

Minnesota Department of Health

Request for Proposals



Health Care Homes: Community Care Team Grants June 1, 2011 – June 30, 2012

Published: April 15, 2011
Due Date: May 16, 2011

<http://www.health.state.mn.us/healthreform/homes/index.html>

Health Care Homes: Community Care Team

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Health Care Homes: Community Care Team Grant

Introduction

This document provides the forms and instruction you will need to complete the Health Care Homes: Community Care Teams Grant application. It is suggested that you review this document completely before you begin to write your application, including the Criteria for Grant Review provided at the end of each grant component: Applicant Experience and Capacity; Project Plan; and Budget. You will find copies of the HCH statute (M.S.456B.0751) and rule (4764.0010-4764-0070) included in the Appendices. Other materials to assist you in completing this application are available on the HCH website <http://www.health.state.mn.us/healthreform/homes/index.html> - including answers to "Frequently Asked Questions" about this grant.

The Minnesota Department of Health will provide consultation and guidance during the application process. For any questions related to this RFP, or for assistance please contact Marie Maes-Voreis Marie.maes-voreis@state.mn.us or by phone at 651-201-3626 or TTY line: 651-201-5797 (MDH's main phone line).

MDH will host one optional conference call to answer questions:

Thursday, April 21, 2011, 1:00-2:00 p.m. More details on this conference call are posted on the HCH website noted above. Questions and responses from the conference will be posted on the website noted above.

Background Information about Health Care Homes and Community Care Teams

A "health care home," also called a "medical home," is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities. The development of health care homes in Minnesota is part of the ground-breaking health reform legislation passed in May 2008. The legislation includes payment to primary care providers for partnering with patients and families to provide coordinated care and services. In order to qualify for reimbursement for care coordination activities primary care providers and clinics are required to meet a set of standards around access and communication, population-based registries, care coordination, care planning, and quality improvement.

One of the primary principles of health care homes is the delivery of patient and family centered care. Care that is patient centered is holistic; recognizing that a person's health is determined by physical, psychosocial, and environmental factors. In alignment with patient and family centered care HCH recertification standard 4764.0040 Subj. 6 B requires primary care practices to "identify and work with community-based organizations and public health resources such as disability and aging services, social services, transportation services, school-based services, and home health care services to facilitate the availability of appropriate resources for participants". The intent of the rule is that certified HCH providers and clinics take a proactive approach to planning and partnering with community resources to ensure that their patients have access to needed resources and services.

Providing the level of care required by the state's HCH certification standards can be more challenging for small to medium sized rural clinics and those serving low income populations such as the safety net clinics. Shared support networks such as community care teams are one way smaller practices can pool their resources to partner with community agencies to support healthy management of a community population.

The foundation of the Community Care Team is patient and family centered care that meets patients and family's needs by coordinating seamlessly with a broad range of health and community service providers. The Community Care Team is a multidisciplinary team that partners with primary care offices (certified health care homes), the hospital, and existing health and social service organizations. The goal is to provide citizens with the support they need for well-coordinated preventive health services and coordinated linkages to available social and economic support services. The Community Care Team is flexible in terms of staffing, design, scheduling and site of operation, resulting in a cost-effective, core community resource which minimizes barriers and provides the individualized support that patients need in their efforts to live as fully and productively as possible.

Community care teams have been utilized effectively in other states to extend the work of primary care practices. North Carolina utilizes a community team model called Community Care Networks to bring together physicians, hospitals, social service agencies, county public health departments, and other key community leaders to increase access to health and community services with the overarching goal of improving population health. In Vermont community health teams are established in hospital service areas among NCQA certified medical homes. Services offered by community health teams include individual care coordination, health and wellness coaching, behavioral counseling, improved access and communication, and assistance in connecting patients to social and economic support services.

Program Goals: HCH Community Care Team

The goal is to design, document, and implement a Community Care Team that addresses community priorities, care coordination, transitions management, effective use of resources, and engages in collaborative activities with certified health care homes. The Community Care Team will work together to provide outcomes oriented care such that services will be guided by the principle of optimizing clinical outcomes for community members to meet the goals of the Institute for Health Improvement's triple aim: improved health outcomes, enhanced patient experience, and reduced costs / improved value.

Eligibility Requirements to Apply

Eligible applicants include community-based nonprofit and for-profit organizations and government entities or Tribal Government, clinics and hospitals, community health or public health organization and institutes of higher education.

Duration of Funding

MDH anticipates that it will enter into a grant agreement (i.e. contract) with the grantee from the period of June 1, 2011 through June 30, 2012. The funding is for 13 months.

Available Funding

The MDH expects to award 3-4 grants of \$100,000-\$150,000 per contract.

Funding Restrictions

Grant funds may be used to cover costs of personnel, consultants, supplies, grant-related travel, and other grant-related costs. Grant funds may not be used for direct clinical services or clinic operations, building alterations or renovations, construction, fund raising activities, political education or lobbying. There is no requirement for matching funds.

Application Requirements

- Applications must be written in at least 12-point font with one-inch margins with a maximum of 15 pages.
- All pages must be numbered consecutively.
- One signed unbound original and 3 unbound copies of the complete application must be submitted.
- Applications must meet application deadline requirements. Late applications will not be reviewed.
- Applications must be complete and signed where noted.
- Faxed or emailed applications will not be accepted.
- Incomplete applications will not be considered for review.

The deadline for submission of proposals is May 16, 2011. To meet the deadline, proposals must:

- 1. Be hand delivered to the address below before 4:00 p.m., May 16, 2011; or**
- 2. Arrive by mail, Fed Ex, or courier by 4:00 p.m., May 16, 2011.**

The complete application (one original unbound and three (3) unbound copies) should be sent to:

Street Address (hand or courier delivery)	US Postal Service Mailing Address
<p style="text-align: center;">Jan Jernell Minnesota Department of Health Community and Family Health Division Golden Rule Building 85 East Seventh Place, Suite 220 St. Paul, MN 55164</p> <p>*Hand delivered proposals <u>must</u> be dropped off at the 2nd floor reception desk of the Golden Rule Building – Suite 220</p>	<p style="text-align: center;">Jan Jernell Minnesota Department of Health Community and Family Health Division P.O. Box 64882 St. Paul, MN 55164-0882</p>

Late applications, applications lost in transit by courier, faxed or emailed applications will not be considered for review.

Sending in a HCH: Community Care Team Grant application does not guarantee funding. Applications must meet all requirements listed in this packet, organizations must meet all eligibility requirements, and proposals must meet the criteria and requirements listed in this application.

Review Process

Only complete applications, that meet the eligibility and application requirements, received on or before May 16, 2011 will be reviewed by a grant review committee according to the Criteria for Grant Review provided at the end of each component (Applicant Experience and Capacity; Project Plan; and Budget) as noted in the following pages. Reviewers will determine which applications best meet the criteria as outlined and should be recommended for funding. We anticipate that grant award decisions will be made by May 28, 2011. Applicants will be notified by letter whether or not their grant proposal was funded. MDH reserves the right to negotiate changes to budgets submitted.

Grant agreements will be entered into with those organizations that are awarded grant funds. The anticipated effective date of the agreement is June 1, 2011, or the date, upon which all signatures are obtained prior to June 30, 2011. Grant agreements need to be fully executed by June 30, 2011 for funding to be available. Grant agreements will end on June 30, 2012. No work on grant activities can begin until a fully executed grant agreement is in place.

Evaluation Requirements

The evaluation of this program is a collaborative effort between MDH and the grantees. Below is an outline of MDH and grantee duties. The grantee will be required to report on a quarterly basis to MDH, in a format provided by MDH, including information on fiscal and programmatic performance and status. Evaluation responsibilities are outlined below.

MDH will:

- Hold regular conference calls or meetings with the grantee. These calls/meetings will include monitoring of grantee activities and evaluating success towards reaching program goals.
- Provide grantees with technical assistance about how to conduct evaluation requirements outlined in the Project Narrative section of this RFP.

Applicants/Grantees will:

- Participate in regular conference calls or quarterly meetings with MDH and Health Care Home Community Care Team planning staff.
- Participate in training activities or meetings developed for Health Care Homes or Community Care Teams.
- Complete status reports to MDH as agreed upon.
- Provide input into the development of the evaluation tools and activities.
- Develop a plan for process evaluation of this activity.
- Send one member of the community care team on a trip to Vermont to meet with the Vermont and North Carolina community care team members through a learning community sponsored by National Academy of State Health Policy (NASHP). Grantees should include \$2,000 dollars for this two day trip in their overall budget.
- Provide a brief quarterly report of the community care team's current status, activities, learning, and challenges.
- Provide a final report that includes the following elements:
 - Description of the Community Care Team's population and how community participation evolved throughout the pilot.

- The Dissemination and Sustainability plans and lessons learned as described above.
- Summary of Community Care Team's evaluation activities.
- Prepare a presentation and present about this project at one meeting or conference to be determined jointly by grantee and HCH staff.

Grant Application and Program Summary

Eligibility for Grant Funds	Individuals, Community Based Nonprofit Organizations, Clinics or Hospitals, and Institutes of Higher Education.
Total Funds Available	\$550,000 for the 13 month grant cycle
Maximum Grant Amount	Approximately 3 to 4 grant awards of \$100,000 to \$150,000
Duration of Funding	6/1/2011 through 6/30/2012
Grant Purpose	To design, document and implement 3-4 community care teams that have the capacity to engage in collaborative activities with certified health care homes.
Application Requirements	<ul style="list-style-type: none"> <input type="checkbox"/> Applications must be written in at least 12-point font with one-inch margins. <input type="checkbox"/> All pages must be numbered consecutively. <input type="checkbox"/> One signed unbound original and 3 unbound copies of the complete application must be submitted. <input type="checkbox"/> Applications must meet application deadline requirements. Late applications will not be reviewed. <input type="checkbox"/> Applications must be complete and signed where noted.
Order for Completed Application Submission	<ul style="list-style-type: none"> <input type="checkbox"/> Application Face Sheet (Form A) <input type="checkbox"/> Description of Application Experience and Capacity <input type="checkbox"/> Project Plan <input type="checkbox"/> Project Implementation Plan (Form B) <input type="checkbox"/> Project Budget <input type="checkbox"/> Budget Justification Sheet with Instruction (Form C) <input type="checkbox"/> Administrative Cost Questionnaire (Form D) <input type="checkbox"/> Administrative Cost Allocation Worksheet (If applicable, Form E) <input type="checkbox"/> Budget Summary Sheet (Form F) <input type="checkbox"/> Accounting System Financial Capability Questionnaire (If applicable, Form G)
Application Deadline	All applications must be received by MDH no later than 4:00 p.m. on May 16, 2011 . Faxed or emailed applications will not be accepted. Late applications will not be considered for review.
Applications Sent	<p>Mailing Address: Jan Jernell Minnesota Department of Health Community and Family Health Division P.O. Box 64882 St. Paul, MN 55164-0882</p> <p>Delivery Address: Jan Jernell Minnesota Department of Health Community and Family Health Division Golden Rule Building 85 East Seventh Place, Suite 220 St. Paul, MN 55164</p>
Beginning Grant Agreement Date	Date upon which all signatures to the agreement are obtained or June 1, 2011, whichever is later.
Statutory Authority	M.S.456B.0751 (see Appendix A)

Project Narrative Instructions

Following are the minimum requirements of the Proposal Narrative. Applicants should place emphasis on completeness and clarity of content.

Order of documents to be submitted:

1. Description of the Applicant Experience and Capacity. Keep this section to 3 or fewer pages. This section must describe:

- A brief history of the entity and any notable accomplishments.
- A brief description of experience of the applicant entity related to health care homes, health clinics, practice transformation, and health care reform.
- A brief overview of the capacity of the agency and specifically how it is prepared to accomplish the grant objectives.
- Skill and experience of the Project's lead staff (include CVs of lead staff in an appendix).
- Anticipated barriers and challenges in implementing this project and potential solutions.

Criteria for Grant Review: The Agency Information section of the application will be reviewed and scored according to the following criteria (20 Points):
--

- | |
|--|
| <ul style="list-style-type: none">• Does the description give a clear picture of the history, structure, services provided, and clientele served by the agency?• Does the agency have a successful history of providing proposed services?• Does the agency have the capacity (infrastructure, facilities, staffing) to develop proposed community care team services?• Does the agency have experience in working with multidisciplinary teams and community collaboration?• Does the agency have a current relationship with a Health Care Home?• What barriers does the agency anticipate and what are the identified potential solutions? |
|--|

2. Project Plan Keep this section to 12 or fewer pages.

Proposals must address in sufficient detail how the applicant would fulfill the expected outcomes and features set forth below. This section should detail how the Project would be carried out in an effective and efficient manner, including who would be involved, what resources are required, target dates for Project activities, and the timeframe for completion. This section must describe:

A. The proposed community to be served by the Community Care Team

- 1) Describe the geographic area you will serve
- 2) Describe your target population(s).
- 3) Describe how you plan to involve the target population(s) either in program-planning or implementation.
- 4) Describe how the target population will know about your services

- 5) Describe the Health Care Home certification status for primary care practices/clinicians in the community (certified, in process, or under consideration).
- B. Description of priority issues that you propose to target with the Community Care Team and provide a goal and objective for each priority issue.
- C. Rationale for why the Community Care Team is a good fit for the specific community to be served.
- D. Members and Partners. Letters of support from each key partner are required to be included as attachments.
- 1) Proposed **membership and infrastructure** of the Community Care Team that includes participation by community primary care providers, one certified (or soon to be certified) health care home must participate, and will include team members with expertise in coordination of chronic conditions, health maintenance, and prevention to address the health of the community. The intent is to have a flexible locally designed team approach based on the needs of your population.
 - 2) Proposed **staffing and administrative structure** for Community Care Team operations. This should be based on your specific proposal and where possible should build on existing community and public infrastructure and reflect the population's needs in your community.
 - Describe how you will use existing staff, if additional training will be sought, and if additional staff members will be hired.
 - 3) Proposal for a local **oversight structure** that emphasizes improved communication between Community Care Team partners and a clear understanding of services and referral structures. The Community Care Team must include at least two consumers from the community as part of their oversight structure.
 - 4) If other agencies will help provide services or be involved in your proposal, describe who they are and describe their roles.
 - 5) Describe how the Community Care Team will work together to implement a **transitional care approach** for patients who are hospitalized. The goal is to have a structured approach that streamlines, simplifies, and optimizes the opportunity for patients to engage in effective care coordination that is supported by the Community Care Team.
 - 6) Describe how the Community Care Team will develop an infrastructure for **patient care communication**. While ideally this is an electronic communication structure, for the period of the grant this may not be possible and therefore is not required. Communication structures must be in place to prevent gaps in care and improve communication for consumer patient participants.
- E. Goals, Objectives, and Implementation Plan
- 1) For each component of the project plan listed above provide at least one goal and objective.

- 2) Describe how you propose to meet your stated goals and objectives by providing proposed strategies related to each objective.
 - 3) Describe the methods and criteria that will be used to measure whether the project goals and objectives have been achieved.
 - 4) Outline the major tasks and deliverables, project milestones, and start and finish dates for key activities associated with program implementation and operation. (Implementation Plan)
- Required Plans. State commitment that the Community Care Team will work to develop the following plans during the grant cycle:
 - Dissemination plan- description of the action steps taken to develop and implement the Community Care Team including, oversight structure, community partners, implementation planning and how the Community Care Team met its goals. This plan is to inform other communities about their lessons learned and the challenges and successes in creating a Community Care Team.
 - Sustainability plan- development of a plan for identifying resources (including reimbursement for services provided) to support future activities of the Community Care Team after this grant has ended.

Criteria for Grant Review: The Project Plan section of the application will be reviewed and scored according to the following criteria (65 points):

- Does the applicant clearly describe the community care team members and relationships, including patient involvement?
- Is there a Letter of Support from key members and/or partners?
- Are adequate resources allotted to provide administration?
- Does the applicant provide clear goals for each proposed component?
- Are the proposed Objectives for each component clearly described, measurable, and realistic?
- To what extent do the proposed indicators effectively measure the project's progress toward meeting their objectives?
- To what extent is the project likely to meet its objectives in the grant cycle?
- Overall, is the Implementation Plan sufficiently detailed, clear and easy to understand and does it demonstrate a clear relationship between the identified problem and the goals, objectives, and activities?
- Does the applicant provide a clear description of how they intend to serve the geographic area?
- Does the applicant clearly identify their target population(s) and how the Community Care Team is suited to that target population?
- Does the applicant clearly identify their priority issues and how the Community Care Team is suited to deal with those issues?
- Does the applicant clearly describe the local oversight structure?

3. Project Budget: Describe and explain the estimated costs. Identify any ancillary services to be provided that have associated costs, and the components essential to delivering quality services. Explain the proposed use of the grant funds. Include a budget narrative for each line item as noted. Be sure that the Budget Justification Sheet (Form C) provides sufficient detail to justify the total amount budgeted in each category. The program budget must be complete and reasonable, must link to the proposed program activities, and must specify how the amounts for each budget item were determined. Responders are encouraged to

apply for only the amount needed for their proposed programs. The selected applicant will not be guaranteed the entire amount requested. Budget Proposals will be judged on overall cost-effectiveness and efficient use of funds (meaning funds are being spent on direct costs versus administrative costs).

Criteria for Grant Review: The Budget Summary and Budget Justification Section of the application will be reviewed and scored according to the following criteria (15 Points):

- PLEASE REVIEW THIS CRITERIA
- Are the Budget Summary Form and the Budget Justification Sheet complete?
- Do the amounts on Budget Summary Form match what is in the Budget Justification Sheet?
- Is the information contained in the Budget Justification Sheet consistent with what is proposed in the Project Narrative and Implementation Plan?
- Are the projected costs reasonable and sufficient to accomplish the proposed activity?

Proposal Evaluation

The factors and weighting for proposals are as follows:

- | | |
|--|-----|
| 1. Applicant Experience and Capacity | 20% |
| 2. Project Description, Implementation and Accountability Plan | 65% |
| 3. Budget, and Budget Justification | 15% |

Required Forms

Required Forms:

Form A: Application Face Sheet with Instructions

Form B: Project Implementation Plan

Form C: Budget Justification Sheet with Instructions

Form D: Budget Summary Sheet

Form E: Accounting System and Financial Capability Questionnaire (If applicable)

FORM A
Application Face Sheet
Health Care Homes Community Care Team Grant

1. Legal name and address of the applicant agency with which grant agreement would be executed		
2. Minnesota Tax I.D. Number		Federal Tax I.D. Number
3. Requested funding for the total grant period \$		
4. Director of applicant agency		
Name, Title, and Address:		Email Address: Telephone Number: () FAX Number: ()
5. Fiscal management officer of applicant agency		
Name, Title and Address:		Email Address: Telephone Number: () FAX Number: ()
6. Operating agency (if different from number 1 above)		
Name, Title and Address:		Email Address: Telephone Number: () FAX Number: ()
7. Contact person for operating agency (if different from number 5 above)		
Name, Title and Address:		Email Address: Telephone Number: () FAX Number: ()
8. Contact person for further information on grant application		
Name, Title and Address:		Email Address: Telephone Number: () FAX Number: ()
9. Certification		
I certify that the information contained herein is true and accurate to the best of my knowledge and that I submit this application on behalf of the applicant agency.		
_____ Signature of Authorized Agent for Grant Agreement	_____ Title	_____ Date

(FORM A) Application Face Sheet Instructions

Please type or print all items on the Application Face Sheet.

1. **Applicant agency**
Legal name of the agency authorized to enter into a grant contract with the Minnesota Department of Health
2. **Applicant agency's Minnesota and Federal Tax I.D. number**
3. **Requested funding for the total grant period**
Amount the applicant agency is requesting in grant funding for the grant period (June 1, 2011 - June 30, 2012).
4. **Director of the applicant agency**
Person responsible for directing the applicant agency.
5. **Fiscal Management Officer of applicant agency**
The chief fiscal officer for applicant agency who would have primary responsibility for grant agreement and grant funds expenditure and reporting.
6. **Operating Agency**
Complete only if other than the applicant agency listed in number 1 above.
7. **Contact Person for Operating Agency**
Person who may be contacted concerning questions about implementation of this proposed program. Complete only if different from the individual listed in number 5.
8. **Contact person for Further Information**
Person who may be contacted for detailed information concerning the application, or the proposed program.
9. **Signature of Director of Applicant Agency**
Provide original signature of the Director of the applicant agency and the date of signature.

Community Care Team Implementation Plan

Form B

Goal: _____

<i>OBJECTIVES</i>	<i>ACTIVITIES</i>	<i>TRACKING METHODS</i>	<i>MILESTONES/TIMELINES</i>

**Budget Summary and Justification Narratives and Forms C, D, E,
Minnesota Department of Health
Community Care Team Grant**

The Budget Section of the application is composed of a total of three (3) possible forms:

- i. Budget Justification Sheet (Form C)
- ii. Budget Summary Sheet (Form D)
- iii. Accounting System and Financial Capability Questionnaire
(If applicable, Form E)

Complete the Budget Justification Sheet (Form C) for your grant program. The grant period will be from June 1, 2011 through June 30, 2012.

The Budget Justification Sheet will provide the details of your expenses and a brief description of how they support your proposed grant activity. (The full description of the purpose of each grant-funded position and the necessity of budgeted items should appear in your Project Narrative.)

The Budget Summary Sheet (Form D) is where you will provide the total expenses for the proposal.

The Accounting System and Financial Capability Questionnaire (Form E) is only required for non-profit, private colleges and tribal colleges to complete. If your organization is part of the MnSCU or University of MN system, it is not necessary to complete Form E.

FORM C

**Budget Justification Sheet
Community Care Team Grant**

Applicant Agency: Contact Person: Phone Number: Email Address: Budget Period: June 1, 20__ to June 30, 20__ Revision # (MDH use only) _____
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Salary and Fringe Benefits:	
For each proposed funded position, list the title, the full time equivalent, the expected rate of pay, and the total amount you expect to pay the position.	REQUESTED DOLLARS
<i>Budget Justification:</i>	
Total Salary and Fringe:	
Contractual Services:	
List the services you expect to contract out, the contractor's or consultant's name, whether the contractor is non-profit or for-profit, the length of time the services will be provided and the total amount you expect to pay. Supplies and travel should be included, if applicable. Itemize equipment rented or leased for the project.	REQUESTED DOLLARS
<i>Budget Justification:</i>	
Total Contractual Services:	
Travel:	
Send one member of the community care team on a trip to Vermont to meet with the Vermont and North Carolina community care team members through a learning community sponsored by National Academy of State Health Policy (NASHP). Grantees should include \$2,000 dollars for this two day trip in their overall budget.	REQUESTED DOLLARS
Explain your expected travel costs, including mileage, hotel and meals. If project staff will travel, itemize the costs, frequency and the nature of the travel.	
<i>Budget Justification:</i>	
Total Travel:	
Supplies and Expenses:	
Briefly explain the expected costs for items and services you will purchase to run your program. Include telephone expenses that are part of your proposal. Estimate postage if it is part of the project. List any printing and copying costs necessary for the project (other than occasional copying on an office copy machine). List office and program supplies and expendable equipment such as training materials, curriculum and software. Generally supplies include items that are consumed during the course of the project participant transportation, participant training and other direct costs as needed.	REQUESTED DOLLARS

<i>Budget Justification:</i>		
Total Supplies and Expenses:		
Other Expenses:		
Briefly describe any expenses that do not fit in any other category. An example is staff training, which can be charged to the grant at a rate not to exceed \$250.		REQUESTED DOLLARS
<i>Budget Justification:</i>		
Other Expenses Total:		
SUBTOTAL (Enter subtotal of expenses from all previous categories):		
Subtotal:		

Evaluation:		
10% of grant expenses must be included in the budget for evaluation costs. Multiply the amount of the Subtotal by 10% and enter here. It is not necessary to include any information on evaluation procedures.		REQUESTED DOLLARS
Evaluation:		

DIRECT COST TOTAL (Subtotal + Evaluation):		
Direct Cost Total:		

Administrative Costs:		
Administrative costs are defined as “costs that represent the expenses of doing business that are not easily identified with a particular grant, contract, project, function, or activity but are necessary for the general operation of the organization and the conduct of activities it performs.” Examples of such expenses include accounting, administration, and costs to operate and maintain facilities.		REQUESTED DOLLARS
Administrative cost rate is _____		
Administrative Total:		
GRANT FUNDS TOTAL:		

FORM D

**Budget Summary Sheet
Community Care Team Grant**

Applicant Agency:	
Contact Person for further information:	
Phone:	
Email address:	
Grant Funds Requested	
Budget by Line Item	Total Dollars
Salaries and Fringe	\$0.00
Contractual Services	\$0.00
Travel Expenses	\$0.00
Supplies and Expenses*	\$0.00
Other Expenses	\$0.00
Sub Total	0.00
<i>*Includes telephone, postage, print, copy, rent, and equipment under \$5,000.00</i>	
10% Evaluation	\$0.00
Direct Cost Total <i>(Subtotal + Evaluation)</i>	\$0.00
Administrative Costs <i>(Refer to Form C)</i>	\$0.00
GRANT FUNDS TOTAL	\$0.00

FORM E (If Applicable)

MDH Accounting System and Financial Capability Questionnaire*

This form must be completed by applicants that are non-profit, educational institutions. However, if your institution of higher education is part of MnSCU or the University of Minnesota, it is not necessary to complete this form. No applicants will be excluded from receiving funding based solely on the answers to these questions.

SECTION A: APPLICANT INFORMATION		
1. Organization Name and Address	2. Employer Identification Number	3. Number of Employees Full Time: Part Time:
		4. When did the applicant receive its 501(c)3 status? (MM/DD/YYYY)?
5. Is the applicant affiliated with or managed by any other organizations (Ex. regional or national offices)? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes," provide details:		6a. Total revenue in most recent accounting period (12 months).
5b. Does the applicant receive management or financial assistance from any other organizations? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes," provide details:		6b. How many different funding sources does the total revenue come from?
7. Does the applicant have written policies and procedures for the following business processes?		
a. Accounting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure If yes please attach a copy of the table of contents		
b. Purchasing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure If yes please attach a copy of the table of contents		
c. Payroll <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure If yes please attach a copy of the table of contents		
SECTION B: ACCOUNTING SYSTEM		
1. Has a Federal or State Agency issued an official opinion regarding the adequacy of the applicants accounting system for the collection, identification and allocation of costs for grants <input type="checkbox"/> Yes <input type="checkbox"/> No Note: If a financial review occurred within the past three years, omit Questions 2 – 6 of this Section and 1-3 of Section C.		
a. If yes, provide the name and address of the reviewing agency:		b. Attach a copy of the latest review and any subsequent documents.
2. Which of the following best describes the accounting system? <input type="checkbox"/> Manual <input type="checkbox"/> Automated <input type="checkbox"/> Combination		
3. Does the accounting system identify the deposits and expenditures of program funds for each and every grant separately? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		
4. If the applicant has multiple programs within a grant, does the accounting system record the expenditures for each and every program separately by budget line items? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Not Applicable		
5. Are time studies conducted for an employee(s) who receives funding from multiple sources? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> No Multiple Sources		
6. Does the accounting system have a way to identify over spending of grant funds? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		
SECTION C: FUND CONTROL		
1. Is a separate bank account maintained for grant funds? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		
2. If grant funds are mixed with other funds, can the grants expenses be easily identified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		
3. Are the officials of the organization bonded? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		
SECTION D: FINANCIAL STATEMENTS		
1. Did an independent certified public accountant (CPA) ever examine the organization's financial statements? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		
SECTION E: CERTIFICATION		
I certify that the above information is complete and correct to the best of my knowledge.		
1. Signature		2. Date / /

3. Title

**This is the standard form to be used to determine the financial capacity of grant applicants. The creation and implementation of this form is in response to the best practices stated in the Office of Legislative Auditor's report "State Grants to Nonprofit Organizations," January 2007.*

Appendices

Appendix A Minnesota Statute §256B.0751

Appendix B Minnesota Rules 4700.1900-2500, Health Care Homes Rules

Appendix C Sample MDH Grant Agreement

Minnesota Statute §256B.0751 .

CHAPTER 358--S.F.No. 3780

ARTICLE 2

HEALTH CARE HOMES

Section 1. §256B.0751 HEALTH CARE HOMES. Subdivision 1. Definitions. (a) For purposes of sections 256B.0751 to 256B.0753, the following definitions apply. (b) "Commissioner" means the commissioner of human services. (c) "Commissioners" means the commissioner of human services and the commissioner of health, acting jointly. (d) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4. (e) "Personal clinician" means a physician licensed under chapter 147, a physician assistant registered and practicing under chapter 147A, or an advanced practice nurse licensed and registered to practice under chapter 148. (f) "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 2. Development and implementation of standards. (a) By July 1, 2009, the commissioners of health and human services shall develop and implement standards of Certification for health care homes for state health care programs. In developing these standards, the commissioners shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the commissioners must meet the following criteria: (1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians; (2) focus on delivering high-quality, efficient, and effective health care services; (3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language; (4) provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition; (5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions; (6) enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license; (7) focus initially on patients who have or are at risk of developing chronic health conditions; (8) incorporate measures of quality, resource use, cost of care, and patient experience; (9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and (10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools. (b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates. The commissioners may satisfy this requirement by continuing the provider directed care coordination advisory committee. (c) For the purposes of developing and implementing these standards, the commissioners may use the expedited rulemaking process under section 14.389.

Subd. 3. Requirements for clinicians certified as health care homes. (a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health care home. In order to be certified as a health care home, a clinician or clinic must meet the standards set by the commissioners in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their Certification annually. (b) Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health

conditions who are interested in participation. (c) Health care homes must participate in the health care home collaborative established under subdivision 5.

Subd. 4. **Alternative models.** Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner

Sec. 2. from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

Subd. 5. **Health care home collaborative.** By July 1, 2009, the commissioners shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Subd. 6. **Evaluation and continued development.** (a) For continued Certification under this section, health care homes must meet process, outcome, and quality standards as developed and specified by the commissioners. The commissioners shall collect data from health care homes necessary for monitoring compliance with Certification standards and for evaluating the impact of health care homes on health care quality, cost, and outcomes. (b) The commissioners may contract with a private entity to perform an evaluation of the effectiveness of health care homes. Data collected under this subdivision is classified as nonpublic data under chapter 13.

Subd. 7. **Outreach.** Beginning July 1, 2009, the commissioner shall encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

[256B.0752] HEALTH CARE HOME REPORTING REQUIREMENTS. Subdivision 1. **Annual reports on implementation and administration.** The commissioners shall report annually to the legislature on the implementation and administration of the health care home model for state health care program enrollees in the fee-for-service, managed care, and county-based purchasing sectors beginning December 15, 2009, and each December 15 thereafter. Subd. 2. **Evaluation reports.** The commissioners shall provide to the legislature Sec. 3. comprehensive evaluations of the health care home model three years and five years after implementation. The report must include: (1) the number of state health care program enrollees in health care homes and the number and characteristics of enrollees with complex or chronic conditions, identified by income, race, ethnicity, and language; (2) the number and geographic distribution of health care home providers; (3) the performance and quality of care of health care homes; (4) measures of preventive care; (5) health care home payment arrangements, and costs related to implementation and payment of care coordination fees; (6) the estimated impact of health care homes on health disparities; and (7) estimated savings from implementation of the health care home model for the fee-for-service, managed care, and county-based purchasing sectors.

Health Care Homes Rule

4764.0010 – 4764.0070

1.1 4764.0010 APPLICABILITY AND PURPOSE.

1.2 Subpart 1. **Applicability.** Parts 4764.0010 to 4764.0070 apply to an eligible provider

1.3 that is an applicant or is certified as a health care home.

1.4 Subp. 2. **Purpose.** Parts 4764.0010 to 4764.0070 establish the standards and

1.5 procedures for certification of health care homes. The purpose of the standards is to

1.6 require health care homes to deliver services that:

1.7 A. facilitate consistent and ongoing communication among the health care

1.8 home and the patient and family, and provide the patient with continuous access to the

1.9 patient's health care home;

1.10 B. use an electronic, searchable patient registry that enables the health care

1.11 home to manage health care services, provide appropriate follow-up, and identify gaps

1.12 in patient care;

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

1.14 D. include a care plan for selected patients with a chronic or complex condition,

1.15 involve the patient and, if appropriate, the patient's family in the care planning process; and

1.16 E. reflect continuous improvement in the quality of the patient's experience, the

1.17 patient's health outcomes, and the cost-effectiveness of services.

1.18 4764.0020 DEFINITIONS.

1.19 Subpart 1. **Scope.** The terms used in parts 4764.0010 to 4764.0070 have the

1.20 meanings given them in this part.

1.21 Subp. 2. **Applicant.** "Applicant" means an eligible provider that has applied for

1.22 certification or recertification under parts 4764.0010 to 4764.0070.

1.23 Subp. 3. **Care coordination.** "Care coordination" means a team approach that

1.24 engages the participant, the personal clinician or local trade area clinician, and other

2.1 members of the health care home team to enhance the participant's well-being by

2.2 organizing timely access to resources and necessary care that results in continuity of

2.3 care and builds trust.

2.4 Subp. 4. **Care coordination payment system.** "Care coordination payment system"

2.5 means a system established under Minnesota Statutes, section 256B.0753, subdivision 1,

2.6 or 62U.03, paragraph (a), to compensate health care homes.

2.7 Subp. 5. **Care coordinator.** "Care coordinator" means a person who has primary

2.8 responsibility to organize and coordinate care with the participant in a health care home.

2.9 Subp. 6. **Care plan.** "Care plan" means an individualized written document,

2.10 including an electronic document, to guide a participant's care.

2.11 Subp. 7. **Chronic condition.** "Chronic condition" means a medical condition that

2.12 has lasted at least six months, can reasonably be expected to continue for at least six

2.13 months, or is likely to recur.

2.14 Subp. 8. **Clinic.** "Clinic" means an operational entity through which personal

2.15 clinicians or local trade area clinicians deliver health care services under a common set of
2.16 operating policies and procedures using shared staff for administration and support. The
2.17 operational entity may be a department or unit of a larger organization as long as it is a
2.18 recognizable subgroup.

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

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

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

3.1 Subp. 12. **Comprehensive care plan.** "Comprehensive care plan" means the care
3.2 plan for a participant plus all available and relevant portions of any external care plans
3.3 created for that participant.

3.4 Subp. 13. **Continuous.** "Continuous" means 24 hours per day, seven days per week,
3.5 365 days per year.

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

3.9 Subp. 15. **Direct communication.** "Direct communication" means an exchange
3.10 of information through the use of telephone, electronic mail, video conferencing, or

3.11 face-to-face contact without the use of an intermediary. For purposes of this definition, an
3.12 interpreter is not an intermediary.

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

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

3.19 Subp. 18. **Evidence-based guidelines.** "Evidence-based guidelines" means clinical
3.20 practice guidelines that are recognized by the medical community for achieving positive
3.21 health outcomes and are based on scientific evidence and other authoritative sources,
3.22 such as clinical literature.

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

4.1 Subp. 20. **Family.**

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

4.3 (1) any person or persons identified by the patient as a family member;

4.4 (2) legal guardian according to appointment or acceptance under Minnesota

4.5 Statutes, sections 524.5-201 to 524.5-317;

- 4.6 (3) a health care agent as defined in Minnesota Statutes, section 145C.01,
4.7 subdivision 2; and
4.8 (4) a spouse.

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

4.10 (1) the natural or adoptive parent or parents or a stepparent who live in
4.11 the home with the patient;

4.12 (2) a legal guardian according to appointment or acceptance under
4.13 Minnesota Statutes, sections 260C.325 or 524.5-201 to 524.5-317;

4.14 (3) any adult who lives with or provides care and support for the patient
4.15 when the patient's natural or adoptive parents or stepparents do not reside in
4.16 the same home as the patient; and

4.17 (4) a spouse.

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

4.20 Subp. 22. **Health care home learning collaborative or collaborative.** A "health
4.21 care home learning collaborative" or "collaborative" means an organization established
4.22 under Minnesota Statutes, section 256B.0751, subdivision 5, in which health care home
4.23 team members and participants from different health care organizations work together in a

5.1 structured way to improve the quality of their services by learning about best practices and
5.2 quality methods, and sharing experiences.

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

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

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

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

5.19 Subp. 27. **Patient and family-centered care.** "Patient and family-centered
5.20 care" means planning, delivering, and evaluating health care through patient-driven,

5.21 shared decision-making that is based on participation, cooperation, trust, and respect of
5.22 participant perspectives and choices. It also incorporates the participant's knowledge,
5.23 values, beliefs, and cultural background into care planning and delivery. Patient and
5.24 family-centered care applies to patients of all ages.

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

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

6.6 Subp. 30. **Previsit planning.** "Previsit planning" means planning for the participant's
6.7 visit by reviewing the participant's medical record and, if applicable, communicating with
6.8 the participant before a health care appointment to review changes in the participant's
6.9 condition and determine a plan for the visit.

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

6.13 Subp. 32. **Primary care services patient population.** "Primary care services patient

6.14 population" means all of the patients who are receiving primary care services from the
6.15 health care home, regardless of whether a patient has chosen to participate in the health
6.16 care home.

6.17 Subp. 33. **Referral.** "Referral" means a written document, including an electronic
6.18 document, given by a provider to a participant recommending that the participant receive
6.19 a consultation for evaluation, treatment, or services from a provider outside of the health
6.20 care home.

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

7.1 Subp. 35. **Specialist.** "Specialist" means a health care provider or other person
7.2 with specialized health training not available within the health care home. This includes
7.3 traditional medical specialties and subspecialties. It also means individuals with special
7.4 training such as chiropractic, mental health, nutrition, pharmacy, social work, health
7.5 education, or other community-based services.

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

7.8 Subp. 37. **Statewide quality reporting system.** "Statewide quality reporting

7.9 system" means a system used by the commissioner to collect data necessary for monitoring
7.10 compliance with certification standards and for evaluating the impact of health care homes
7.11 on outcomes.

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

7.15 4764.0030 CERTIFICATION AND RECERTIFICATION PROCEDURES.

7.16 Subpart 1. Eligibility for certification.

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

7.19 B. A clinic will be certified only if all of the clinic's personal clinicians and local
7.20 trade area clinicians meet the requirements for participation in the health care home. It is
7.21 the clinic's responsibility to notify the department when a new clinician joins a certified
7.22 clinic and intends to become a certified clinician. The clinic has 90 days from the date of
7.23 hiring the new clinician or until its next annual anniversary date to apply for recertification,
7.24 whichever is sooner. A clinic may operate as a certified clinic with the new clinician
7.25 acting as though certified until the new clinician is certified. If the clinician chooses not to
8.1 be certified, the clinic will no longer be certified, but the clinicians who were previously
8.2 certified as part of the clinic will automatically hold an individual certification only.

8.3 Subp. 2. **Contents of application.** The applicant must submit the following to
8.4 the commissioner:

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

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

8.9 C. any other information required by the commissioner to show that the
8.10 applicant meets the standards for certification or recertification.

8.11 Subp. 3. **On-site review and additional documentation.** The commissioner may
8.12 conduct an on-site review and may request additional documentation to determine whether
8.13 the applicant complies with certification or recertification requirements.

8.14 Subp. 4. **Completed application for certification.** An application for certification
8.15 or recertification is complete when the commissioner has received all information in
8.16 subpart 2; the on-site review, if any, has been completed; and the commissioner has
8.17 received any additional documentation requested under subpart 3.

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

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

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

8.23 (2) the requirements for the end of year one for each health care home

8.24 standard in part 4764.0040 are met.

9.1 B. At the end of year two and all subsequent years, unless the applicant obtains

9.2 a variance for superior outcomes and continued progress on standards as provided

9.3 in part 4764.0050, subpart 3, an applicant must demonstrate:

9.4 (1) the requirements for initial certification and recertification at the end of

9.5 year one continue to be met; and

9.6 (2) the requirements for recertification at the end of year two in part

9.7 4764.0040, subpart 11, are met, including the requirement that the

9.8 applicant's outcomes in its primary care services patient population achieve the benchmarks for

9.9 patient health, patient experience, and cost-effectiveness established by the commissioner

9.10 under subpart 6.

9.11 Subp. 6. **Benchmarks.** The commissioner must announce benchmarks for patient

9.12 health, patient experience, and cost-effectiveness annually. The benchmarks must be

9.13 based on one or more of the following factors:

9.14 A. an improvement over time as reflected by a comparison of data measuring

9.15 quality submitted by the health care home in the current year to data submitted in prior

9.16 years;

9.17 B. a comparison of data measuring quality submitted by the health care home to

9.18 data submitted by other health care homes;

- 9.19 C. standards established by state or federal law;
- 9.20 D. best practices recommended by a scientifically based outcomes development
- 9.21 organization;
- 9.22 E. measures established by a national accrediting body or professional
- 9.23 association; and
- 9.24 F. additional measures that improve the quality or enhance the use of data
- 9.25 currently being collected.

10.1 Subp. 7. Notice of decision and timelines.

- 10.2 A. The commissioner must notify an applicant in writing regarding whether the
- 10.3 applicant is certified or recertified as a health care home within 90 days after receiving
- 10.4 a completed application.

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

- 10.8 C. If the commissioner denies the application for certification or recertification,
- 10.9 the commissioner must notify the applicant in writing of the reasons for the denial. The
- 10.10 applicant may file an appeal under part 4764.0060.

10.11 4764.0040HEALTH CARE HOME STANDARDS.

- 10.12 Subpart 1.**Access and communication standard; certification requirements.** The

10.13 applicant for certification must have a system in place to support effective communication

10.14 among the members of the health care home team, the participant, and other providers.

10.15 The applicant must do the following:

10.16 A. offer the applicant's health care home services to all of the applicant's

10.17 patients who:

10.18 (1) have or are at risk of developing complex or chronic conditions; and

10.19 (2) are interested in participation;

10.20 B. establish a system designed to ensure that:

10.21 (1) participants are informed that they have continuous access to designated

10.22 clinic staff, an on-call provider, or a phone triage system;

11.1 (2) the designated clinic staff, on-call provider, or phone triage system

11.2 representative has continuous access to participants' medical record
information, which

11.3 must include the following for each participant:

11.4 (a) the participant's contact information, personal clinician's or local

11.5 trade area clinician's name and contact information, and designated
enrollment in a

11.6 health care home;

11.7 (b) the participant's racial or ethnic background, primary language,

11.8 and preferred means of communication;

11.9 (c) the participant's consents and restrictions for releasing medical
11.10 information; and

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

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

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

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

11.20 C. collect information about participants' cultural background, racial heritage,
11.21 and primary language and describe how the applicant will apply this information to
11.22 improve care;

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

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

12.6 F. establish adequate information and privacy security measures to comply with
12.7 applicable privacy and confidentiality laws, including the requirements of the Health
12.8 Insurance Portability and Accountability Act, Code of Federal Regulations, title 45, parts
12.9 160.101 to 164.534, and the Minnesota Government Data Practices Act, Minnesota
12.10 Statutes, chapter 13.

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

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

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

12.23 B. The registry must contain:

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

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

13.3 Subp. 4. **Participant registry and tracking participant care activity standard;**
13.4 **recertification at the end of year one.** By the end of the first year of health care home
13.5 certification, the applicant for recertification must use the registry to identify gaps in
13.6 care and implement remedies to prevent gaps in care such as appointment reminders
13.7 and previsit planning.

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

13.11 A. collaboration within the health care home, including the participant, care

13.12 coordinator, and personal clinician or local trade area clinician as follows:

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

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

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

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

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

- 14.6* D. provides the care coordinator with dedicated time to perform care
14.7 coordination responsibilities; and
- 14.8* E. documents the following elements of care coordination in the participant's
14.9 chart or care plan:
- 14.10* (1) referrals for specialty care, whether and when the participant has been
14.11 seen by a provider to whom a referral was made, and the result of the referral;
- 14.12* (2) tests ordered, when test results have been received and communicated
14.13 to the participant;
- 14.14* (3) admissions to hospitals or skilled nursing facilities, and the result of
14.15 the admission;
- 14.16* (4) timely postdischarge planning according to a protocol for participants
14.17 discharged from hospitals, skilled nursing facilities, or other health care institutions;
- 14.18* (5) communication with participant's pharmacy regarding use of
14.19 medication and medication reconciliation; and
- 14.20* (6) other information, such as links to external care plans, as determined by
14.21 the care team to be beneficial to coordination of the participant's care.

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

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

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

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

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

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

- 15.15* A. establish and implement policies and procedures to guide the health care
- 15.16* home in assessing whether a care plan will benefit participants with complex or chronic
- 15.17* conditions. The applicant must do the following in creating and developing a care plan:
- 15.18* (1) actively engage the participant and verify joint understanding of the
- 15.19* care plan;
- 15.20* (2) engage all appropriate members of the health care team, such as nurses,
- 15.21* pharmacists, dieticians, and social workers;
- 15.22* (3) incorporate pertinent elements of the assessment that a qualified
- 15.23* member of the care team performed about the patient's health risks and chronic conditions;
- 16.1* (4) review, evaluate, and, if appropriate, amend the care plan, jointly with
- 16.2* the participant, at specified intervals appropriate to manage the participant's health and
- 16.3* measure progress toward goals;
- 16.4* (5) provide a copy of the care plan to the participant upon completion of
- 16.5* creating or amending the plan; and
- 16.6* (6) use and document the use of evidence-based guidelines for medical
- 16.7* services and procedures, if those guidelines and methods are available;
- 16.8* B. a participant's care plan must include goals and an action plan for the

16.9 following:

16.10 (1) preventive care, including reasons for deviating from standard

16.11 protocols;

16.12 (2) care of chronic illnesses;

16.13 (3) exacerbation of a known chronic condition, including plans for the

16.14 participant's early contact with the health care home team during an acute episode; and

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

16.16 C. the applicant must update the goals in the care plan with the participant as

16.17 frequently as is warranted by the participant's condition.

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

16.19 of the first year of health care home certification, the applicant must ask each participant

16.20 with a care plan whether the participant has any external care plans and, if so, create a

16.21 comprehensive care plan by consolidating appropriate information from the external plans

16.22 into the participant's care plan.

16.23 Subp. 9. **Performance reporting and quality improvement standard;**

16.24 **certification requirements.** The applicant for certification must measure the applicant's

17.1 performance and engage in a quality improvement process, focusing on patient experience,

17.2 patient health, and measuring the cost-effectiveness of services, by doing the following:

17.3 A. establishing a health care home quality improvement team that reflects the

17.4 structure of the clinic and includes, at a minimum, the following persons at the clinic level:

17.5 (1) one or more personal clinicians or local trade area clinicians who

17.6 deliver services within the health care home;

17.7 (2) one or more care coordinators;

17.8 (3) two or more participant representatives who were provided the

17.9 opportunity and encouraged to participate; and

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

17.11 clinic administration or management;

17.12 B. establishing procedures for the health care home quality improvement team

17.13 to share their work and elicit feedback from health care home team members and other

17.14 staff regarding quality improvement activities;

17.15 C. demonstrating capability in performance measurement by showing that the

17.16 applicant has measured, analyzed, and tracked changes in at least one quality indicator

17.17 selected by the applicant based upon the opportunity for improvement; and

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

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

17.23 (2) one or more care coordinators;

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

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

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

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

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

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

18.17 (1) improvement in patient health;

18.18 (2) quality of patient experience; and

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

18.20 C. submit health care homes data in the manner prescribed by the commissioner
18.21 to fulfill the health care homes evaluation requirements in Minnesota Statutes, section
18.22 256B.0752, subdivision 2.

18.23 Subp. 11. **Performance reporting and quality improvement standard;**
18.24 **recertification at the end of year two and subsequent years.**

19.1 A. By the end of the second year of certification as a health care home, and each
19.2 year thereafter, the applicant must continue to participate in the statewide quality reporting
19.3 system by submitting outcomes for the additional quality indicators identified and in the
19.4 manner prescribed by the commissioner.

19.5 B. To qualify for recertification, the applicant's outcomes in primary care
19.6 services patient population must achieve the benchmarks for patient health, patient
19.7 experience, and cost-effectiveness established under part 4764.0030, subpart 6.
19.8 **4764.0050 VARIANCE.**

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

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

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

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

19.24 Subp. 3. **Variance for superior outcomes and continued progress on standards.**

19.25 The commissioner may grant a variance to the requirements in part 4764.0030, subpart

20.1 5, item B, based on superior achievement reflected in the outcomes data and continued

20.2 progress on the health care home standards in part 4764.0040. The commissioner must

20.3 annually announce benchmarks for superior achievement based on the factors in part

20.4 4764.0030, subpart 6. To receive the variance, the applicant must:

20.5 A. demonstrate that the applicant has met or surpassed the benchmarks for

20.6 superior achievement in outcomes related to patient health, patient experience, and

20.7 cost-effectiveness, as reflected in the data submitted by the applicant to the statewide

20.8 quality reporting system;

20.9 B. submit a signed statement affirming that the applicant continues to comply

20.10 with the requirements for initial certification, recertification at the end of year one, and

20.11 recertification at the end of year two, according to part 4764.0040;

20.12 C. demonstrate continued progress on the health care home standards by

20.13 identifying at least one approach that is new to the applicant for each of the five health

20.14 care home standards in part 4764.0040, except for the standard for performance reporting

20.15 and quality improvement;

20.16 D. provide any additional documentation of superior outcomes and continued

20.17 progress on standards requested by the commissioner; and

20.18 E. continue to participate in a health care home learning collaborative.

20.19 Subp. 4.**Experimental variance.** The commissioner may grant a variance from one
20.20 or more requirements to permit an applicant to offer health care home services of a type or
20.21 in a manner that is innovative if the commissioner finds that the variance does not impede
20.22 the achievement of the criteria in Minnesota Statutes, section 256B.0751, subdivision 2,
20.23 paragraph (a), and may improve the health care home services provided by the applicant.

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

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

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

21.7 **4764.0060 APPEALS.**

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

21.11 notice of the decision to appeal the decision.

21.12 Subp. 2.**How to appeal.** The applicant may appeal by submitting either item A

21.13 or B, or both:

21.14 A. a written statement of the applicant's grounds for disputing the

21.15 commissioner's decision; or

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

21.17 improvement:

21.18 (1) the corrective steps that have been taken by the applicant;

21.19 (2) a plan for continued improvement; and

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

21.21 Subp. 3.**Optional request for meeting.** Upon request, an applicant is entitled to a

21.22 meeting with the commissioner's designee to discuss disputed facts and findings, present

21.23 the applicant's corrective action plan, or both.

22.1 Subp. 4.**Notice of decision and timeline.** The commissioner must grant or deny the

22.2 appeal and notify the applicant of the decision within 60 days after receipt of a completed

22.3 appeal, or, if the applicant meets with the commissioner's designee, within 60 days after

22.4 the meeting.

22.5 **4764.0070 REVOCATION, REINSTATEMENT, AND SURRENDER.**

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

22.10 Subp. 2.**Reinstatement.** A provider whose certification as a health care home has
22.11 been revoked may apply for reinstatement. If the provider was previously certified for one
22.12 year or longer at the time of revocation, it must meet the recertification requirements to
22.13 be reinstated. During the 12 months following revocation of certification, the provider
22.14 may obtain technical or program assistance from the Minnesota Department of Health
22.15 and through a health care home learning collaborative to assist the provider to regain
22.16 certification.

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

APPENDIX C

Sample Grant Agreement Community Care Team Grant

The following is a sample grant agreement to be used if the applicant is awarded funding. Please note: The University of Minnesota and the MDH are obligated to utilize a grant agreement that is specific to their work, and consequently differs from the one below.

Grant Agreement

THIS GRANT AGREEMENT, and amendments and supplements thereto, is between the State of Minnesota, acting through its Commissioner of Minnesota Department of Health (hereinafter "STATE") and [INSERT GRANTEE'S FULL LEGAL NAME], an independent organization, not an employee of the State of Minnesota, address [INSERT GRANTEE'S ADDRESS], (hereinafter "GRANTEE"), witnesseth that:

WHEREAS, the STATE, pursuant to Minnesota Statute §[INSERT THE AUTHORIZING STATUTE OR LEGISLATION] is empowered to [GIVE A BRIEF DESCRIPTION OF THE PURPOSE OF THIS GRANT PROGRAM]; and

WHEREAS, _____, and

WHEREAS, GRANTEE represents that it is duly qualified and willing to perform the services set forth herein.

NOW, THEREFORE, it is agreed:

- I. GRANTEE'S DUTIES [ATTACH ADDITIONAL PAGE IF NECESSARY WHICH IS INCORPORATED BY REFERENCE AND MADE PART OF THIS AGREEMENT] GRANTEE shall:

II. CONSIDERATION AND TERMS OF PAYMENT

- A. Consideration for all services performed by GRANTEE pursuant to this grant agreement shall be paid by the STATE as follows:
 1. Compensation. The total obligation of the STATE for all compensation and reimbursement to GRANTEE shall not exceed [AMOUNT IN WORDS] dollars [\$(AMOUNT IN NUMERALS)].
 2. Matching Requirements. [IF APPLICABLE INSERT THE CONDITIONS OF MATCHING REQUIREMENT. IF NOT APPLICABLE, PLEASE DELETE THIS ENTIRE MATCHING PARAGRAPH] GRANTEE certifies that the following matching requirement, for the grant will be met by GRANTEE:
- B. Terms of Payment
 1. Payments shall be made by the STATE promptly after GRANTEE'S presentation of invoices for services performed and acceptance of such services by the STATE'S Authorized Representative pursuant to Clause VI. Invoices shall be submitted in a form prescribed by the STATE and according to the following schedule:

2. **FEDERAL FUNDS** Payments are to be made from federal funds obtained by the STATE through Title _____ of the Act of _____ (Public law and amendments thereto.) If at any time such funds become unavailable, this grant agreement shall be terminated immediately upon written notice of such fact by the STATE to the GRANTEE. In the event of such termination, GRANTEE shall be entitled to payment, determined on a pro rata basis, for services satisfactorily performed.
- III. **CONDITIONS OF PAYMENT** All services provided by GRANTEE pursuant to this grant agreement shall be performed to the satisfaction of the STATE, as determined at the sole discretion of its Authorized Representative, and in accord with all applicable federal, state, and local laws, ordinances, rules and regulations. GRANTEE shall not receive payment for work found by the STATE to be unsatisfactory, or performed in violation of federal, state or local law, ordinance, rule or regulation.
- IV. **TERMS OF AGREEMENT** This grant agreement shall be effective on _____, 20 _____, or upon the date that the final required signature is obtained by the STATE, pursuant to Minnesota Statute §16C.05, Subdivision 2, whichever occurs later, and shall remain in effect until _____, 20 _____, or until all obligations set forth in this grant agreement have been satisfactorily fulfilled, whichever occurs first. GRANTEE understands that NO work should begin under this grant agreement until ALL required signatures have been obtained, and GRANTEE is notified to begin work by the STATE'S Authorized Representative.
- V. **CANCELLATION**
- A. If the GRANTEE fails to comply with the provisions of this grant agreement, the STATE may terminate this grant agreement without prejudice to the right of the STATE to recover any money previously paid. The termination shall be effective five business days after the STATE mails, by certified mail, return receipt requested, written notice of termination to the GRANTEE at its last known address.
- B. The STATE or GRANTEE may cancel this grant agreement at any time, with or without cause, upon thirty (30) days written notice to the other party.
- VI. **STATE'S AUTHORIZED REPRESENTATIVE** The STATE'S Authorized Representative for the purposes of administration of this grant agreement is _____. Such representative shall have final authority for acceptance of GRANTEE'S services and if such services are accepted as satisfactory, shall so certify on each invoice submitted pursuant to Clause II, paragraph B. The GRANTEE'S Authorized Representative for purposes of administration of this grant agreement is _____. The GRANTEE'S authorized Representative shall have full authority to represent GRANTEE in its fulfillment of the terms, conditions and requirements of this grant agreement.
- VII. **ASSIGNMENT** GRANTEE shall neither assign nor transfer any rights or obligations under this grant agreement without the prior written consent of the STATE.
- VIII. **AMENDMENTS** Any amendments to this grant agreement shall be in writing, and will not be effective until it has been fully executed by the same parties who executed the original grant agreement, or their successors in office.
- IX. **LIABILITY** GRANTEE shall indemnify, save, and hold the STATE, its representatives and employees harmless from any and all claims or causes of action, including all attorneys' fees incurred by the STATE, arising from the performance of this grant agreement by GRANTEE or GRANTEE'S agents or employees. This clause shall not be construed to bar any legal remedies GRANTEE may have for the STATE'S failure to fulfill its obligations pursuant to this grant

agreement. Nothing herein shall be construed as a waiver by GRANTEE of any of the immunities or limitations of liability to which GRANTEE may be entitled to pursuant to Minnesota Statute Chapter 466 or pursuant to any other statute or law.

- X. STATE AUDITS The books, records, documents, and accounting procedures and practices of the GRANTEE relevant to this grant agreement shall be made available and subject to examination by the STATE, including the contracting Agency/Division, Legislative Auditor, and State Auditor for a minimum period of six (6) years from the end of this grant term.
- XI. DATA PRACTICES ACT The GRANTEE and the STATE shall comply with the Minnesota Data Practices Act and other applicable laws as it applies to all data provided by the STATE in accordance with this grant agreement and as it applies to all data created, gathered, generated or acquired in accordance with this grant agreement.

XII. OWNERSHIP OF EQUIPMENT

Disposition of all equipment purchased under this grant shall be in accordance with Code of Federal Regulations, Title 45, Part 74, Subpart C. For all equipment having a current per unit fair market value of \$5,000 or more, the STATE shall have the right to require transfer of the equipment (including title) to the Federal Government or to an eligible non-Federal party named by the STATE. This right will normally be exercised by the STATE only if the project or program for which the equipment was acquired is transferred from one grantee to another.

XIII. OWNERSHIP OF MATERIALS AND INTELLECTUAL PROPERTY RIGHTS

- A. The STATE shall own all rights, title and interest in all of the materials conceived or created by the GRANTEE, or its employees or subgrantees, either individually or jointly with others and which arise out of the performance of this grant agreement, including any inventions, reports, studies, designs, drawings, specifications, notes, documents, software and documentation, computer based training modules, electronically, magnetically or digitally recorded material, and other work in whatever form ("MATERIALS").

The GRANTEE hereby assigns to the STATE all rights, title and interest to the MATERIALS. GRANTEE shall, upon request of the STATE, execute all papers and perform all other acts necessary to assist the STATE to obtain and register copyrights, patents or other forms of protection provided by law for the MATERIALS. The MATERIALS created under this grant agreement by the GRANTEE, its employees or subgrantees, individually or jointly with others, shall be considered "works made for hire" as defined by the United States Copyright Act. All of the MATERIALS, whether in paper, electronic, or other form, shall be remitted to the STATE by the GRANTEE. Its employees and any subgrantees shall not copy, reproduce, allow or cause to have the MATERIALS copied, reproduced or used for any purpose other than performance of the GRANTEE'S obligations under this grant agreement without the prior written consent of the STATE'S Authorized Representative.

- B. GRANTEE represents and warrants that MATERIALS produced or used under this grant agreement do not and will not infringe upon any intellectual property rights of another including but not limited to patents, copyrights, trade secrets, trade names, and service marks and names. GRANTEE shall indemnify and defend the STATE, at GRANTEE'S expense, from any action or claim brought against the STATE to the extent that it is based on a claim that all or parts of the MATERIALS infringe upon the intellectual property rights of another. GRANTEE shall be responsible for payment of any and all such claims, demands, obligations, liabilities, costs, and damages including, but not limited to, reasonable attorney fees arising out of this grant agreement, amendments and supplements thereto, which are attributable to such claims or actions. If such a claim or action arises or in GRANTEE'S or the STATE'S opinion is likely to

arise, GRANTEE shall at the STATE'S discretion either procure for the STATE the right or license to continue using the MATERIALS at issue or replace or modify the allegedly infringing MATERIALS. This remedy shall be in addition to and shall not be exclusive of other remedies provided by law.

- XIV. PUBLICITY Any publicity given to the program, publications, or services provided resulting from this grant agreement, including, but not limited to, notices, informational pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the GRANTEE or its employees individually or jointly with others, or any subgrantees shall identify the STATE as the sponsoring agency and shall not be released without prior written approval by the STATE'S Authorized Representative, unless such release is a specific part of an approved work plan included in this grant agreement.
- XV. ENDORSEMENT The Grantee must not claim that the STATE endorses its products or services.
- XVI. WORKERS' COMPENSATION The GRANTEE certifies that it is in compliance with Minnesota Statute §176.181, Subdivision 2, pertaining to workers' compensation insurance coverage. The GRANTEE'S employees and agents will not be considered STATE employees. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees and any claims made by any third party as a consequence of any act or omission on the part of these employees are in no way the STATE'S obligation or responsibility.
- XVII. JURISDICTION AND VENUE This grant agreement, and amendments and supplements thereto, shall be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this grant agreement, or breach thereof, shall be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.
- XVIII. OTHER PROVISIONS
A. Contractor Debarment, Suspension and Responsibility Certification

Federal regulation 45 CFR 92.35 prohibits the State from purchasing goods or services with federal money from vendors who have been suspended or debarred by the Federal Government. Similarly Minnesota Statute §16C.03, Subdivision 2, provides the Commissioner of Administration with the authority to debar and suspend vendors who seek to contract with the State.

Vendors may be suspended or debarred when it is determined, through a duly authorized hearing process, that they have abused the public trust in a serious manner. In particular, the Federal Government expects the State to have a process in place for determining whether a vendor has been suspended or debarred, and to prevent such vendors from receiving federal funds.

By signing this contract, GRANTEE certifies that it and its principals:

1. Are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from transacting business by or with any federal, state or local governmental department or agency; and,
2. Have not within a three-year period preceding this contract: a) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction or contract; b) violated any federal or state antitrust statutes; or c) committed embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and,

3. Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: a) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction; b) violating any federal or state antitrust statutes; or c) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement or receiving stolen property; and,
4. Are not aware of any information and possess no knowledge that any subcontractor(s) that will perform work pursuant to this grant/contract are in violation of any of the Certifications set forth above.

B. Audit Requirements to be Included in Grant Agreements with Subrecipients

1. For subrecipients (GRANTEES) that are state or local governments, non-profit organizations, or Tribal Governments:

If the GRANTEE expends total federal assistance of \$500,000 or more per year, the grantee agrees to: a) obtain either a single audit or a program-specific audit made for the fiscal year in accordance with the terms of the Single Audit Act of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133; and, b) to comply with the Single Audit Act of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133.

Audits shall be made annually unless the grantee is a state or local government that has, by January 1, 1987, a constitutional or statutory requirement for less frequent audits. For those governments, the federal cognizant agency shall permit biennial audits, covering both years, if the government so requests. It shall also honor requests for biennial audits by state or local governments that have an administrative policy calling for audits less frequent than annual, but only audits prior to 1987 or administrative policies in place prior to January 1, 1987.

For subrecipients (GRANTEES) that are institutions of higher education or hospitals:

If the GRANTEE expends total direct and indirect federal assistance of \$500,000 or more per year, the GRANTEE agrees to obtain a financial and compliance audit made in accordance with OMB Circular A-110, "Requirements for Grants and Agreements with Universities, Hospitals and Other Nonprofit Organization" as applicable. The audit shall cover either the entire organization or all federal funds of the organization.

The audit must determine whether the GRANTEE spent federal assistance funds in accordance with applicable laws and regulations.

2. The audit shall be made by an independent auditor. An independent auditor is a state or local government auditor or a public accountant who meets the independence standards specified in the General Accounting Office's "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions."
3. The audit report shall state that the audit was performed in accordance with the provisions of OMB Circular A-133 (or A-110 as applicable).

The reporting requirements for audit reports shall be in accordance with the American Institute of Certified Public Accountants' (AICPA) audit guide, "Audits of State and Local Governmental Units," issued in 1986. The Federal Government has approved the use of the audit guide.

In addition to the audit report, the GRANTEE shall provide comments on the findings and recommendations in the report, including a plan for corrective action taken or planned and comments on the status of corrective action taken on prior findings. If corrective action is not necessary, a statement describing the reason it is not should accompany the audit report.

4. The GRANTEE agrees that the grantor, the Legislative Auditor, the State Auditor, and any independent auditor designated by the grantor shall have such access to GRANTEE'S records and financial statements as may be necessary for the grantor to comply with the Single Audit Act Amendments of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133.
5. GRANTEES of federal financial assistance from subrecipients are also required to comply with the Single Audit Act Amendments of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133.
6. The Statement of Expenditures form can be used for the schedule of federal assistance.
7. The GRANTEE agrees to retain documentation to support the schedule of federal assistance for at least four (4) years.
8. The GRANTEE agrees to file required audit reports with the State Auditor's Office, Single Audit Division, and with federal and state agencies providing federal assistance, within nine (9) months of the GRANTEE'S fiscal year end.

OMB Circular A-133 requires recipients of more than \$500,000 in federal funds to submit one copy of the audit report within 30 days after issuance to the central clearinghouse at the following address:

Bureau of the Census, Data Preparation Division
1201 East 10th Street Jeffersonville, Indiana 47132
Attn: Single Audit Clearinghouse

C. Drug-Free Workplace

GRANTEE agrees to comply with the Drug-Free Workplace Act of 1988, and implemented at 34 CFR Part 85, Subpart F.

D. Lobbying

The GRANTEE agrees to comply with the provisions of United States Code, Title 31, Section 1352. The GRANTEE must not use any federal funds from the STATE to pay any person for influencing or attempting to influence an officer or employee of a federal agency, a member of Congress, an officer or employee of Congress, or any employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If the GRANTEE uses any funds other than the federal funds from the STATE to conduct any of the aforementioned activities, the GRANTEE must complete and submit to the STATE the disclosure form specified by the STATE. Further, the GRANTEE must include the language of this provision in all contracts and subcontracts and all contractors and subcontractors must comply accordingly.

E. Equal Employment Opportunity

GRANTEE agrees to comply with the Executive Order 11246 "Equal Employment Opportunity" as amended by Executive Order 11375 and supplemented by regulations at 41 CFR Part 60.

F. Cost Principles and cost principles for 501c 3s.
[OPTION #1]:

The GRANTEE agrees to comply with the provision of OMB Circular A-21 regarding cost principles for administration of this grant award for educational institutions.

Or [OPTION #2]:

The GRANTEE agrees to comply with the provisions of OMB Circular A-87 regarding cost principles for administration of this grant award for state and local governments and Indian tribal governments.

[OPTION #3]:

The GRANTEE agrees to comply with the provisions of OMB Circular A-122 regarding cost principles for administration of this grant award for non-profit organizations.

G. Rights to Inventions – Experimental, Developmental or Research Work

The GRANTEE agrees to comply with 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements" and any implementing regulations issued by the awarding agency.

H. Clean Air Act

The GRANTEE agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act as amended (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.). Violations shall be reported to the Federal Awarding Agency Regional Office of the Environmental Protection Agency (EPA).

IN WITNESS WHEREOF, the parties have caused this grant agreement to be duly executed intending to be bound thereby.

APPROVED:

1. GRANTEE
The Grantee certifies that the appropriate persons(s) have executed the grant agreement on behalf of the Grantee as required by applicable articles, bylaws, resolutions, or ordinances.

2. STATE AGENCY
Grant Agreement approval and Certification that STATE funds have been encumbered as required by Minn. Stat. §§16A.15 and 16C.05.

By: _____

By: _____

(with delegated authority)

Title: _____

Title: _____

Date:

Date:

By:

Title:

Date:

Distribution:
Agency – Original (fully executed) Grant Agreement
Grantee
State Authorized Representative