**Second Amendment to the Iowa Dental Wellness Pre-Paid Ambulatory Health Plan (PAHP) Contract**

This Amendment to Contract Number MED-25-011 is effective as of January 1, 2025, between the Iowa Department of Health and Human Services (Agency) and Managed Care of North America (MCNA) Insurance Company (Contractor).

**Section 1: Amendment to Contract Language**
The Contract is amended as follows:

**Revision 1. Agency Contract Owner (hereafter "Contract Owner")/Address, is hereby replaced as follows:**
Kera Oestreich
Iowa Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-1002
E-Mail: kera.oestreich@hhs.iowa.gov

**Revision 2. Section C.2.17. Information Requirements, is hereby replaced as follows:**

Contractor shall utilize the model Enrollee handbook developed by the State that includes how to exercise an advance directive. See: 42 C.F.R. § 438.10(g)(2)(xii); 42 C.F.R. § 438.3(j); 42 C.F.R. § 457.1207. {From CMSC C.2.37}.

**Revision 3. Section C.8.04. Advance Directives Information, is hereby replaced as follows:**
Contractor shall provide adult Enrolled Members with written information on advance directives policies and include a description of applicable State law. See: 42 C.F.R. § 438.3(j)(3). {From CMSC C.8.07}.

**Revision 4. Section C.8.05. Changes in State Law – Advance Directives, is hereby replaced as follows:**
Contractor shall reflect changes in State law in its written advance directives information as soon as possible, but no later than ninety (90) Days after the effective date of the change. See: 42 C.F.R. § 438.3(j)(4). {From CMSC C.8.08}.

**Revision 5. Section D.4.18. Reporting Requirements, the CFR reference is hereby added as follows:**
See: 42 C.F.R. § 438.8(k)(1)(xii) and 42 C.F.R. § 438.8(i)

**Revision 6. Section E.5.01. Adequacy, is hereby replaced as follows:**
Under this Contract:

a) The Contractor and its Network Providers shall meet the State standards for timely Access to care and services, considering the urgency of need for services.
b) The Contractor's Network Providers shall offer hours of operation that are no less than the hours offered to commercial Enrollees or are comparable to Medicaid FFS, if the Provider serves only Medicaid and/or CHIP Enrolled Members.

c) The Contractor shall make services available twenty-four (24) hours a day, seven (7) Days a week, when medically necessary.
d) The Contractor shall establish mechanisms to ensure that its Network Providers comply with the timely Access requirements.
e) The Contractor shall monitor Network Providers regularly to determine compliance with the timely Access requirements.
f) The Contractor shall take corrective action if it, or its Network Providers, fail to comply with the timely Access requirements.

See: 42 C.F.R. § 438.206(c)(1)(i) - (vi); 42 C.F.R. § 457.1230(a). {From CMSC E.5.01 - E.5.06}.

**Revision 7. Section F.6.25. Early and Periodic Screening, Diagnostic Treatment (EPSDT) Services, is hereby replaced as follows:**

The Contractor shall provide EPSDT services to all Enrolled Members under twenty-one (21) years of age in accordance with law. EPSDT covers dental services regardless of whether these services are provided under the State Plan and regardless of any restrictions that may be imposed on coverage. Pre-release and post-release screening and diagnostic services covered under the state plan are available to Hawki incarcerated former foster care enrollees up to age 26 per the Consolidated Appropriations Act of 2023, Section 5121.

*a) Partnering with Local Agencies for Screening*.

The Contractor shall partner with Maternal Health, Screening Center, and Public Health agencies to ensure the completion of dental screens and preventive visits in accordance with the EPSDT periodicity schedule. Screening exams consist of a health history, developmental history, complete physical exam, vision screening, hearing test, appropriate laboratory tests, immunizations, nutrition screen, health education including anticipatory guidance, oral health assessment, other tests as needed and referrals for treatment. Treatment consists of any treatment necessary to correct or ameliorate a child's physical, dental, or behavioral health condition as deemed medically necessary on a case-by-case basis. EPSDT medical necessity determinations shall consider a child's long-term needs.

The determination of whether a screening service outside of the periodicity schedule is necessary may be made by a child's physician or dentist, or by a health, developmental, or educational professional who encounters a child outside of the formal health care system.

Note that screenings need not be conducted by a Medicaid provider to trigger EPSDT coverage for follow up diagnostic services and medically necessary treatment by a qualified Medicaid provider. Additionally, screening service provided before a child enrolls in Medicaid is sufficient to trigger EPSDT coverage, after Enrollment, for follow-up diagnostic services and necessary treatment.

b)*Services*.

The Contractor must assure availability and payment diagnostic services which are necessary to fully evaluate defects and physical, behavioral, or dental illnesses or conditions discovered by the screening services.

The Contractor shall provide payment for dental treatment, diagnostic or other measures which are necessary to correct or ameliorate defects and physical, behavioral, and/ or dental conditions discovered by the screening service and/or dental exam.

The Contractor must provide payment for any dental screening, diagnostic and/or treatment services, including continuing medical treatment after an initial referral, if medically necessary.

Dental services that must be provided, at minimum, under EPSDT requirements include: dental care needed for relief of pain, infection, restoration of teeth, and maintenance of dental health; emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures; and orthodontic services to the extent necessary to prevent disease and promote oral health, and restore oral structures to health and function. Applicable services with limits can be exceeded based on medical necessity and/or provided outside of periodicity schedule.

The Contractor shall cover out-of-State services in the following circumstances under EPSDT: the out-of-State services are required because of an emergency; the child's health would be endangered if required to travel to Iowa/their home state; the Agency determines that the needed services are more readily available in another state; pre-release services for juveniles residing and incarcerated in Iowa, but placed in a facility out-of-state and when it is a general practice of the locality to use the services of an out-of-State provider (e.g., in areas that border another state).

The Contractor shall consider the child's quality of life when covering services in the most cost-effective mode if a less expensive service is equally effective and available.

c) *Transportation*.
EPSDT-eligible beneficiaries shall be offered appointment scheduling assistance and assured necessary transportation to and from medical appointments. Related travel expenses are covered if medically necessary, including meals and lodging for a child and necessary attendant.

*d) Reports and Records*.
The Agency has the obligation of assuring the Federal government that EPSDT services are being provided as required. The Contractor shall ensure that all requested records, including dental and peer review records, shall be available for inspection by State or Federal personnel or their representatives. The Contractor shall record dental screenings and examination related activities and shall report those findings in an Agency approved format at the Agency established frequency.

*e) Outreach*.
The Contractor shall implement outreach, monitoring, and evaluation strategies for EPSDT, including collaboration with local community stakeholders and public health agencies. The Contractor shall develop Provider and Enrolled Member education activities that increase beneficiary awareness of and Access to applicable EPSDT services.

**Revision 8. Section F.8.06. Copayments, is hereby replaced as follows:**
The Contactor shall impose copayments, if required by the Agency, for Iowa Dental Wellness Plan participants in accordance with Iowa Administrative Code - - 441 IAC § 79.1(13). If the Agency requires

the Contractor to impose copayments it shall ensure compliance with the requirements outlined in this section.

**Revision 9. F.8.07. Exempt Populations, f) is hereby replaced as follows:**
f) Pregnant women, during pregnancy and through the postpartum period;

**Revision 10. Section F.14.01. Written Policies and Procedures, is hereby replaced as follows:**
Contractor shall maintain written policies and procedures on advance directives for all adults receiving medical care by or through the Contractor. See: 42 C.F.R. § 438.3(j)(1) and (2); 42 C.F.R. § 422.128(a); 42 C.F.R. § 422.128(b); 42 C.F.R. § 489.102(a). {From CMSC F.14.01}.

**Revision 11. Section F.14.02. Prohibition on Conditioning Care, is hereby added as follows:**
Contractor shall not condition the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. See: 42 C.F.R. § 438.3(j)(1) and (2); 42 C.F.R. § 422.128(b)(1)(ii)(F); 42 C.F.R. § 489.102(a)(3). {From CMSC F.14.02}.

**Revision 12. Section F.14.03. Education of Staff, is hereby added as follows:**
Contractors shall educate staff concerning their policies and procedures on advance directives. See: 42 C.F.R. § 438.3(j)(1) and (2); 42 C.F.R. § 422.128(b)(1)(ii)(H); 42 C.F.R. § 489.102(a)(5). {From CMSC F.14.03}.

**Revision 13. G.2.43 Special Health Care Needs Plan Obligations is hereby replaced as follows:**
For Enrolled Members with special health care needs as required by the Agency:

a) Contractor's treatment or service plan shall be approved by the Contractor in a timely manner, if this approval is required by the Contractor.
b) Contractor's treatment or service plan shall be developed in accordance with any applicable State Quality assurance and Utilization Review standards.
c) Contractor's treatment or service plan shall be reviewed and revised upon reassessment of functional need, at least every twelve (12) months, or when the Enrolled Member's circumstances or needs change significantly, or at the request of the Enrolled Member.

See: 42 C.F.R. § 438.208(c)(3)(iii) - (v); 42 C.F.R. § 441.301(c)(3); 42 C.F.R. § 457.1230(c). {From CMSC G.7.11 - G.7.13}.

**Revision 14. G.7.03. NCQA Accreditation Obligation, is hereby retitled as follows:**
G.7.03. Accreditation Obligation

**Revision 15. G.7.03. Accreditation Obligation, is hereby replaced as follows:**
The Contractor shall attain and maintain accreditation from the NCQA or the Utilization Review Accreditation Commission (URAC). If not already accredited, the Contractor shall demonstrate it has initiated the accreditation process as of the Contract effective date. The Contractor shall achieve accreditation at the earliest date allowed by NCQA. Accreditation shall be maintained throughout the life of the Contract at no additional cost to the Agency. When accreditation standards conflict with the standards set forth in the Contract, the Contract prevails unless the accreditation standard is more stringent.

**Revision 16. I.8.02. Recovery of Improper Payments, is hereby replaced as follows:**
I.8.02. Recovery of Improper Payments. The Managed Care Plans shall initiate administrative action and recover improper payments or overpayments related to claims paid by the Contractor within twenty-four (24) months from the date the claim was paid or from the date of any applicable reconciliation, whichever is later. Except for Overpayments identified under a Credible Allegation of Fraud, the Contractor shall confer with the Agency before pursuing Overpayment recoveries for Claims where more than twenty-four (24) months have passed since the claims were paid or adjudicated. The Contractor shall not subject these claims to repayment or offset against future claim reimbursements without prior consent from the Agency.

a) Payment Disputes- Request for Agency Review and Mediation: The Contractor shall facilitate a provider's request for Agency review and mediation to resolve remaining disputes after first exhausting the Contractor's dispute or grievance process and a final notice of decision has been issued to the Provider. The Contractor shall escalate a provider's written request for review and remediation to the Agency for review. The Contractor shall direct the provider to submit a written request to the Agency within ten (10) business days of the date of the final notice of decision from the Contractor. At any time during this review, the Agency may require the Contractor to reconsider its decision and permit the Provider to submit additional information as a rebuttal to the Contractor's final notice of decision. If the evidence supports erroneous findings by the Contractor, the Agency has sole discretion to uphold, overturn, or amend the Contractor's notice of decision. If the Contractor's decision is amended or overturned, the Agency may require the Contractor to waive timely filing requirements and allow the Provider to reprocess claims for payment.

**Revision 17. I.9.08. Contact Before Proceeding, is hereby retitled as follows:**
I.9.08. Agency-Identified Overpayments

**Revision 18. I.9.08. Agency-Identified Overpayments, is hereby replaces as follows:**
If the Agency discovers and identifies an improper payment or overpayment after twenty-four (24) months from the date the claim was paid, the Agency will recover the identified Overpayment from the Contractor. The Contractor shall not recover Overpayments for which it did not discover or issue a, overpayment finding to the Provider. The Contractor may dispute the Agency's notice of findings in accordance with the Payment Integrity Audit process.

**Revision 19. Special Contract Exhibits - Exhibit A: Capitation Rate Information, MLR, Pay for Performance, Liquidated Damages, and Carved-Out Services. Section 5: Carved-Out Services, is hereby deleted and Section 5 is reserved as follows:**

**Revision 20. Special Contract Exhibit B. Glossary of Terms/Definitions, is hereby replaced as follows:**
*Annual Benefit Maximum (ABM):* A $1,000 maximum State Fiscal Year (July 1 to June 30) benefit limit that applies to every Dental Wellness Plan adult member, age twenty-one (21) and older, as well as the Hawki population. By program design, certain services are excluded from the ABM calculation including emergency dental services. ABM is determined using the Medicaid FFS rates, regardless of reimbursement rate to providers. Effective June 1, 2025, the Hawki population is no longer included in the ABM.

**Revision 21. Exhibit F. Program-Specific Cost Sharing and Annual Benefit Maximum (ABM) Requirements, is hereby replaced as follows:**

**Section I: Annual Benefit Maximum (ABM) - Overview**

DWP Enrolled Members aged twenty-one (21) years and over and Hawki Enrolled Members are limited to an Annual Benefit Maximum (ABM) of $1,000 per State fiscal year (July 1 - June 30). ABM is determined using the Medicaid FFS rates, regardless of reimbursement rate to providers. Effective June 1, 2025, the Hawki population is no longer included in the ABM.

**Section III: Annual Benefit Maximum (ABM) – Hawki**

The Hawki dental ABM applies to all covered services a member receives, except medically necessary orthodontia services and services considered emergent. If the member's ABM is met, services that meet medically necessity can still be received through an exception to policy. Effective June 1, 2025, the Hawki population is no longer included in the ABM.

**Section 2: Ratification & Authorization**

Except as expressly amended and supplemented herein, the Contract shall remain in full force and effect, and the parties hereby ratify and confirm the terms and conditions thereof. Each party to this Amendment represents and warrants to the other that it has the right, power, and authority to enter into and perform its obligations under this Amendment, and it has taken all requisite actions (corporate, statutory, or otherwise) to approve execution, delivery and performance of this Amendment, and that this Amendment constitutes a legal, valid, and binding obligation.

**Section 3: Execution**

**IN WITNESS WHEREOF,** in consideration of the mutual covenants set forth above and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into the above Amendment and have caused their duly authorized representatives to execute this Amendment.

| **Contractor, MCNA Insurance Company** | | **Agency, Iowa Department of Health and Human Services** | |
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| Signature of Authorized Representative: | Date: | Signature of Authorized Representative: | Date: |
| Printed Name: Shannon LePage | | Printed Name: Kelly Garcia | |
| Title: Chief Executive Officer | | Title: Director | |