IOWA | Health and Human Services

Iowa Care for Yourself
Breast and Cervical Cancer Service Entity Agreement

This agreement is entered into between the Iowa Department of Health and Human Services (Agency) and the service provider entity identified in the signature block at the end of this document (Service Entity). The Service Entity's legal name, as it appears on the entity's tax documents, National Provider Identifier (NPI) registration, and related official records, shall be used in this agreement.

I. Purpose

This agreement outlines the responsibilities of both parties to ensure that participants of the Care for Yourself Program (Program) receive timely and appropriate diagnostic and treatment follow-up services for breast and cervical cancer abnormalities. The Program is authorized under the Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354) and funded through a competitive grant by the Centers for Disease Control and Prevention (CDC) and state funds.

II. Responsibility of the Service Entity

The Service Entity agrees to:

1. **Adhere to Professional Standards**: Adhere to professional standards and levels of service as set forth in all applicable, local, state, and federal laws, rules, and regulations as well as administrative policies and procedures set forth by the Agency relating to services performed under this agreement.
2. **Assure Civil Rights and Privacy Compliance**: Abide, to the extent required, by the provisions of:
   i. Title VI of the Civil Rights Act of 1964, as amended.
   ii. Section 504 of the Rehabilitation Act of 1973, as well as the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101), and associated regulations (28 C.F.R. §§ 36.101–.999).
   iii. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and associated regulations (45 C.F.R. parts 160 and 164), and all applicable laws protecting the confidentiality of patients and members receiving services through Iowa HHS, Medicaid, and other programs.
3. **Ensure Enrollment of Facilities Providing Services**: This agreement covers all facilities associated to the Tax ID# listed in the signature block.
   a. Provide Tax Information: The Service Entity shall provide a completed IRS Form W-9 upon execution of this agreement or as requested by the Agency. A W-9 form is required only oncer per Tax ID# associated with this agreement, unless there are changes to the entity's tax information.
   b. Individual facilities, providing services authorized by the Program, associated with this Tax ID#, must provide documentation to the Program. To become an approved facility, facilities should follow enrollment procedures at hhs.iowa.gov/cfy-providers.

i. Provide NPI information for providers or facilities providing approved services.

ii. Under the Clinical Laboratory Improvement Amendments (CLIA), any facility that performs even one test on human specimens for diagnosis, prevention, or treatment of disease is considered a laboratory and must have a CLIA certificate. If an individual facility is providing these services a CLIA certificate is required upon application for enrollment from individual facilities. It is the Service Entities responsibility to ensure individual approved facilities send current CLIA certificates to the Program.

1. At each renewal, approximately every 2 years, within 5 business days.
2. If a provider adds a new reference lab or changes test complexity, a new CLIA certificate must be sent to the Program within 5 business days.
3. Approved facilities must notify the Program within 5 business days of any CLIA suspension, revocation, lapse, or change in certificate type.

4. **Ensure Individual Approved Facilities Comply:** The Service Entity should ensure that individual facilities, associated with this Tax ID# and are enrolled and approved by the Program prior to providing services to participants. The Service Entity should ensure approved facilities follow all standards set by this agreement.
5. **Provide Authorized Services**: Deliver services authorized by the Program, which may include, but are not limited to:

   - Diagnostic imaging (e.g., diagnostic mammograms, ultrasounds)
   - Biopsies (e.g., breast, cervical)
   - Colposcopy and related procedures
   - Pathology and lab services
   - LEEP and cryotherapy (if applicable)

   All services must align with the Program's approved CPT codes and the current Program fee schedule available at hhs.iowa.gov/cfy-providers.
6. **Submit Claims for Program Services Performed**: Bill only for services authorized by the Program and performed for eligible Program participants.
7. **Accept Reimbursement at Medicare Part B Rates**: Accept claim reimbursement at Medicare Part B, participating provider rates for Iowa. Services will be reimbursed at the current Medicaid Part B reimbursement rate.
8. **Seek Preauthorization When Required**: Obtain written authorization from the local program before delivering any procedure not already authorized.

   ***Example**: If a participant presents for a Pap test and a LEEP is deemed necessary, the LEEP must not be performed until the Agency provides the local program with written authorization.*
9. **Assure Timely Claims Submission**: Submit claims within 180 days of the service date. Claims submitted after this period will not be reimbursed by the Agency, and the Service

Entity agrees not to bill or seek reimbursement from the participant. The Program operates as the payor of last resort under Federal guidelines. Insurance or other sources of payment must be billed and payment received prior to billing the Program. The Service Entity should submit the EOB from the other payment source to document the remaining claim amount, up to the Medicare Part B reimbursement rate, requested from the Program.

10. **Agree Not to Bill Participant**: Participants may not be billed for services covered under the Program.
11. **Accept the Program's Reimbursement as Payment in Full:** By entering into this agreement, Service Entity agrees to accept the Program reimbursement rate as payment in full and will not bill the participant for additional costs for the Program services provided.
12. **Maintain Licensure**: Ensure all staff providing Program services are appropriately licensed and practicing within their professional scope.
13. **Maintain Records**: Maintain accurate documentation of all services rendered under the Program. Retain records for six (6) years. Records must be made available to the Agency upon request.
14. **Follow Screening Guidelines**: Adhere to diagnostic and follow-up protocols consistent with CDC and U.S. Preventive Services Task Force (USPSTF) guidelines.
15. **Ensure Confidentiality**: Safeguard participant health information in accordance with applicable federal and state privacy laws (i.e. Iowa Code 217.30 and HIPAA regulations, where applicable).

III. Responsibilities of the Agency

The Agency agrees to:

1. **Authorize Services**: Provide authorization for services to Program participants according to Program guidelines.
2. **Reimburse Services**: Reimburse the Service Entity for approved services at Medicare Part B Participating Provider Rates for Iowa, contingent on proper claim submission and available funding.
3. **Provide Support**: Offer technical assistance related to Program implementation.
4. **Monitor Compliance**: Review the Service Entity's adherence to this agreement through audits or record reviews.

IV. Term and Expiration

1. **Effective Date and Duration and Renewal**: This agreement becomes effective on the date signed by the Agency and will remain active for six years from that date unless terminated earlier.
   It is the Service Entity's responsibility to access the Program's renewal information at hhs.iowa.gov/cfy-providers and complete the renewal process before the agreement expiration date. All approved facilities associated with this Tax ID# will expire 6 years after the signed date below, regardless of individual facility enrollment.
2. **Termination**: Either party may terminate this agreement with 30 days' written notice. The Agency may terminate immediately in the event of a breach of agreement terms of violation of law, or if state and/or federal funds are de-appropriated, reduced, not

allocated, or receipt of funds is delayed, or if any funds or revenues needed by the Agency to make any payment hereunder are insufficient or unavailable for any other reason as determined by the Agency in its sole discretion, or for any other reason that impacts the Agency's ability to carry out its obligations under the agreement.

3. **Amendments**: Any changes to this agreement must be made in writing and signed by both parties.
4. **Participant Financial Protection upon Termination:** In the event this Agreement is terminated, for any reason, the Service Entity shall not bill or seek reimbursement from any Program participant for any services provided under this Agreement. This includes services delivered prior to termination for which the Program had authorized payment, regardless of whether the Agency later determines not to reimburse due to lack of funds, change in law, or any other reason. The Service Entity acknowledges and agrees that participants shall bear no financial responsibility for services rendered pursuant to this Agreement.

V. General Provisions

1. **Confidentiality**: The Service Entity must protect participant information in compliance with federal and state privacy laws.
2. **Non-Discrimination**: The Service Entity agrees to comply with all applicable civil rights laws and not discriminate based on race, color, national origin, sex, age, or disability.
3. **Compliance with Law**: Both parties agree to comply with all applicable federal, state, and local laws, rules, and regulations.
4. **Indemnification / Hold Harmless**: The Service Entity agrees to indemnify, defend, and hold harmless the State of Iowa, the Iowa Agency of Health and Human Services, and their officers, employees, and agents (collectively, "Indemnitees") from and against any and all claims, actions, suits, liabilities, damages, losses, or expenses—including attorney fees—arising out of or resulting from (a) the negligent acts or omissions or willful misconduct of the Service Entity, its employees, contractors, or agents in connection with the performance of this Agreement; or (b) any breach of this Agreement by the Service Entity. This provision shall survive termination or expiration of the Agreement.
5. **Access to Participant Records**: The Service Entity shall retain and make available to the Agency, its auditors, or authorized representatives all records related to services provided under this agreement for six (6) years. This obligation survives expiration or termination.
6. **Key Compliance Obligations**:
    a. The Service Entity shall comply with all financial, recordkeeping, and audit-related obligations as described in the Agency's General Terms and Conditions, incorporated herein by reference.
    b. This agreement is funded in whole or in part with federal funds. The Service Entity shall comply with all applicable requirements set forth in the Agency's *Contingent Terms for Federally Funded Contracts*, available at https://hhs.iowa.gov/media/9495/download?inline, as of the effective date of this agreement. These terms are incorporated herein by reference and made a part of this agreement as if fully set forth herein.

This form must be completely filled out to be considered valid; handwritten submissions will not be accepted. If the Service Entity has multiple Tax ID#s, each Tax ID# will require a separate Service Entity Agreement. By signing this document, the parties agree to the terms and conditions set forth in this agreement.

For the Iowa Department of Health and Human Services: Signature: Jill Lange, MPH, RD, LD Division Administrator, Health Promotion & Prevention Division of Public Health	**For the Service Entity:** Legal Name of Entity: Doing Business As (DBA) Name (if different than Legal Name): Tax ID # relevant to this agreement: Authorized Representative Name: Title: Signature: Date: Phone: Email:

Required Billing Information			
Billing Entity Name			
Billing Address			
Street			
PO Box or Other*			
City			
State			
County			
Billing Contacts			
Name		Name 2*	
Phone Number		Phone Number 2*	
Email Address		Email Address 2*	

*Optional