Iowa Medicaid Chronic Condition Health Home Provider Agreement

This Iowa Medicaid Chronic Condition Health Home ("CCHH") Provider Agreement (the "CCHH Agreement") is entered into on the Effective Date, as noted below, between the State of Iowa, Department of Human Services, (the "Agency") and the Chronic Condition Home Health Provider (the "CCHH Provider") (collectively, the "Parties").

Through this CCHH Agreement, the CCHH Provider agrees to perform services as a Health Home, a specific designation under 42 U.S.C. § 1396w-4 or 42 U.S.C. § 1396w-4a. The CCHH program affords the CCHH Provider an opportunity to provide personal, coordinated care to eligible members for a tiered per-member-per-month ("PMPM") fee paid by Iowa Medicaid directly for fee-for-service members and by a member's Medicaid managed care organization ("MCO") for members enrolled with an MCO.

Health Home practices may include but are not limited to primary care practices, Community Mental Health Centers, Federally Qualified Health Centers, and Rural Health Clinics.

Accordingly, the Parties agree as follows:

Section 1. Provider Qualifications. The CCHH Provider shall meet all of the following requirements to provide Heath Home services in the Iowa Medicaid program.

1.2 Recognition and Certification. The CCHH Provider shall:

a) Adhere to all federal and state laws in regard to Health Home recognition/certification.
b) Comply with standards specified in the Iowa Department of Human Services rules. Those rules will likely require National Committee for Quality Assurance (NCQA) or other national accreditation.
c) Until the rules identified in subsection (b) are final, providers shall achieve PCMH Recognition or Certification, such as NCQA, other national accreditation, or another program recognized by the State within the first year of operation and maintain it.
d) Notwithstanding subsections (b) and (c) above, a CCHH Provider that has not achieved the required Recognition or Certification within the first year of operation shall be deemed to have sufficient Recognition or Certification if the CCHH provider has submitted an appropriate application for Recognition or Certification within the first year and the determination is pending. However, if the CCHH provider does not achieve such Recognition or Certification within two years of beginning operations, the State may terminate its enrollment. The Health Home shall prove application submission status on demand.

1.2 **Enrollment and Credentialing.** The CCHH Provider shall enroll with Iowa Medicaid and enroll and credential with one or more of the MCOs to provide Health Home services to the target population.

1.3 Self-assessment. When enrolling and annually, the CCHH Provider shall complete and submit to Iowa Medicaid within the time designated by Iowa Medicaid, a self-assessment that ensures that the CCHH has a demonstrated capacity to fulfill the requirements of this CCHH Agreement.

1.4 State Plan, Statutes, and Regulations. The CCHH Provider shall meet and shall ensure that individual providers and practices that are part of the CCHH Provider meet the requirements, qualifications, and standards of the Iowa Medicaid State Plan, and state and federal statutes and regulations.

1.5 Health Home Services and Staffing. The CCHH Provider shall be qualified to provide Health Home services to the target population and shall, at a minimum, meet the following staffing requirements.

- Designated Practitioner
- Nurse Practitioner/Physician Assistant
- Dedicated Care Coordinator
- Health Coach

Section 2. Provider Obligations.

2.1 Qualifying Diagnosis.

a) Before billing for CCHH service to the member, the CCHH Provider shall
   - Confirm that the member has an eligible chronic condition diagnosis and is at risk for developing another, which combination makes the member eligible for CCHH services; and
   - Document in the member's health records the chronic condition diagnosis, the chronic condition that the member is at risk of developing, and the criteria identified in subsection (c) on which the determination that the member is at risk has been made.

b) For CCHH services, the only chronic condition diagnoses that qualify a member for services are:
   - Mental Health Condition
   - Substance Abuse Disorder
   - Asthma
   - Diabetes
   - Heart Disease
   - BMI over 25
   - Chronic Pain
   - COPD
   - Hypertension
   - BMI over 85th percentile for pediatric populations

c) At risk means a documented family history of a verified heritable condition described above, a diagnosed medical condition with an established comorbidity to a condition described above, or a verified environmental exposure to an agent or condition known to be causative of a condition from a condition described above.

2.2 Full Medicaid Benefits. The CCHH Provider shall confirm that each member in the provider's Health Home has full Medicaid benefits at the time services are rendered. The CCHH Provider shall use the latest Medicaid eligibility file to determine eligibility.

2.3 Health Home Provider Selection. The CCHH Provider shall ensure that the member has selected the CCHH Provider as his or her Health Home. Passive enrollment with the CCHH Provider does not suffice to prove provider selection by the member. The CCHH Provider shall not bill for CCHH services absent documentation of the member's selection. The CCHH Provider shall give potential enrollees information regarding the Health Home benefit in plain language and in a manner that is accessible to individuals with limited English proficiency and to individuals with disabilities.

2.4 Provision of Core Services. The CCHH Provider shall provide at least one of six core services per month to each provider-enrolled member. Absent documentation of the provision of one of the six core services for each CCHH member each month, the CCHH Provider shall not bill a PMPM payment for that member. The six core services set forth in Section 1945(h)(4)(B) of the Social Security Act and the current State Plan Amendment are:

a) Comprehensive care management
b) Care coordination
c) Health promotion
d) Comprehensive transitional care and follow-up
e) Patient and family support
f) Referral to community and social support services.

2.5 Legal Compliance. The CCHH Provider shall have policies and processes in place to ensure compliance with Federal and State requirements, including but not limited to the statutory, regulatory, and guidance requirements found in state and federal law. The CCHH Provider shall maintain documentation of its policies and processes and make those policies and processes readily available to any state or federal officials upon request.

2.6 SMDL #10-024. The CCHH Provider shall fulfill all of the requirements of SMDL #10-024.

2.6.1 The CCHH shall provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services.

2.6.2 The CCHH shall coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.

2.6.3 The CCHH shall coordinate and provide access to preventive and health promotion services.

2.6.4 The CCHH shall coordinate and provide access to mental health and substance abuse services.

2.6.5 The CCHH shall coordinate and provide access to comprehensive care management, care coordination, and transitional care and medication reconciliation across settings. Transitional care includes appropriate follow-up from inpatient care/PMIC/group care to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.

2.6.6 The CCHH shall coordinate and provide access to chronic disease management, including self-management support to individuals and their families.

2.6.7 The CCHH shall coordinate and provide access to individual and family supports, including education and referral to community, social support, and recovery and resiliency services.

2.6.8 The CCHH shall coordinate and provide access to long-term care supports and services.

2.6.9 The CCHH shall develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.

2.6.10 The CCHH shall demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.

2.6.11 The CCHH shall establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

2.7 Continuity of Care Document (CCD).

2.8.1 The CCHH Provider shall update and maintain the CCD record for each member served by the CCHH Provider.

2.8.2 The CCHH Provider shall ensure that the CCD details all important aspect of the member's medical needs, treatment plan, and medication list.

2.8.3 The CCHH Provider shall share CCD records with the State.

2.8 Whole Person Orientation.

2.9.1 The CCHH Provider shall provide or take responsibility for appropriately arranging care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care.

2.9.2 The CCHH Provider shall complete status reports to document member's housing, legal issues, employment status, education, custody, and other social determinants of health, as applicable.

2.9.3 The CCHH Provider shall implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.

2.9.4 The CCHH Provider shall work to develop capacity to receive members redirected from emergency departments, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC).

2.9.5 The CCHH Provider shall have evidence of bi-directional and integrated primary care/behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State.

2.9.6 The CCHH Provider shall provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the CCHH on care coordination and hospital/ER notification.

2.9.7 The CCHH Provider shall advocate in the community on behalf of their members as needed.

2.9 Duplication of Services. The CCHH Provider shall be responsible for preventing fragmentation or duplication of services provided to members.

2.10 Coordinated/Integrated Care.

2.11.1 The CCHH Provider shall ensure that the Nurse Care Manager or Care Coordinator is responsible for assisting members with medication adherence, appointments, and referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support or lifestyle modification, and behavior changes.

2.11.2 The CCHH Provider shall utilize member level information, member profiles, and care coordination plans for high-risk individuals.

2.11.3 The CCHH Provider shall incorporate tools and evidenced-based guidelines designed for identifying care opportunities across the age and diagnostic continuum, integrating clinical practices, and coordinating care with other providers.

2.11.4 The CCHH Provider shall conduct interventions as indicated based on the member's level of risk.

2.11.5 The CCHH Provider shall communicate with the member and authorized family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

2.11.6 The CCHH Provider shall monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services.

2.11.7 The CCHH Provider shall coordinate or provide access to:

- 2.11.7.1 Mental healthcare
- 2.11.7.2 Oral Health
- 2.11.7.3 Long-term care
- 2.11.7.4 Chronic disease management
- 2.11.7.5 Recovery services and social health services available in the community
- 2.11.7.6 Behavior modification interventions aimed at supporting health management (including, but not limited to, obesity counseling, tobacco cessation, and health coaching)
- 2.11.7.7 Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- 2.11.7.8 Crisis services

2.11.9 The CCHH Provider shall assess social, educational, housing, transportation, and vocational needs that may contribute to disease and present as barriers to self-management.

2.11.10 The CCHH Provider shall coordinate with Community-based Case Managers (CBCM), Case Manager (CM) and Service Coordinators for members that receive service coordination activities.

2.11.11 The CCHH Provider shall maintain system and written standards and protocols for tracking member referrals.

2.11 Enhanced Access

2.12.1 The CCHH Provider shall provide for 24/7 access to the care team that includes, but is not limited to, a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations.

2.12.2 The CCHH Provider shall monitor access outcomes such as the average third next available appointment and same day scheduling availability.

2.12.3 The CCHH Provider shall demonstrate use of email, text messaging, patient portals and other technology to communicate with members as able.

2.12 Emphasis on Quality and Safety

2.12.1 The CCHH Provider shall have an ongoing quality improvement plan to address gaps and opportunities for improvement

2.12.2 The CCHH Provider shall participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported to the State

2.12.3 The CCHH Provider shall demonstrate continuing development of fundamental Health Home functionality through an assessment process applied by the State.

2.12.4 The CCHH Provider shall have strong, engaged organizational leadership whom are personally committed to and capable of:

- 2.12.4.1 The CCHH Provider shall lead the practice through the transformation process and sustaining transformed practice
- 2.12.4.2 The CCHH Provider shall agree to participate in learning activities including in person sessions, webinars, and regularly scheduled phone calls

2.12.5 The CCHH Provider shall agree to participate in or convene ad hoc or scheduled meetings to plan and discuss implementation of goals and objectives for practice transformation.

2.12.6 The CCHH Provider shall participate in CMS and State required evaluation activities

2.12.7 The CCHH Provider shall submit reports as required by the State (e.g., describe CCHH activities, efforts and progress in implementing CCHH services)

2.12.8 The CCHH Provider shall maintain compliance with all of the terms and conditions as a CCHH provider or face termination as a provider of CCHH services

2.12.9 The CCHH Provider shall complete web-based member enrollment, disenrollment, enrollee authorizations for information sharing, and health risk questionnaires for all members.

2.12.10 The CCHH Provider shall demonstrate use of clinical decision support within the practice workflow.

2.12.11 The CCHH Provider shall demonstrate use of a population management tool, (patient registry) and the ability to evaluate results and implement interventions that improve outcomes overtime.

2.12.12 The CCHH Provider shall demonstrate evidence of acquisition, installation and adoption of a certified EHR system and establish a plan to meaningfully use health information in accordance with the Federal law.

2.12.13 The CCHH Provider shall implement or support a formal diabetes disease management program. The disease management program shall include:

2.12.13.1 The goal to improve health outcomes using evidence-based guidelines and protocols.

2.12.13.2 A measure for diabetes clinical outcomes that include timeliness, completion, and results of AlC, LDL, microalbumin, and eye examinations for each patient identified with a diagnosis of diabetes.

2.12.13.3 The Department may choose to implement subsequent required disease management programs any time after the initial year of the health home program. Based on population-specific disease burdens, individual Health Homes may choose to identify and operate additional disease management programs at any time.

2.12.14 The CCHH Provider implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.

2.13 Utilization of IMPA. The CCHH Provider shall use the Iowa Medicaid Portal Access (“IMPA”) for the management of enrolled Health Home members.

2.14 Report on Quality Measures. The CCHH Provider shall report to the State, in accordance with such requirements as the State may specify, on all applicable measures for determining the quality of such services.

Section 3. Documentation of Services, Consent, and Payment.

3.1 Documentation of Services and Member Consent. The CCHH Provider shall maintain adequate supporting documentation in readily reviewable form to assure that all applicable state and federal requirements related to Health Home services have been met. See Social Security Act § 1902(a)(27); Iowa Admin. Code r. 441-79.3(2)(c)(3). Provider shall not bill for Health Home services absent any of the following documentation:

3.1.1 Eligibility:

3.1.1.1 The CCHH Provider shall document in the enrolled member’s health record that the member has full benefits at the time services are rendered.

3.1.1.2 The CCHH Provider shall document in the member's health record the member's diagnosis or diagnoses that confirm eligibility for Health Home services.

3.1.2 **Provider Selection:** The CCHH Provider shall document in the member's health record that the member has selected the CCHH Provider as his or her Health Home. At a minimum, this documentation must indicate that the individual has received information explaining the Health Home program (including the purpose of the benefit, Health Home services generally, the individual's right to choose, change, or disenroll from the CCHH Provider at any time) and has consented to receive Health Home services.

3.1.3 **Services Provided**: The CCHH Provider shall document any outreach services provided to specific members in each member's health record. The CCHH Provider shall also document the delivery of at least one core Health Home service provided to the member each month of Health Home enrollment.

3.1.5 **Policies and Processes:** The CCHH Provider shall have policies and processes in place to ensure compliance with Federal and State requirements and shall have documentation of policies and processes readily available.

Section 4. **Payment**. For qualifying services provided to eligible beneficiaries by qualified staff, the CCHH Provider may bill for CCHH services in accordance with the fee schedule published on the DHS Website.

Payment for services may be billed to (a) Iowa Medicaid for fee-for-service members, or (b) for members enrolled with an MCO, the member's MCO. Provider shall not bill for services if the CCHH Provider has not satisfied all obligations of state and federal law, including but not limited to the federal statutory requirements (42 U.S.C. § 1396w-4 and 42 U.S.C. § 1396w-4a), all relevant federal guidance, the then-approved State Plan Amendment authorizing the state to provide CCHH services, all applicable state administrative rules, and any state guidance.

Section 5. **Incorporation of Iowa Medicaid Provider Agreement, Form 470-2965**. The Iowa Medicaid Provider Agreement, Form 470-2965, posted at https://dhs.iowa.gov/sites/default/files/470-2965.pdf is incorporated into this CCHH Agreement by reference. This CCHH Agreement is supplementary to the Provider Agreement. All provisions of the Provider Agreement remain in full force and effect, except to the extent superseded by the specific terms of this CCHH Agreement.

Section 6. General Terms for Service Contracts. The version of the General Terms for Services Contracts Section posted to the Agency's website at https://dhs.iowa.gov/contract-terms that is in effect as of the date of last signature of this CCHH Agreement, or a more current version if agreed to by amendment, is incorporated into this Agreement by reference. The contract warranty period (hereafter "Warranty Period") referenced within the General Terms for Services Contracts is the term of this CCHH Agreement. For purposes of this incorporation paragraph, this CCHH Agreement constitutes the Contract Declarations and Execution Section as well as the Special Terms.

Section 7. Contingent Terms for Service Contracts. The version of the Contingent Terms for Services Contracts posted to the Agency's website at https://dhs.iowa.gov/contract-terms that is in effect as of the date of last signature in the Contract Declarations and Execution section, or a more current version if agreed to by amendment, is incorporated into this CCHH Agreement by reference. All of the terms set forth in the

Contingent Terms for Service Contracts apply to this CCHH Agreement unless indicated otherwise in the table below:

Contractor a Business Associate? Yes	**Contractor a Qualified Service Organization?** Yes
Contractor subject to Iowa Code Chapter 8F? No. (Funding is from Title XIX)	**Contract Includes Software (modification, design, development, installation, or operation of software on behalf of the Agency)?** No.
Contract Payments include Federal Funds? Yes **The Contractor for federal reporting purposes under this Contract the CCHH Provider is a: vendor** **The Name of the Pass-Through Entity:** Iowa Department of Human Services	
CFDA #: xxxxxx **Federal Awarding Agency Name:** CMS **Grant Name:** Title XIX: Medical Assistance	

Section 8. Effective Date, Term & Termination

8.1 Effective Date. This CCHH Agreement is effective on the date that the last party executes this CCHH Agreement as indicated by the date stated under the party's signature below.

8.2 Term. This CCHH Agreement's term begins on the Effective Date and ends on the day preceding the third anniversary of the Effective Date, unless terminated in accordance with the provisions of this CCHH Agreement.

8.3 Termination. If the primary Medicaid Provider Agreement (Form 470-2965) between the Chronic Condition Health Home and the Iowa Medicaid Enterprise terminates, this CCHH Agreement automatically terminates.

Contract Execution:

In consideration of the mutual covenants in this Contract and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the Parties have entered into this CCHH Agreement and have caused their duly authorized representatives to execute this CCHH Agreement.

Provider (Integrated Health Home)	Agency, Iowa Department of Human Services
Signature of Authorized Representative	Signature of Authorized Representative
Print Name and Title	Print Name and Title
Date	Date