CEU's for nursing, providers, MDs.
- Recognition of Care Coordinators who go above and beyond.
- The biggest question remains to be WHY?

- The Explanation of the "How" through the tools and documents describing the progression with examples is very helpful. These help to see the transformation from foundational to advanced levels. This is also important for the consumer to understand.
- Tie recognition to MCO, IHP, State, and Federal funding-this must be hardwired.
- Communicate to patients so they can appreciate the value of advanced levels. "This is what it means to YOU as a patient/consumer." To fosters patient pride and could help engage patients in their own care and self-efficacy.
- More communication is needed from MDH about the value of HCH.
- Marketing and promotion targeted to patients and clinic staff.
- **(phone)** How might recognition work? **Response:** Could be internal. Could be around recertification time. Still to be determined and a number of options
- What about a certificate, like at recertification? Maybe something for the system as a whole, saying "this is how much you've improved"
- What's the incentive to go through the effort to advance to Level 2? Recognition is nice, but what's the overall benefit? Otherwise, you are relying on clinic's excitement to just do it. Financial incentives would be nice, but it is understood that this is probably not realistic
- One possible way of offering value would be to emphasize how the HCH model enhances your ability to be successful in value-based payment arrangements. **Comment:** That is very high level and difficult to see in the day-to-day work.

Metrics

- Need to think about measuring **outcomes as well as process** to reinforce accountability; outcomes may include cost, utilization, provider well-being (**Quadruple Aim**)
- Need to think about how metrics support the overall goal – **Quadruple Aim**? Other patient outcomes might include quality of life, longevity, social outcomes, mortality
- You can measure process, but **measuring outcomes is harder**
- **In a partnership environment, how do you attribute successful change?**
- **Goals are community specific**; rural and urban communities are quite different from each other
- **Long time required to measure impact** for the new rule revisions – social changes leading to improved community health can take a long time to show improvement, some are generational
- **Access to data will continue to be challenging**, especially social determinants of health.
- Consider how to **quantify risk**

Concerns, Comments on Requirements

- What is the minimum for meeting a requirement? For example, registry lists several health determinants – is addressing one such as food security enough, or is it all? How in-depth must the factor be met? What is the entry point? Should the minimum test for meeting the requirement be 2? more?
- Not all patients need level 2 or 3. Could a system designate some care coordination staff to work at this level but not all?
- Could credit be given for the community health needs assessment?
- What does monitoring for this look like?
- (phone)Under Access and Communication, the first Proposed Level 2 requirement (Registries & Tracking as well): MDH will continue to be as non-prescriptive as possible. So, in terms of how you implement, we will continue to leave things in the power of the clinic. The examples listed are just that. And no single screening tool will be required. Clinics appreciate guidance, but do not want to be dictated to in terms of which tool to use

- When considering the various payers beyond DHS/Medicaid, must consider the “underemployed” and employees. An example was shared of how Lakewood/Staples developed a plan to address food insecurity for their patient population and then learned their own employees/underemployed also struggled with food insecurity and so they expanded their plan for food pharmacy to employees and patients and community.
- **Screening** around social determinants of health – there are many screening tools available; we would need to select ONE – SOD metrics would probably measure screening activity/volume
- Need to think about **access to resources as a corollary to screening**; it does not do any good to screen if there are not resources for follow up (example: screening for violence in the home without resources to address it is frustrating for patients and providers and does not lead to improved outcomes)
- The rule revisions **fill in some of the gaps regarding “how” to meet standards** –they are achievable
- Level 2 looks **manageable and reasonable** – can we **choose a tool for risk stratification**?

Other

- Patients need to know they can bring input.
- Recommended reading: “Make a Trend 20-20” (could not locate on internet)

Appendix F: Rule Advisory Committee Meeting Minutes

Meeting Date and Location

Thursday September 20, 2018, 1:30-3:30 pm

Institute for Clinical Systems Improvement (ICSI), Riverview Office Tower, 8009 34th Avenue South, Bloomington

Committee Members Attending

Carolyn Allshouse, Sandy Anderson, Bev Annis, Sara Bonneville, Rhonda Cady, Brittney Dahlin, Kristen Godfrey Walters, Beth Gyllstrom, Sarah Horst, Clarence Jones, Jane Kluge, Jenny Kolb, Nicky Mack, Jodi Painschab, Anne Schloegel, Cherylee Sherry, Isolina Soto, Jill Swenson, Will Wilson

Health Care Homes Staff Attending

Carol Bauer, Chris Dobbe, Danette Holznagel, Dorothy Hull, David Kurtzon, Bonnie LaPlante, Tina Peters, Rosemarie Rodriguez-Hager, Tim Jenkins, Diane Rydrych (Health Policy Division director)

Meeting Objectives

- Rule Advisory Committee (RAC) members will have increased understanding of the foundational standards for Registry and Tracking and Performance Reporting and Quality Improvement
- RAC members will review, discuss, and provide recommendations on possible revisions and progression level criteria for the Registry and Tracking and Performance Reporting and Quality Improvement standards

Agenda Items & Discussion

Welcome, introductions, approval of minutes

Bonnie LaPlante facilitated introductions, reviewed the agenda, and provided an overview of the Health Care Homes proposed progression model and how levels 2 and 3 compare and differ.

Levels 2 and 3 are new but many clinics are already achieving the goals and requirements of the advanced levels. Level 2 includes use of shared data and a broader or expanded use of data to affect whole person care needs. Level 3 has been tested nationally and in MN with the Accountable Communities for Health. There is no expectation that all clinics will, should, or need to achieve levels 2 or 3, although there are examples of work being done at levels 2 and 3 in MN.

Registry and Tracking standard and possible requirements for advanced levels

- Recommendation to check this standard in the Foundations course on the Learning Management System
- Current requirements:
  - A searchable electronic registry used to identify sub-groups of the population. An example: Clinic A identifies patients with Diabetes who are using the ED, pulling the data on this population out of their registry
  - Registry elements include: Name, age, gender, contact information, identification number, and other “gaps in care” measures
- Recertification requirements:
  - Clinic should be looking for opportunities to standardize how they address and monitor care via registry work

        - Registry used to address gaps in care including: pre-visit planning, reminders for preventative care, tests, follow-up
- Proposed Level 2 criteria
        - Registry use expanded to include criteria to address and identify social determinants of health
        - Potential elements: Housing, transportation, food insecurity, race, ethnicity, and language
        - Example: CentraCare is interested in chronic disease management and preventative care, but if a patient is homeless, that is going to be a higher priority for them. CentraCare understands that this needs to be addressed before more routine medical care can be delivered
        - HCH clinic plans and implements interventions to address patients' unmet physical and social needs
        - Example: NowPow is an organization that matches needs with community resources. Using NowPow, a clinic could identify five resources in a given area to meet a particular need, such as transportation or housing

Registry and Tracking discussion and recommendations

The committee split into three separate discussion groups, two in-person and one consisting of phone/WebEx participants. After discussion the larger group reconvened to share conclusions. What follows is a summary of feedback provided by discussion groups.

- The new rule encourages population based care and the public health model.
- Clinic registry variability and staff capacity issues need to be addressed for the new rule to be effective.
- New Rule should:
    - Call out mental health.
    - Require sufficient and uniform demographic data collection needed to identify disparities and advance equity.
    - Require patient preferred contact method to reflect patient realities [especially patients who don't have access or have communication barriers] and most current communication technologies.

More detailed notes from each discussion group follow at the end of the meeting minutes.

Performance Measurement and Quality Improvement standard and possible requirements for advanced levels

Tina Peters provided an overview of the Performance Measurement and Quality Improvement standard and the potential requirements for progression levels 2 and 3. Jane Kluge from CentraCare Health presented to the group on how a CentraCare Clinic and local public health partnership exemplified progression level 3 requirements by sharing data, prioritizing community health issues, and working toward mutually determined goals.

Performance Measurement and Quality Improvement discussion and recommendations

Committee split into three separate discussion groups, two in-person and one consisting of phone/WebEx participants. After discussion the larger group reconvened to share conclusions. What follows is a summary of feedback provided by discussion groups.

- Many clinics are not familiar with community level and public health data. They need support in this areas for the rule to be successful.
- Peer educators can bring a patient and community voice to the process.
- Clinics need support on balancing partnerships to not deplete community resources.
- Defining the community in the population health approach is challenging but there doesn't have to be a single community definition.

More detailed notes from each discussion group follow at the end of the meeting minutes.

Next steps and adjourn

Bonnie LaPlante stated that the original intent was for the committee to meet quarterly. The November 29, 2018 meeting will cover the final two standards, care plan and care coordination, although HCH will schedule a committee meeting early in 2019 if we do not complete the standards review on November 29. MDH plans to reconvene the committee to review the rule amendments based on committee and other input later in 2019 when the rule drafting process is further along.

Discussion group notes – Registry and Tracking

Notes from the three separate discussion groups are combined and included below.

	Potential Requirements for Progression Level 2	Rationale and Need
1.	At Level 2, the HCH clinic expands registry criteria to identify and address social determinants of health (SDOH). Potential elements include • Housing • Transportation • Food insecurity • Race, ethnicity, and language	The current registry standard does not incorporate elements referred to as social determinants of health (SDOH). Advanced levels of the HCH registry standard will enable the clinic to address whole person health through the consideration of SDOH elements that affect the health risks and outcomes for a population.
2.	At level 2, the HCH clinic plans and implements interventions to address patients' unmet physical and social needs.	Health Care Home clinics provide and coordinate care considering current and emerging needs of the population they serve.

Discussion – Registry and Tracking:

- Re: collecting and analyzing data: It is not an all or nothing deal breaker. We want people to have data, but if they don't do anything with it, who cares? We need to ask people to develop the system for data exchange and then act.

- We need to use registry data for SDOH. I think it is doable and it's definitely the way to move toward population health. We can gather this data from a whole host of places. Doing something with it is also important. I think when you get into requiring organizations to do data exchange, that is where you start getting into issues where some clinics cannot easily do this.
- I would definitely agree. Collecting SDOH is definitely doable. The federal government requires that we do this. PREPARE is a tool that we are asked to use for collecting SDOH, but there are many tools out there (Health Leads is another one). It would be great if there were a common tool, but there isn't. We like ICD10 codes for SDOH after you have used the tool that makes sense for you.
- SDOH is a very important topic and I understand why it is in the registry. My population is children and youth with special health needs, and this populations has significant needs that are not part of SDOH (accessing services, medical equipment, insurance, etc.) They should be part of registry. Many children served through pediatrics have multiple specialty providers that they work with and a registry can be an important place to coordinate care among specialists. So I'm concerned that this is very focused on adults.
- I wonder if we are really out of Level 1 yet. Sometimes clinics are not able to access a registry during a patient visit--even a certified clinic in good standing. If the care team cannot access the registry, can they identify gaps in care? Does that mean we should make Level 1 more robust? Is making a registry separate from providing patient care? I think people are getting credit for creating patient registries, but not using them. Maybe it is making recertification requirements more robust.
- Does this move us toward value based payment/population health?
- Collecting data tends to elevate it. Naming SDOH will move it that direction. (Agreement)
- Putting it in place makes it real. The payers will decide about payment; reimbursement does not match it yet.
- I agree that the more we can name it and make it clear without making it too prescriptive, the better it will work. We get SDOH data from our ACO partners, and it helps that we are part of IHP. If the requirement is too prescriptive, it may negatively affect organizations without fewer resources. If the requirement is flexible, we can find different ways to meet it. If it is too prescriptive, it will only work for the really big and well-resourced organizations. That is not fair to the little people. We can still do the work without as much technology.
- Many of our health centers are using a data collection tool but they're not using *all* of it. Each clinic needs to decide which SDOHs make sense for their population. When we talk about resources to address SDOHs, there is pushback. For example, if we cannot do anything about homelessness, why ask? Being able to choose which questions are appropriate makes sense. Also, finding a way to use this information and standardize somewhat would be good.
- We have many clinic based registries that can be broken out into various views and levels depending on the need or user. The robust nature requires a registry analyst; it is like a pre-visit planning tool on steroids. QI Department ensures that the data is accurate.
- Represented clinics use various EMR's and data analytics: Epic, Meditec, Cerner.
- We really must ask, with all of this data the important question is, "So What? So what will we do with it to change care and outcomes?"

- Looking at organizing findings with a sensitivity to all of the gaps in care calls, “Patients do not want to receive multiple calls related to multiple gaps in care as we work our various registries, one for preventive care, another for chronic disease care or multiple touches.”
- Also needs to be sensitivity toward the collection of social determinants of health (SDOH), this is sensitive and private information, how do we collect this and get good data that can be acted upon? What should be considered regarding privacy and security for this data?
- The new SDOH platform within EPIC is editable depending on the unique population.
- As we consider the collection of this SDOH data and Registries we must consider both the ‘Science’ of managing data as well as the ‘Art’ of addressing these needs.
- Another challenge is having the right role, scope of practice, and profession for the population needs; do we need a social worker (SW) or a behavioral health nurse practitioner (NP). NP can place orders; whereas a SW cannot. We need to better understand the ‘How’- all of this is clinic dependent-how does the unique team work? Even in large systems there are gaps.
- This kind of data will take us out to the community; we used to do this work together with public health (PH), then this stopped and now this approach has come full circle.
- What should HCH consider related to learning; specific to care coordination? 1) School SDOH 2) Community SDOH – and the challenges associated with sharing information to coordinate care for these. 3) provide learning to address both the science around the technology to do this work, as well as the ART of providing this care.
- Recommend change of language in #1 of Registry- Delete the ‘Address’ that is actually more clear in the next one and instead it should read ‘Assess”.
- The advancement of the registry standard is clearly moving clinics to the public health model and perspective, which is progressive. Public health is good and should be a selling point. As clinics develop more of a public health approach and perspective they will start to detect how environmental factors impact the clinic population and the community as a whole, this includes the social determinants of health. How will the new registry standard require continuous improvement on the registry between original certification and subsequent recertifications? There should be measured progress each time (this is in the context of clinics moving toward the public health model mentioned before).
- Process Question – How are clinics using the registry now? Is this something that would be helpful to know [assessment] in terms of supporting documentation for the proposed rule change? The range of registries in clinics is across the continuum from excel spreadsheets to robust population health management tools, to multi-relational registry databases on which cross-reference searches can be performed. The population health model requires a multi-relational tool. Are registries the best tool for population-based and whole person care? Suggest incorporating language into the rule that clinics need to demonstrate technical and staff capacity for cross-registry dashboards that provide a comprehensive picture of the patient and the clinic population. Also feel that the new rule should require registries to collect data, on the patient’s preferred method of contact, that reflects the most contemporary methods of contact, including text messaging. Discussion that this is in the current requirements, but that it depends on a clinic’s capacity.
- The Epic system has population health capability, such as patient dashboards that capture all the patient health issue and care plans, so gaps in care can be detected. The health care community is recognizing that registries have evolved into data management systems but there is a high

degree of variability among clinics in registry capability and staff capacity for data informatics, analysis, and reporting. Commitment among clinics to address to social determinants of health is fairly prolific but many registries in clinics do not have adequate and comprehensive demographic required fields needed to advance health equity and identify social determinants of health for patients and clinic populations. Is there a step missing in the process for this potential requirement? Where is the 'collection and utilization of information about SDOH when working with patients'? If the information isn't being collected or used at a patient level then how will it be captured and used at the tracking level here? Discussion included that this piece was addressed in the 'access and communication' standard. Recommends that these requirements be flexible, continuing to use 'potential elements'

- language, so that it can be driven by clinic specific needs and capacity. It would likely be a barrier if this was too prescriptive.
- Drawing from multiple disparate registries for whole person care is very challenging but it is achievable. Mental health should be named and called out more in the new rule.
- CentraCare has the ability to draw out numerous elements from their registry and sort them in a variety of ways. They employ registry analysts who work to use the registry to support the health care team. Question: how do you ensure the data in the registry is accurate and up-to-date? Response: The quality team verifies the accuracy of data. Comment: Smaller clinics may lack the capacity to accomplish what CentraCare does. This progression to Level 2 will take more than the clinical coordinator as we know it
- Small clinics sometimes use Excel as a registry. There are other EMRs in use as well, such as Meditec and Cerner, that might not be as effective as Epic or have complicating factors in their use (e.g. shift to web-based operations)
- Comments: Need to consider clinics that will need staff with the right technical expertise. This might be a challenge
- Comment: If you collect the proposed data on social determinants, what will the clinics do with it? Need to set up systems to respond to new information
- Example: CentraCare partnered with local public health to make anti-tobacco efforts streamlined and effective. The data drove these interventions
- CentraCare is also looking at organizing their findings with a sensitivity to all of the gaps in care calls, "Patients do not want to receive multiple calls related to multiple gaps in care as we work our various registries, one for preventive care, another for chronic disease care or multiple touches."
- It can be challenging to collect information on social determinants, as not everyone wants to volunteer this kind of information
- Large organizations have social workers that can assist with gathering and responding to this information
- Epic has social determinants screening as a function
- For smaller organizations, there's a need for connections beyond the walls of the clinic. This can, again, be quite challenging
- CentraCare example: Well-fare check data is shared with the police department. Is this HIPPA compliant? Expertise needed to determine this

- Progression to Level 2 will involve an expanded need for training around use of staff and technology
- Who is the appropriate staff person to hire? If it's a social worker, what type? How should a clinic go about hiring that person? Again, strong need for training
- Very dependent from clinic to clinic in terms of how the team works. If licenses mental health therapists are on staff and members of the care team, easy to do a warm hand off and coordinate behavioral and physical health. Question: What are the gaps in larger organizations? Response: Behavioral health not always integrated throughout the system.
- Question: what's the difference between Levels 1 and 2? Response: Level 2 involves not just identifying social needs but strategizing how to address them and implementing interventions.
- Suggestion: Strike the word "address" from the language for Level 1 as it is not quite accurate. Replace with "assess"
- Danette: Is whole person care realistic to ask for clinics to address in Level 2?
- Response: This will force clinics to go beyond the clinic walls and really stretch themselves. Example: clinic holding listening sessions in their community to determine what the needs are
- Clinics and public health used to work closely together, but no longer. There is a need to return to that sort of partnership, as no one can do it alone, regardless of organizational size
- Schools are a big deal when it comes to social determinants. With pediatric patients, are they going to school? What type of school (there are many varieties now)? Is there a nurse at the school? Work is being done like sending asthma action plans to the schools. But this can be challenging due to nursing resources at the schools and HIE issues. Schools must deliver information to the clinic verbally
- Many clinics are already struggling to meet medical needs; very challenging to add in social determinants
- Danette: If HCH could provide better education, what would that look like?
- Response: If you want to add staff such as social workers, who are the right people? How do you identify them? Also, education around working with the community to address social determinants. People need to know the science of registry use as well as the art of caring for the patient
- Need for clinic and partners to speak the same language in order to most effectively work together
- Potentially could use ICD-10 codes to code social determinants in a more standard way
- Are we really sure what is going on quality wise at the foundational level? How might we work to make sure everything is functional at the foundational level before moving to a Level 2?
- Comment that the existing standards are medical, the future ones public health. This is a good thing
- Mechanics of the registry, differences in how they use it
- Suggestion to expand the registry to incorporate more information
- Important to ensure that mental health is included through this process
- Registry and Tracking seems like a good foundation for a Level 2

Discussion Group Notes – Performance Measurement and Quality Improvement

Notes from the three separate discussion groups are below.

	Potential Requirements for Progression Level 2	Rationale and Need
1.	Uses community health data to inform HCH organizational strategies and improvement plans.	Community health data can identify key social and well-being drivers that influence the health of the HCH's patient population.
2.	Measures, analyzes, tracks, and addresses health disparities.	Delivering and tailoring care according to the disparities in health outcomes and patient experiences improves health equity. Making inequities visible brings them to the forefront for identifying potential solutions.
3.	Participation in HCH learning collaborative activities to support Progression Level 2.	The HCH learning collaborative activities support progression of HCH and allows for the sharing of improvement ideas and strategies with peers and partners.
	Potential Requirements for Progression Level 3	**Rationale and Need**
1.	Contribute to a coordinated community health needs assessment process by providing applicable information or data.	Comprehensive data sources are essential to understanding community health needs and population health. HCHs have important information and data that can contribute to a comprehensive community health assessment.
2.	Engage with community partners to prioritize community health issues and plan for population-based health improvement.	Population health requires a multi-sector approach. The most effective, efficient, and sustainable way to improve population health is for health care organizations to develop relationships and skills to work effectively with community partners.
3.	Share data, information and responsibility in the implementation of a population-based health improvement plan.	Achievement of improved health and cost savings outcomes requires shared accountability across clinic and community partners.
4.	Participation in HCH learning collaborative activities to support Progression Level 3.	The HCH learning collaborative activities support progression of HCH and allows for the discussion of improvement ideas and strategies with peers and partners.

Discussion group input – Performance Measurement and Quality Improvement:

- Question: #2 of Level 2 is speaking of social determinants of health (SDOH) but calls it disparities- keep the language in all of these templates consistent. Then also how are these different - facilitator explains the use of the verbs to differentiate what is happening in these different standards; registry is identifying and addressing; whereas QI is measuring.
- Learning should include WebEx support with training in needed areas.
- In Progression Level 3 there was discussion around the use of local public health Community Health Improvement Plan (CHIP) versus hospital Community Health Needs Assessment (CHNA); and again the question is asked… So What? How is this used?
- As quality is considered, the partnerships must be fluid, constantly considering what kind of data is needed and should be shared- there must be guidelines.
- We use QI to impact medication reconciliation- began with zip bags for patients to bring meds to their appointments and evolved to taking photos of the meds so they could also be reviewed in that manner.
- HCH should consider that the implementation of HCH that impact SDOH will wax and wane-need thresholds.
- If the community is not connected to or aware of community level data, they won't be able to use it. There needs to be a lot of capacity development and education for clinics and partners in this area for the rule revision changes to be successfully implemented. Clinics should be accountable for dissemination of information to the community and their partners. There should be a measure for this. What is the standard? Ideas – reporting on instances of media dissemination, events, community meetings, etc. If clinics engage communities and partners in the community they will be more successful with improving patient and community health because the community will provide key information, like for example how to best refer to a certain condition that is not comfortable to talk about, culturally specific, so that impacted community members feel comfortable with the clinic as a resource.
- How do you manage a clinic population vs. a community population? Clinics using hospital community health needs assessment data is an example but not all clinics are using the community health assessment data [per facilitator.] In regard to payment, will Level 3 be reimbursed at a higher rate than Level 2? Facilitator response: Potentially indirectly through alignment with other standards and structure that do more directly lead to payment. As a reminder, HCH is a care delivery model and not a payment model. The relationship between the two is that the care delivery model directly impacts the ability to be successful in a payment model. This is what the progression model is working to support and align.
- Community voice is a needed requirement! More input is needed on how to ensure clinics are authentically including community voice into decision making. [Need to go beyond how engagement is often conducted and used so that community shares equitably in decision making.]
- Partnerships are key to supplying and helping clinics understand community level data. There needs to be a call out to public health to be more accessible to clinics in regard to networking for community partnerships and getting access to population health data.

- Peer educators and peer support roles can be a good way to bring the community and patient perspective and voice into the clinic setting.
- The QI Standard proposed rule revisions for levels 2 and 3 are in line with IHP. Struggle with what the expectations are going to be for the concepts set forth with the proposed new standards. How much will be enough, for example, what percentage of the population will need to be reached or included to meet the new standard? Community and partner engagement should be better defined in rule or policy without being over-prescriptive. Sustainability of partnerships should be measured and reflected in the rule. These are the challenges they have been discussing at DHS IHP.
- MDH OHIT is working for optimal health information exchange. The rule revision is an opportunity to better align with the MDH Office of Health Information and Technology (OHIT) so HCH and OHIT can work with clinics in a more integrated manner. There are opportunities for clinics to contribute to hospital community health assessments but there are legal and privacy issues to work through. Do hospitals and clinics have technical assistance for this? Also, the rule needs to be rolled out with a community data educational campaign so clinics know about data sources, know where to get them and how to use them. The proposed rule requirements for advancing levels seem to align with the continuum of HIE being addressed in MN: moving from foundational to robust to optimal and supporting the use of HIE for individual and community health.
- Clinics can't deplete community resources. Their partnerships need to be mutually beneficial.
- There is a great example of a clinic in Todd County using data driven care to change diabetes outcomes in patients. Provided other examples to assist the group in making linkages from the proposed rule requirements as 'concepts' to 'practice'.
- Is the proposal feasible? Can it be implemented while keeping flexibility? How are health disparities defined in the context of the rule, within the patient population or the community in which the clinic resides, both?
- ZIP Code as health determinant**:** There is not one definition of community. There is the geographical community in which the clinic is physically located and the patient community from which individual members can come from multiple zip codes. There is increasing data available that nexuses health outcomes with zip codes and this data should be available to clinics, clinics need to understand it and know how to use it.
- Re: quality improvement standard potential requirements for progression level 2>item 2. 'Measures, analyzes, tracks, and addresses health disparities': maintain flexibility for clinics to be able to address this based on patient needs; clarify that this requirement is specific to the patient population (although implied based on Level 2 concept/themes, this isn't clear, and can be overwhelming to think about how clinics might do this for a larger community population).
- Is Level 3 missing the community voice and how to incorporate the community voice in the planning and be engaged in that work? This is essential to the development of a population based health improvement plan. Discussion acknowledged that but the tension laid in how to make that a proposed requirement for a clinic?

- Also missing in Level 3 is the dissemination of information/sharing of results/communication processes that are parallel to what is expected at the foundational level across clinic level QI processes. There should be something similar required for Level 3.
- Re: quality improvement standard potential requirements for progression level 3>item 2. 'Engage with community partners to prioritize community health issues and plan for population based health improvement'. What does 'engage' look like? How do you quantify that? Better guidance on the creation of partnerships, shared goals, with an effort and intentional thought around the sustainability of the partnerships is needed. The intentionality of that might be missing.
- No one in the small group had any concern about the 'readiness' for Level 3 concepts and themes. Overall the group felt it was a good direction and a necessary way to move population health and cost effectiveness in MN.
- Question about how this aligned with HRSA's requirements of 'enabling services'.

Level 2 Changes

- Q: What kind of data are we talking about? A: Community health needs assessments. Other health data that clinics do not need to collect themselves. Public health data, for example. How can you leverage all that information?
- I am thinking about implementing this in urban versus rural settings. Will community health data be so obvious and readily available for big urban systems? What community health data should they access? How will they know? This seems more logical and obvious for rural clinics.
- I agree. We are big. It is easy for rural clinics to define community health. Urban systems may not be so clear.
- What are the planned learning collaborative activities, and could the learning collaborative teach clinics how to access and use community health data?
- Smaller community clinics definitely have an easier time defining their community and accessing community health data, but larger systems have capacity. Some large systems have dedicated staff who work on data analysis. Smaller clinics and systems may not have capacity for analyzing and using data.
- This seems very reasonable. We have been talking about REL data for a long time. I think it feels right for the next level. It is sufficiently vague, so it leaves flexibility as to how to do it.

Level 3 Changes

- I represent the non-clinic side of things and I am thrilled to see it outlined. I hope clinics do not feel like they are in this alone. It is exciting.
- Same concerns that large systems may have a hard time identifying community. How can community health data be accessed and acted upon for the many communities that are served within their population? How will they do that?
- Re-word #3 population-based improvement plan. Population based improvement plan means different things to different people. Do we mean community based health improvement plan? Many clinics will think that they are already doing this through registry work. It is kind of like team -based care, but it means something different to everyone. (Agreement)
- We definitely heard this before. Clinic and public health definitions of community health and population health are different.
- Re 2: It is not controversial. It is exciting that these things are here. Many systems are doing this.

- Re 3: Would we be too prescriptive if we used the language “community health improvement plan”?
- Re 3:   Are requirements on exchanging data too prescriptive? Maybe just share information. Share data when possible.
- Re 3: Data sharing doesn’t necessarily have to be at the “person level.” It is sharing information, but the data is aggregated and de-identified to get by privacy requirements.
- Re 4. Learning Collaborative Activities. Sounds reasonable.
- Data sharing is a very challenging area. Need for information on what can and can’t be shared in certain settings.
- Medication management is an area where good information sharing is critical. Comment: Sleepy Eye provided zippered bags for bringing medications in to their visits with clinicians so the bottles can be examined. Comment: Need for a patient learning collaborative to provide suggestions, as they may come up with out of the box ideas
- Comment: While benchmarks and reporting and data are important, always important to return to the importance of the patients. Measures and data must be useful, not just checking a box. Need to go to the people using the clinic’s processes and find out how it’s working and what can be made better
- At Level 3, still a lot of language about data. At this point, you should already know you have to use the data. Need for more emphasis on what to do with the data
- Data sharing is a major issue for the higher level of this standard
- Is there a centralized compilation of CHNAs in order to compare needs? Not entirely sure. Though counties are very active in trying to work together. Partnerships vary across the state. Healthy Northland has seven counties working together, for example

Appendix G: Letter to Minnesota Management and Budget

Protecting, Maintaining and Improving the Health of All Minnesotans

November 17, 2021

Ms. Lindsay Dean
Executive Budget Officer
Minnesota Management and Budget
658 Cedar St., Ste. 400
St. Paul, MN 55155

Re: Proposed Amendment to Rules Governing Health Care Homes, Minnesota Rules, 4764.0010-.0070; Revisor's ID Number RD4548; OAH Docket No. 82-9000-37454

Dear Ms. Dean:

Minnesota Statutes, section 14.131, requires that an agency engaged in rulemaking consult with the Commissioner of Minnesota Management and Budget "to help evaluate the fiscal impact and fiscal benefits of the proposed rule on units of local government."

Enclosed for your review are copies of the following documents on the above-referenced rule revisions:

1. November 3, 2021, Revisor's draft of the proposed rule; and
2. October 14, 2021, draft SONAR.

If you or any other representative of the Commissioner of Minnesota Management & Budget has questions about the proposed rule revisions, please email me at *josh.skaar@state.mn.us*. If necessary, you can also call me at 651-201-5923.

Regards,

Josh Skaar
Attorney and Department Rulemaking Coordinator

Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164

An equal opportunity employer.

References

American Instiutes for Research. (2012). *Guide to patient and family engagement: environmental scan report.* Rockville: Agency for Healthcare Research and Quality.

Blue Cross Blue Shield of Minnesota, University of Minnesota. (2018). *The cost of health inequities in Minnesota.* Retrieved from Blue Cross Blue Shield of Minnesota: https://www.bluecrossmn.com/healthy/public/portalcomponents/PublicContentServlet?contentId=P11GA_16928228

Centers for Disease Control and Prevention. (2019, October 23). *Health literacy*. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/healthliteracy/learn/index.html

Chun, R. (2008). *2008 health care reform act: implementation timelines.* St. Paul: Minnesota House of Representatives Research Department.

Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion. (2017, January 31). *Alzheimer's Disease and Health Aging*. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/aging/disparities/index.htm

Epperly, T. (2019). The shared principles of primary care: a multistakeholder initiative to find a common voice. *Family Medicine*, 179-184.

Health Care Homes. (2017, February 23). *Request for Information (RFI) Analysis of Health Care Homes Stakeholders.* Retrieved from https://www.health.state.mn.us/facilities/hchomes/documents/rfiinbrief.pdf

Kindig, D. (2003). What is population health. *American Journal of Public Health*, 380-383.

Kindig, D. (2014). Population health improvement: a community health business model that engages partners in all sectors. *Frontiers of Health Services Management*, 3-20.

Loehrer, S. (2016). Improving the health of populations. *Healthcare Executive*, 82-83.

Manatt Health. (2016, January 28). *Health Care Financing Task Force Final Report.* Retrieved from Department of Human Services: https://mn.gov/dhs/assets/final-materials-final-report_01-28-2016_tcm1053-165972.pdf

Mikkonen. (2010, May). *Social determinants of health: the Canadian facts.* Toronto: York University School of Health Policy and Management. Retrieved from The Canadian Facts: https://thecanadianfacts.org/

Minnesota Department of Health. (2014). *Advancing health equity in Minnesota: report to the Legislature.* St. Paul.

Minnesota Management and Budget. (2019, June 25). *Summary of Findings: Community Engagement Sessions, January-May 2019.* Retrieved from Minnesota Department of Health: https://www.health.state.mn.us/facilities/hchomes/rulerevision/docs/cereport.pdf

National Academies of Sciences, Engineering, and Medicine. (2018, August 10). *Taking action against clinician burnout: a systems approach to professional well-being.* Retrieved from National Academy of Medicine: https://nam.edu/systems-approaches-to-improve-patient-care-by-supporting-clinician-well-being/

National Institute for Health Care Management Foundation. (2019, October). *Addressing social determinants of health can improve community health & reduce costs.* Retrieved from NIHCM: https://www.nihcm.org/categories/sdoh-2019-infographic

Prendergast, M. (2010). Issues in defining and applying evidence-based practices criteria for treatment of criminal justice involved clients. *J Psychoactive Drugs*, 10-18.

Prevention Institute. (2020). *Prevention Institute*. Retrieved from Health delivery and payment transformation: https://www.preventioninstitute.org/taxonomy/term/235

Primary Care Collaborative. (2020). *About us*. Retrieved from Primary Care Collaborative.

SAMHSA-HRSA. (2014, January). *SAMHSA-HRSA Center for Integrated Health Solutions.* Retrieved from Core competencies for integrated behavioral health and primary care: https://www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf

Stout, S. (2017). *Pathways to population health: an invitation to health care change agents.* Retrieved from Institute for Health Care Improvement: http://www.ihi.org/Topics/Population-Health/Documents/PathwaystoPopulationHealth_Framework.pdf

US Centers for Medicare & Medicaid Services. (2020). *Glossary*. Retrieved from HealthCare.gov: https://www.healthcare.gov/glossary/

World Health Organization. (2008). *Social determinants of health*. Retrieved from World Health Organization: https://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

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.

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

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

2.7 (2) improve wellness and early prevention; and

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

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

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

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

2.18 **4764.0020 DEFINITIONS.**

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

2.21 Subp. 2. [See repealer.]

2.22 Subp. 3. **Care coordination.** "Care coordination" means a team approach that engages
2.23 the ~~participant~~ patient, the personal clinician or local trade area clinician, and other members
2.24 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.]

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. [See repealer.]

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~~ 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.

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~~ 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.

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

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

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

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

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

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

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

6.24 Subp. 24. **Local trade area clinician.** "Local trade area clinician" means a physician,
6.25 physician assistant, or advanced practice registered nurse who provides primary care services

7.1 outside of Minnesota in the local trade area of a state health care program recipient and
7.2 maintains compliance with the licensing and certification requirements of the state where
7.3 the clinician is located. For purposes of this subpart, "local trade area" has the meaning
7.4 given in part 9505.0175, subpart 22.

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

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

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

7.16 Subp. 27. **Patient and family-centered care.** "Patient and family-centered care"
7.17 means planning, delivering, and evaluating health care through patient-driven, shared
7.18 decision-making that is based on participation, cooperation, trust, and respect of ~~participant~~
7.19 patient perspectives and choices. It also incorporates the ~~participant's~~ patient's knowledge,
7.20 values, beliefs, and cultural background into care planning and delivery. Patient and
7.21 family-centered care applies to patients of all ages.

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

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

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

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

8.10 Subp. 28c. **Population management.** "Population management" means the delivery
8.11 of health care services toward the achievement of specific health care-related metrics and
8.12 outcomes for a defined populations.

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

8.16 Subp. 30. [See repealer.]

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

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

8.23 Subp. 33. [See repealer.]

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

9.6 Subp. 34a. **Social determinants of health.** "Social determinants of health" are the
9.7 conditions in which people are born, grow, live, work, and age. The distribution of money,
9.8 power, and resources at global, national, and local levels shapes these circumstances. The
9.9 social determinants of health are mostly responsible for health inequities, which are the
9.10 unfair and avoidable differences in health status seen within and between countries.

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

9.17 Subp. 36. **State health care program.** "State health care program" has the meaning
9.18 given in Minnesota Statutes, section 256B.0751, subdivision 1, paragraph (f).

9.19 Subp. 37. [See repealer.]

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

9.23 Subp. 39. **Whole person care.** "Whole person care" means primary care focused on
9.24 the patient's physical, emotional, psychological, and spiritual well-being, as well as cultural,
9.25 linguistic, and social needs.

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~~ 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.

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~~ 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.~~, including 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 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.

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;

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

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

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

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

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

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

13.14 ~~C.~~ B. If the commissioner denies the application for certification or recertification,
13.15 the commissioner must notify the applicant in writing of the reasons for the denial. The
13.16 applicant may file an appeal under part 4764.0060.

13.17 **4764.0040 HEALTH CARE HOME STANDARDS.**

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

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

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

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

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

14.6 B. establish a system designed to ensure that:

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

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

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

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

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

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

14.23 (3) the designated clinic staff, on-call provider, or phone triage system
14.24 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~~

16.1 ~~applicant for recertification~~ must demonstrate that ~~the applicant~~ the health care home
16.2 encourages ~~participants~~ patients to take an active role in managing ~~the participant's~~ their
16.3 health care, and ~~that the applicant has demonstrated participant~~ must demonstrate patient
16.4 involvement and communication by identifying and responding to one of the following:
16.5 ~~participants'~~ the patient's readiness for change, literacy level, or other barriers to learning.

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

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

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

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

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

16.20 Subp. 3. **~~Participant~~ Patient registry and tracking ~~participant~~ patient care activity**
16.21 **standard; certification requirements.** The ~~applicant for certification~~ health care home
16.22 must use a searchable, electronic registry to record ~~participant~~ patient information and track
16.23 ~~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, 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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19.24 D. engage ~~participants~~ patients in planning for transitions among providers, and
19.25 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:

(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~~ 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 ~~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

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.

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

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

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

24.10 (1) improvement in patient health;

24.11 (2) quality of patient experience; and

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

24.13 C. submit health care homes data in the manner prescribed by the commissioner
24.14 to fulfill the health care homes evaluation requirements in Minnesota Statutes, section
24.15 256B.0752, subdivision 2~~.~~; and

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

24.19 Subp. 11. [See repealer.]

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

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

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

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

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

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

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

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

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

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

25.20 **4764.0050 VARIANCE.**

25.21 Subpart 1. **Criteria for variance.** At certification or recertification, the ~~applicant~~
25.22 health care home may request a variance or the renewal of a variance from a requirement
25.23 in parts 4764.0010 to 4764.0040. To request a variance, ~~an applicant~~ a health care home

26.1 must submit a petition, according to the requirements of Minnesota Statutes, section 14.056,
26.2 and demonstrate that the ~~applicant~~ health care home meets the criteria in item A or B.

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

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

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

26.13 Subp. 3. [See repealer.]

26.14 Subp. 4. **~~Experimental~~ Variance for seeking better solutions and testing new**
26.15 **methods.** The commissioner may grant a variance from one or more requirements to permit
26.16 ~~an applicant~~ a health care home to offer health care home services of a type or in a manner
26.17 that is innovative or to participate in a health care home research project that contributes to
26.18 innovation and improvement of care if the commissioner finds that the variance does not
26.19 impede the achievement of the criteria in Minnesota Statutes, section 256B.0751, subdivision
26.20 2, paragraph (a), and may improve the health care home services ~~provided by the applicant~~.

26.21 Subp. 5. **Variance for justifiable failure to show measurable improvement.** The
26.22 commissioner may grant a variance to a health care home seeking recertification that fails
26.23 to show measurable improvement as required by parts 4764.0030, subpart 5, item B, ~~subitem~~
26.24 ~~(3),~~ and 4764.0040, subpart ~~11~~ 10, if the ~~applicant~~ health care home demonstrates the
26.25 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.

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;

(2) a plan for continued improvement; and

(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

28.1 disputed facts and findings, present the ~~applicant's~~ eligible provider's or health care home's
28.2 corrective action plan, or both.

28.3 Subp. 4. **Notice of decision and timeline.** The commissioner must grant or deny the
28.4 appeal and notify the ~~applicant~~ eligible provider or health care home of the decision within
28.5 60 days after receipt of a completed appeal, or, if the ~~applicant~~ eligible provider or health
28.6 care home meets with the commissioner's designee, within 60 days after the meeting.

28.7 **4764.0070 REVOCATION, REINSTATEMENT, ~~AND~~ SURRENDER,**
28.8 **RECOGNITION OF EXTERNAL ACCREDITING BODIES AND**
28.9 **PATIENT-CENTERED MEDICAL HOME PROGRAMS, AND PROVISIONAL**
28.10 **CERTIFICATION AND RECERTIFICATION.**

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

28.15 Subp. 2. **Reinstatement of revocation.** A provider whose certification as a health
28.16 care home has been revoked may apply for reinstatement. If the provider was previously
28.17 certified for ~~one year~~ three years or longer at the time of revocation, it must meet the
28.18 recertification requirements to be reinstated. ~~During the 12 months following revocation of~~
28.19 ~~certification,~~ The provider may obtain technical or program assistance from the Minnesota
28.20 Department of Health and through a health care home learning collaborative to assist the
28.21 provider to regain certification. The provider also may choose to provisionally reinstate
28.22 their certification as outlined in subpart 7.

28.23 Subp. 3. **Surrender.** A health care home ~~may voluntarily surrender~~ that surrenders
28.24 the health care home certification ~~by providing~~ must provide the commissioner and the
28.25 health care home ~~participants~~ patients with ~~90 days'~~ written notice. After the ~~expiration of~~
28.26 ~~the 90-day~~ written notice ~~period~~ is provided, a provider that has surrendered health care

29.1 home certification is no longer ~~eligible for per-person care coordination payments based~~
29.2 ~~on certification~~ certified as a health care home.

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

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

29.13 Subp. 6. **Provisional certification.** Clinics that are experiencing barriers or challenges
29.14 to certification at the foundational level may request provisional certification. During the
29.15 time of provisional certification, that must not last longer than three years, the provider must
29.16 work with the Department of Health to develop an action plan outlining a modified or
29.17 "stepped" certification process. Upon completion of the modified or stepped certification
29.18 process, the provisional status will be removed. The provider may obtain technical or
29.19 program assistance from the Department of Health and through a health care home learning
29.20 collaborative to assist the provider in gaining certification.

29.21 Subp. 7. **Provisional recertification.** Clinics that are experiencing barriers or
29.22 challenges to recertification may request provisional recertification. During the time of
29.23 provisional recertification that must not last longer than three years, the provider must work
29.24 with the Department of Health to develop an action plan outlining a modified or "stepped"
29.25 recertification process. Upon completion of the modified or stepped recertification process,
29.26 the provisional status will be removed. The provider may obtain technical or program

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

30.3 **REPEALER.** Minnesota Rules, parts 4764.0020, subparts 2, 4, 7, 12, 30, 33, and 37;
30.4 4764.0040, subparts 4 and 11; and 4764.0050, subpart 3, are repealed.