**CHRONIC CONDITION HEALTH HOME PROGRAM**

**PARTICIPATION ATTACHMENT TO THE**

**AMERIGROUP IOWA PROVIDER AGREEMENT**

This is an Attachment to the Amerigroup Iowa, Inc. Provider Agreement ("Agreement")entered into by and between Amerigroup and Providerand is incorporated into the Agreement.

**ARTICLE I**

**DEFINITIONS**

The following definitions shall apply to this Attachment:

Iowa Medicaid Enterprise (IME) (“IME”) The organization that administers Medicaid services for the State of Iowa.

Chronic Condition Health Home (CCHH) Program (“CCHH Program”) refers to the IME program for Health Services (“CCHH Services”) to qualifying children and adults. The program operates under the provisions of Section 2703 of the Affordable Care Act and through the Iowa State Plan Amendment (SPA) to its 1915(b) Medicaid Waiver.

Chronic Condition Health Home (CCHH) Participant (“CCHH Participant”) means an individual enrolled in a Chronic Condition Health Home (CCHH) who has been identified by Amerigroup.

Chronic Condition Health Home (CCHH) Provider (“CCHH Provider”) means an organization that is a Participating Provider and contracted with Amerigroup to provide CCHH Program services.

**ARTICLE II**

**ROLE AND RESPONSIBILITIES OF AMERIGROUP**

2.1 Role of Amerigroup. The role of the Amerigroup for purposes of this Attachment shall be to manage the provision of CCHH Program Services as defined on the Scope of Services attached hereto and incorporated herein by reference as Exhibit A of this Attachment (“CCHH Services”) to CCHH Participants by collaborating with Provider, by authorizing the provision of CCHH Services to a designated CCHH Participant, by reimbursing Provider for the provision of the CCHH Services, and by collaborating with CCHH to evaluate the effectiveness of CCHH Services to CCHH Participants

2.2 Collaboration and Education. Amerigroup agrees to provide CCHH Provider with access to continuing educational activities that address the unique medical conditions/needs of CCHH Participants. Additionally, Amerigroup agrees to provide access to primary health/wellness and disease management screening tools which CCHH Provider may elect to use during the provision of CCHH Services. Amerigroup will also provide supports, consultation and training for health home partners including but not limited to the following:

* + 1. Oversight and technical support to deliver chronic condition physical and behavioral health services and supports.
		2. Provide infrastructure and support to health home partners including access to Member 360.
		3. Coordinate care between Amerigroup care managers and medical staff.
		4. Track, monitor and report on medical services to reduce gaps in care.
		5. Provide clinical guidelines and decision support tools, and screening and assessment instruments.
		6. Support CCHH Provider on the implementation and utilization of health information technology including electronic health records and continuity of care document exchange.
		7. Facilitate shared treatment planning meetings for CCHH Participants with complex situations.
		8. Establish a continuous quality improvement program that includes ability to evaluate outcomes on a program basis as well as an individual-level basis. Outcome areas and evaluation activities might include:
		9. clinical outcomes, e.g., percent of members with high blood pressure under control after intervention;
		10. self-management, e.g., percent of members that with diabetes that routinely monitor blood sugar levels;
		11. experience of care, member satisfaction, e.g., response of members on satisfaction survey; and/or
		12. service utilization, e.g., hospital admits per 1,000; inpatient days per 1,000; ED utilization per 1,000.

2.3 Member Identification. Amerigroup, Inc. will identify and assign Members to a CCHH consistent with Iowa’s State Plan Amendment (“SPA”). CCHH Provider may also refer Members to the CCHH program.

2.3.1 To qualify, a CCHH Participant requires two chronic conditions or one chronic condition and the risk of developing another from the following list:

1. Mental Health Condition;
2. Substance Use Disorder;
3. Asthma;
4. Diabetes;
5. Heart Disease;
6. BMI over 25;
7. Hypertension; or
8. Child BMI > 85th percentile.

2.4 Record Access. Amerigroup agrees to ensure CCHH Provider has access to the medical records of the CCHH Participant and contact with each treating medical practitioner as needed by CCHH Provider for the provision of CCHH Services. Amerigroup agrees to collaborate with CCHH Provider to obtain necessary bilateral releases of information to facilitate the exchange of information to coordinate the CCHH Participant’s care.

**ARTICLE III**

**ROLE AND RESPONSIBILITIES OF PROVIDER**

3.1 Role of CCHH Provider. The role of CCHH Provider for purposes of this Attachment shall be to provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered services to each CCHH Participant in order to promote health and recovery.

3.2 Provider Qualifications. Any organization or provider that serves as a CCHH Provider must meet the following criteria:

* + 1. CCHH Providers are selected based upon meeting provider standards as described in the SPA to CMS for chronic health conditions for adults and children.
		2. The CCHH Provider must be an IME Provider and employ the following personnel to fill the following roles:
			1. Designated Practitioner;
			2. Dedicated Care Coordinator;
			3. Health Coach; and
			4. Clinical Support Staff.
	1. Compensation. Payment for CCHH Services will be paid in the following ways:
		1. A fee based on enrolled per-member, per month basis; and
		2. Details of payment are listed in the attached Exhibit B of this Attachment.
		3. A performance based bonus will be paid if CCHH Provider meets specified health outcomes measures and program process measures listed in Exhibit C of this Attachment.

**ARTICLE IV**

**TERMINATION**

4.1 Termination without Cause. This Attachment may be terminated without cause by Amerigroup or CCHH Provider upon ninety (90) days prior written notice at any time without terminating the Amerigroup Provider Agreement.

**ARTICLE V**

**GENERAL PROVISIONS**

5.1 Inconsistencies. In the event of an inconsistency between terms of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern with regard to CCHH Services to CCHH Participants by CCHH Provider. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

5.2 CCHH Provider shall execute a Business Associate Agreement with Amerigroup as required by IME prior to any disclosure or use of PHI under this Attachment.

5.3 Effective Date. The Effective Date of this Attachment is (to be completed by Amerigroup):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and shall continue in effect unless terminated by either
CCHH Provider or Amerigroup.

**AMERIGROUP: PROVIDER:**

Authorized Signature Authorized Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Print Name Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Title Title

Date Date

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 Tax ID and NPI

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 Phone number

**EXHIBIT A**

**CCHH SCOPE OF SERVICES**

CCHH services and supports are established and defined to be consistent with Iowa’s State Plan Amendments for CCHH Program Services and further defined in a health home service manual. Services and supports to include:

1. Meet staff requirements:
	1. Employ or contract with staff to fill required roles and staffing ratios as may be required by Amerigroup and/or Department of Human Services for CCHH.
	2. Staffing ratios will be submitted to Amerigroup and require approval by Amerigroup.
2. Have embedded population health management into their workflow and demonstrate the use of data to drive quality improvements.
3. Use evidenced-based guidelines to improve quality and consistency among providers.
4. Focus on communication and coordination between referring providers to ensure comprehensive patient-centered care.
5. Engage CCHH Participants in their own care plans.
6. Have an ongoing performance measurement system in place that allows the practice to measure current performance to evidence-based guidelines.
7. Identify gaps in care delivered compared to clinical guidelines and deploy interventions designed to increase guideline compliance.
8. Adhere to all federal and state laws regarding Health Home recognition/certification.
9. Ensure each CCHH Participant has an ongoing relationship with a personal provider, physician, nurse practitioner or physician assistant who is trained to provide first contact, continuous and comprehensive care, where both the patient and the provider/care team recognize each other as partners in care. This relationship is initiated by the CCHH Participant choosing the CCHH Provider.
10. Update a Continuity of Care Document CCD for all eligible patients, detailing all important aspects of the CCHH Participant’s medical needs, treatment plan and medication list. The CCD shall be updated and maintained by the CCHH Provider.
11. Provide or take responsibility for appropriately arranging care with other qualified professionals for all the CCHH Participants’ health care needs. This includes:
	1. Ensuring care for all stages of life, acute care, chronic care, preventive services, long term care, and end of life care.
	2. Dedicating a care coordinator, defined as personnel of the CCHH Provider, responsible for assisting the CCHH Participant with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes.

c. Communicating with the CCHH Participant, and authorized family and caregivers, in a culturally-appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

1. Monitor, arrange and evaluate appropriate evidence-based and/or evidence-informed preventives services; coordinate or provide:
	1. Mental health/behavioral health.
	2. Oral health.
	3. Long term care.
2. Chronic disease management.
3. Recovery services and social health services available in the community.
4. Behavior modification interventions aimed at supporting health management (including but not limited to, obesity counseling, tobacco cessation, and health coaching).
5. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up.
6. Assess social, educational, housing transportation, vocation needs that may contribute to disease and/or present as barriers to self-management.
7. Demonstrate use of clinical decision support within the practice workflow.
8. Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system and establish and plan to meaningfully use health information in accordance with the federal law.
9. When available connect and participate with the statewide Health Information Network.
10. Implement or support a formal diabetes disease management program. The disease management program shall include.
	1. The goal to improve health outcomes using evidence-based guidelines and protocols.
	2. A measure for diabetes clinical outcomes that include timeliness, completion, and results of A1C, LDL, micro albumin, and eye examinations for each patient identified with a diagnosis of diabetes.
		1. Amerigroup may choose to implement subsequent required disease management programs any time after the initial year of the CCHH Program. Based on population-specific disease burdens, individual CCHH Providers may choose to identify and operate additional disease management programs at any time.
11. Implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs
12. 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.
13. Monitor access outcomes such as the average third next available appointment and same day scheduling availability.
14. Use email, text messaging, patient portals and other technology as available to the CCHH Provider to communicate with CCHH Participants.
15. Complete reporting requirements as determined by Amerigroup to meet Iowa Department of Human Services (DHS) reporting requirements for Iowa Health Link Medicaid managed care organizations (MCOs). This may include submitting reports and/or completing data entry by the dates due and in specified formats.

**EXHIBIT B**

**REIMBURSEMENT TERMS**

1. Amerigroup shall pay CCHH Provider and CCHH Provider shall accept as payment in full for CCHH Services provided to CCHH Participants the per member per month (PMPM) payment specified below in accordance with the terms of this Agreement.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CCHH Participant Tier** | **Billing Code** | **Modifier** | **Monthly PMPM Rate** | **Potential Bonus PMPM Rate** |
| Tier 1 (1-3 chronic conditions) | S0280 | U1.U3 | $12.80 | $2.56 |
| Tier 2 (4-6 chronic conditions) | S0280 | TF.U3 | $25.60 | $5.12 |
| Tier 3 (7-9 chronic conditions) | S0280 | U2.U3 | $51.91 | $10.38 |
| Tier 4 (10 or more chronic conditions) | S0280 | TG.U3 | $76.81 | $15.36 |

1. The PMPM payment is a reflection of the added value provided to CCHH Participants receiving this level of care and is risk adjusted based on the level of acuity assigned to each patient. The level of acuity assignment is based on the CCHH Provider’s overall health assessment using the Patient Tier Assignment Tool (PTAT) guidelines published by the State.
2. The criteria required to receive a monthly PMPM payment is:
	1. The CCHH Participant has full Medicaid benefits at the time of the PMPM payment is made
	2. The CCHH Participant meets the eligibility requirements as identified by the provider and documented in the member’s electronic health record (EHR);
	3. The CCHH Participant has agreed to services and is enrolled with the designated Health Home Provider;
	4. The CCHH Provider is in good standing with Amerigroup and is operating in adherence with all CCHH Provider standards, and;
	5. The minimum service required to merit the PMPM payment has been met which is that the person has received services as set forth in Attachment A and is in the member’s EHR.
3. A performance based bonus will be paid to the CCHH Provider if specific health outcome measures (Exhibit C) are achieved. The potential bonus amount is based on CCHH PMPM payments made to the IHH Provider as outlined above.

**EXHIBIT C**

**MEASURES AND OUTCOMES**

|  |  |  |
| --- | --- | --- |
| **Time Period** | **Measure Guidelines** | **Population** |
| Quarterly\* | Completion of Initial Health Screen | All members |
| Quarterly\* | Completion of Required Data Reporting | All members |
|  Annually | Seven day follow up – Psychiatric Hospitalization | All members |
| Annually | Diabetic with a Yearly A1c | All members |
| Annually | Preventative Care or Ambulatory Visit | All members |
| Annually | Inpatient Hospital Readmission - All Cause | All members |

Health outcome measure methodology (measure specifications, benchmark values, eligibility rules, reporting period, reporting computation, payment schedule, and allowance of report supplementation) will be developed in collaboration with IME and may be amended by Amerigroup annually.

\*The initial quarterly time period may include an additional 1-2 months as influenced by the transition start date to Iowa Health Link.