mcnadental

MCNA Insurance Company

Response to RFP # MED-24-004: Iowa Dental Wellness Plan and Hawki Dental PAHP

Prepared for the Iowa Department of Health and Human Services

TECHNICAL PROPOSAL

(Redacted Response for Public Disclosure)

Tab 1: Transmittal Letter

July 10, 2023

Mr. Zachary Gillen
Iowa Department of Health and Human Services
1305 East Walnut
Des Moines, IA 50319-0114

RE: MCNA Insurance Company's Response to RFP # MED-24-004: Iowa Dental Wellness Plan and Hawki Dental PAHP

Dear Mr. Gillen:

MCNA Insurance Company is pleased to present our proposal to the Iowa Department of Health and Human Services to administer dental benefits for its DWP and Hawki enrollees.

MCNA Insurance Company is backed by a corporate organization with unparalleled experience administering large-scale dental contracts. MCNA currently administers dental benefits for the Dental Wellness Plan (DWP) in Iowa and on behalf of similar Medicaid and CHIP populations in Texas, Louisiana, Florida, Idaho, Arkansas, Nebraska, and Utah through direct contracts with state agencies.

We have been licensed in Iowa since 2015, and we have deep roots in the Iowa communities we have served since 2016 under our current DWP contract. For example, in 2021, we launched our "Say Cheese, Iowa! Smile Tour," which spanned 4 months, 19 cities, and nearly 4,600 miles to bring smiles and educational materials to hundreds of children and their families from Mason City to Keokuk! MCNA looks forward to continuing our connections with Iowa communities. Most recently, we have participated in Iowa health fairs with our partner organizations at the Charles Lakin YMCA Annual Health Fair in Council Bluffs, the Salvation Army of Siouxland, the Central Iowa Shelter Event, and the Green to Go Health Fair in collaboration with Iowa Total Care.

Since our founding over 30 years ago, MCNA's mission has been delivering value to our state clients and participating dentists by providing access to quality dental care and service excellence that improves the oral health outcomes of our members. This mission has been fully aligned with the Agency's goals to improve the quality of care and outcomes for the state's most vulnerable residents. We focus on improving oral health outcomes through a comprehensive, patient-centered dental home model.

We have successfully passed every readiness review and met every operational start date for the programs we have launched in every state we serve. Our proven track record in effectively transitioning enrollees to our dental managed care programs demonstrates our qualifications and makes us a turnkey solution for the State of Iowa. We commit to the Agency that MCNA will be ready to commence operations under this contract on the specified go-live date.

Per RFP § 3.2.1: *Information to Include Behind Tab 1: Transmittal Letter*, we acknowledge and accept all preliminary capitation rates as calculated and the rate methodology (as a basis for subsequent Contract year capitation rates) as a condition of submitting a responsive Bid Proposal.

MCNA is humbled and grateful for our opportunity to serve Iowa's DWP and Hawki members and hope to continue our successful partnership with the Iowa Department of Health and Human Services for years to come.

Sincerely,

Shannon LePage
Chief Executive Officer
MCNA Dental

Tab 2: Proposal Table of Contents

Tab 3: Bidder's Approach to Meeting Deliverables

Section A: General

A.01: Effects of the Federal Waiver

MCNA understands that the Contract is contingent upon continued federal approval of the State's waiver authority. Further, we understand that should CMS withdraw federal waiver authority, the Agency may terminate the Contract immediately in writing to MCNA without penalty.

A.02: Licensure

Attachment J, A.02.a-b

MCNA Insurance Company maintains a current license in Iowa, with an initial effective date of July 22, 2015, and a Company Number of 3196. Our SBS Company Number is 114490567 and our NAIC Company Code is 14063. Our license as in the State of Iowa is in good standing, in accordance with Iowa Admin. Code.

MCNA has been accredited by NCQA for credentialing and recredentialing since 2011 for Iowa and all other markets. Our most recent reaccreditation was in 2022. MCNA became the first dental plan to receive full URAC accreditation in 2014, and successfully achieved reaccreditation in 2020.

A.03: Organizational Structures

Attachment J, A.03.a-b

MCNA's organization leverages our decades of experience managing Medicaid and CHIP dental programs in multiple states to provide Iowa with economies of scale. We will fulfill all administrative, clinical, and operational contractual requirements and meet or exceed all service level expectations, requirements, and performance standards. Our proprietary information management system DentalTrac™, supports the collection and integration of data across our organization to accurately report our performance. Our administrative structure and practices support the integrated delivery of dental services by leveraging our local Iowa presence and our core Texas and Florida locations to create economies of scale to support Iowa and all MCNA markets.

Our Iowa Dental Wellness Plan (DWP) and Healthy and Well Kids in Iowa (Hawki) programs staffing plan features an Iowa-based team that will be supplemented with corporate and regional resources across the nation. We will locate key functions in Iowa as noted in the following table.

Location of Key Functions for the DWP and Hawki Programs	
Dental Plan Function	**Primary Locations**
Administration and Operations	Iowa and Texas
Provider Relations	Iowa
Member Education and Outreach	Iowa
Utilization Management (Clinical)	Iowa and Texas

Utilization Management (Administrative)	Florida and Texas
Claims Processing and Management	Florida and Texas
Program Integrity	Iowa, Florida, and Texas
Regulatory Compliance	Iowa and Florida
Business Processes	Texas
Information Technology	Florida
Quality Improvement	Iowa and Florida
Grievances and Appeals	Florida
Credentialing	Florida
Network Development	Iowa and Texas
Member Services	Iowa, Texas, and Florida
Training and Quality Assurance	Iowa and Texas

A.04: Staffing Requirements

Attachment J, A.04.a

Our experienced team of over 500 employees nationwide provide Iowa a turnkey solution for the DWP and Hawki Programs. All functions, requirements, roles, and duties specified in the RFP will be completed using our local and virtual office model. Please MCNA's Draft Operational Staffing Plan in Section A.05 for additional details on our approach.

A.05: Staffing Plan

Attachment J, A.05.b

Please see our Draft Operational Staffing Plan on the following pages. This initial operational staffing plan enables MCNA to consistently administer dental benefits for our Iowa members. Our plan contains all staffing areas suggested in Table 1 of the RFP. Within 10 days of contract execution, MCNA will submit to the Agency a final operational staffing plan, which will include the resume for each Key Personnel member.

Iowa DWP and Hawki Staffing Plan

Staffing Plan for Iowa

The MCNA family of companies currently has over 500 experienced team members and has been in business for over 30 years. A well-defined staffing strategy is critical to successfully meeting the operational requirements of this contract. As such, MCNA's staffing strategy features an Iowa-based team that will be supplemented with corporate and regional resources across the nation.

MCNA holds the most insured Medicaid and CHIP dental managed care contracts with state agencies in the nation. Please see the following list of our current contracts for services similar in scope and function, including those of similar size:

1. **Iowa Department of Health and Human Services:** MCNA provides covered dental services to nearly 270,000 children and adults statewide in the Iowa Medicaid program on an insured basis. Our contract began on July 1, 2016, for the adult population. On July 1, 2021, the program was expanded to add Medicaid children, with extensions available through June 30, 2024.

2. **Texas Health and Human Services Commission:** MCNA provides the full spectrum of covered dental services statewide to nearly 1.4 million Medicaid and CHIP members on an insured basis. Our contract began on March 1, 2012, and as a result of our most recent re-procurement, will continue through August 2028.

3. **Louisiana Department of Health:** MCNA manages the full spectrum of dental care, including diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, orthodontic, and oral and maxillofacial surgery services to approximately 928,000 Medicaid and CHIP children and adults statewide on an insured basis. Our contract began on July 1, 2014, and as a result of our most recent re-procurement, will continue through June 2026. Additionally, MCNA was recently awarded an expanded benefit adult ICF population, which began on May 1, 2023.

4. **Florida Agency for Health Care Administration:** MCNA provides covered dental services to over 1,130,000 children and adults statewide in the Florida Medicaid program on an insured basis. Our contract began on December 1, 2018, with extensions available through December 2024. MCNA has administered dental benefits for Medicaid members statewide under various contracts since 2006.

5. **Florida Healthy Kids Corporation:** MCNA provides covered dental services to nearly 37,000 children statewide in the Florida CHIP program on an insured basis. Our contract began on January 1, 2005, and through many successful re-procurements has remained active for over 17 years.

6. **Idaho Department of Health and Welfare:** As the State's sole vendor, MCNA provides the full spectrum of covered dental services statewide to nearly 384,000 Medicaid and CHIP children and adults on a fully insured basis. Our contract began on February 1, 2017, and was extended through October 2025.

7. **Nebraska Department of Health and Human Services:** As the State's sole vendor, MCNA provides the full spectrum of covered dental services statewide to approximately 393,000 Medicaid and CHIP children and adults on an insured basis. Our contract began on October 1, 2017, and the program will end on December 31, 2023.

8. **Arkansas Department of Human Services:** MCNA provides the full spectrum of covered dental services to approximately 323,500 Medicaid and CHIP children and adults statewide on an insured basis. Our contract began on January 1, 2018, with extensions available through December 2024.

Iowa DWP and Hawki Staffing Plan

9. **Utah Department of Human Services:** MCNA provides covered dental services to approximately 85,500 children and adults statewide in the Utah Medicaid program on an insured basis. Our contract began on September 1, 2018, and was successfully reprocured in 2022 with extensions available through July 2027.

10. **Oklahoma Health Care Authority:** MCNA provides medical necessity determinations to over 1.1 million children and adults statewide in the Oklahoma SoonerSelect Dental program. Our contract began on January 5, 2022, and will end on January 31, 2024.

MCNA understands a successful program in Iowa will require clinical and support staff to ensure operations are efficient and effective. All required functions will be supported by our Texas and Florida based staff. Meeting contractual performance goals and providing world-class customer-service to our members and providers are our primary objectives. MCNA's Quality Improvement Committee provides internal control by overseeing all delegated services and assuring contractual and operational key performance indicators (KPIs) are met.

Iowa DWP and Hawki Staffing Plan

Location of Services and Virtual Office Approach

MCNA will maintain a strong Iowa presence with an office in-state to support our Iowa-based staff, in particular those delivering in-person services to DWP and Hawki members and providers. Our regionally located staff will utilize a virtual office model. Our approach has proven to be extremely successful in maintaining business operations during natural disasters such as floods and hurricanes, and most recently, during the coronavirus pandemic.

MCNA maintains a cross-functional structure where we utilize resources across the country to support the plans we serve. We understand and acknowledge that a majority of dedicated Iowa staff will be in Iowa. This dual approach to resources enables best-in-class service that is efficient and cost-effective. For example, we leverage our virtual call center to provide consistent coverage for our members and providers. Our state-of-the-art DentalTrac™ management information system is a secure web-based application that enables staff to work remotely with ease.

All MCNA offices are within the continental United States. We will ensure any staff or operational functions outside of the State of Iowa have personnel available to the Agency to address out-of-state operations during the Agency's normal business hours. The following are physical office addresses that could be used to support the Iowa contract:

- 3100 SW 145th Avenue, Suite #200, Miramar, FL 33027
- 6200 Northwest Parkway, San Antonio, TX 78249
- 2021 Transformation Drive, Suite #1400, Lincoln, NE 68508
- 1401 West Capitol Avenue, Suite #170, Little Rock, AR 72201
- 3850 North Causeway Boulevard, Suite #1510, Metairie, LA 70002

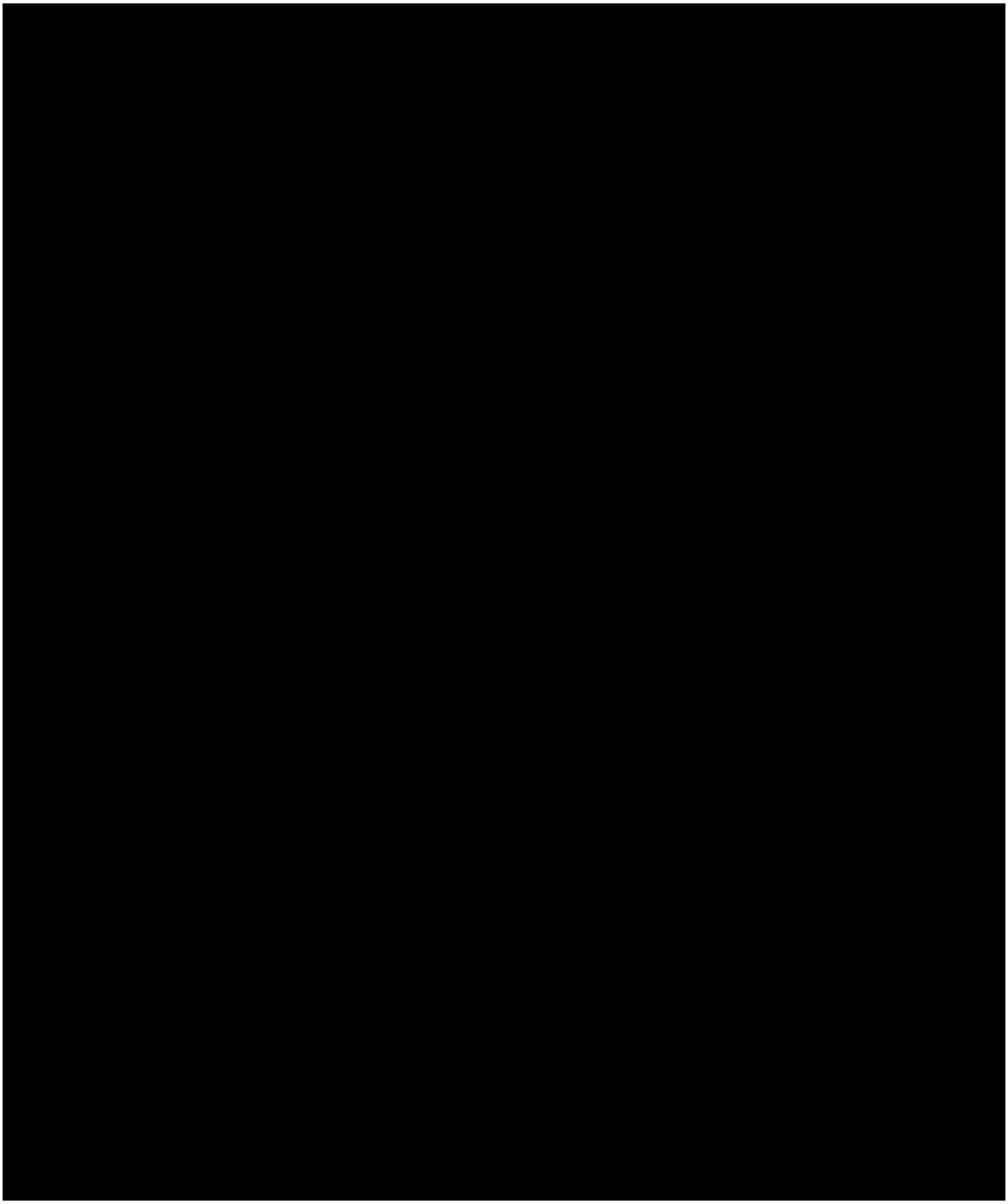
All staff supporting the Iowa Medicaid and CHIP programs will be trained on contract requirements and performance standards. Likewise, our training educates all staff on the other lines of business we serve to ensure that we have resources continuously available. The following high-level table shows the location of key functions:

Location of Key Functions for the DWP and Hawki Programs	
Dental Plan Function	**Primary Locations**
Administration and Operations	Iowa and Texas
Provider Relations	Iowa
Member Education and Outreach	Iowa

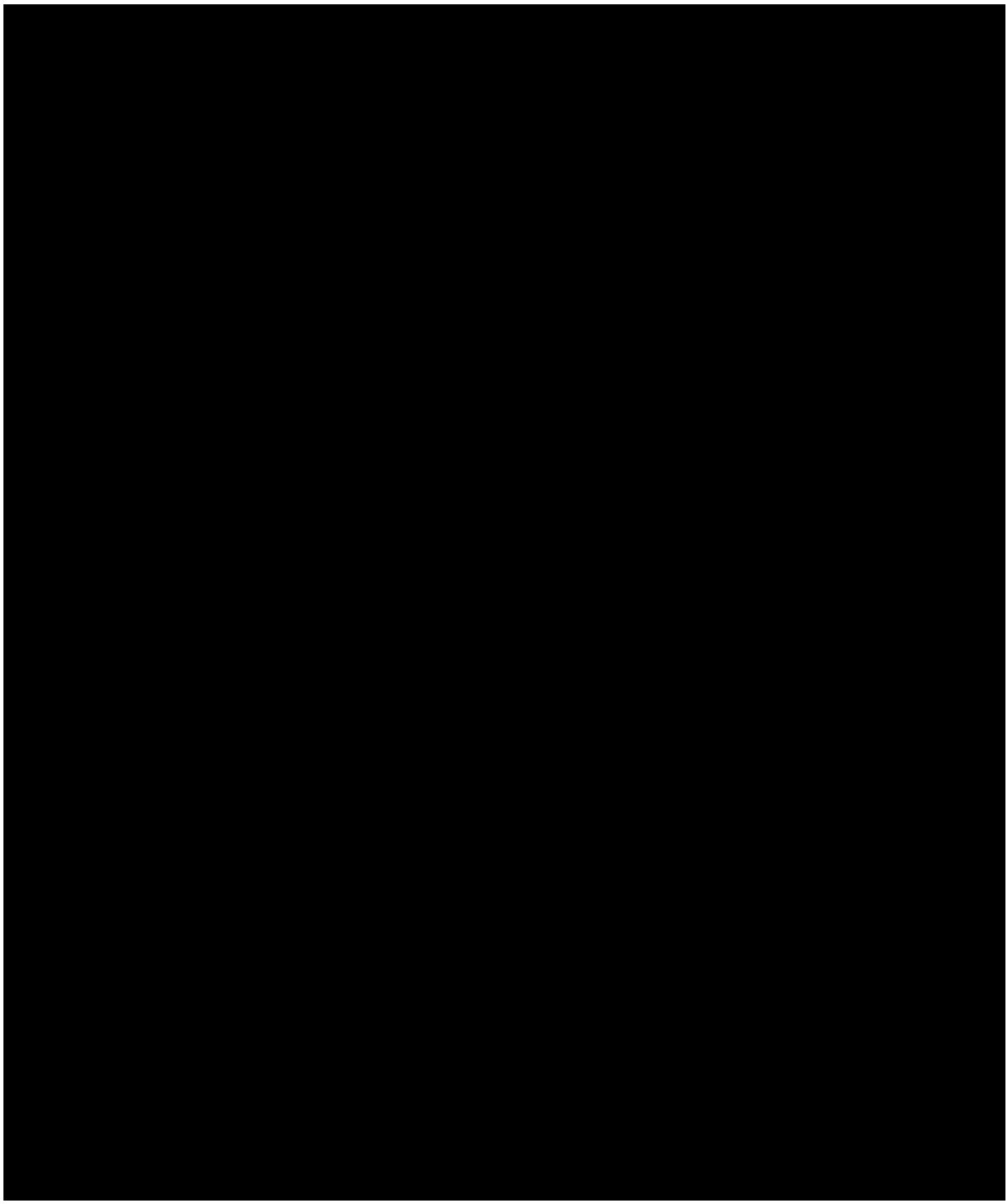
Iowa DWP and Hawki Staffing Plan

Utilization Management (Clinical)	Iowa and Texas
Utilization Management (Administrative)	Florida and Texas
Claims Processing and Management	Florida and Texas
Program Integrity	Iowa, Florida, and Texas
Regulatory Compliance	Iowa and Florida
Business Processes	Texas
Information Technology	Florida
Quality Improvement	Iowa and Florida
Grievances and Appeals	Florida
Credentialing	Florida
Network Development	Iowa and Texas
Member Services	Iowa, Texas, and Florida
Training and Quality Assurance	Iowa and Texas

Iowa DWP and Hawki Staffing Plan



Iowa DWP and Hawki Staffing Plan



Iowa DWP and Hawki Staffing Plan

A.06: Purpose and General Framework of the Staffing Plan - A.07: Inclusion in Staffing Plan

We will always employ sufficient staff to achieve compliance with contractual requirements and performance metrics. MCNA acknowledges and understands that the Agency may require additional staffing obligations in addition to other remedies provided for in the Contract if requirements are not completed.

A.08: Final Operational Staffing Plan Submission/Agency Review

We understand that the Agency will review and approve or disapprove the plan within 15 days of receipt.

A.09: Subsequent Staffing Plans

We will provide a revised Operational Staffing Plan within 10 business of any change.

A.10: Agency Right to Approve Deny Key Personnel

MCNA agrees that the Agency reserves the right to approve or deny our key personnel based on performance or quality of care concerns. In addition, the Agency reserves the right to approve other executive positions, key managers, or supervisors working under key personnel.

A.11: Initial Staff Onboarding Obligation

MCNA will onboard over 50% fifty percent of local staff in each functional area of contract performance within 120 days of contract execution. We will provide written notice to the Agency when changes to key staffing occur, including changes in the key personnel and other management and supervisory level staff at least five business days prior to the employee's last day with MCNA.

A.12: Staffing Changes

Attachment J, A.12.c

We will provide written notification to the Agency at least 30 days in advance of any plans to change, hire, or re-assign designated key personnel. At that time, MCNA will present an interim plan to cover the responsibilities created by the key personnel vacancy. Likewise, MCNA will submit the name and resume of the candidate filling a key personnel vacancy within 10 days after a candidate's acceptance to fill a key personnel position or 10 days prior to the candidate's start date, whichever occurs first. We will ensure that knowledge is transferred from an employee leaving a position to a new employee to the extent possible. All key personnel positions shall be approved by the Agency and filled within 60 days of departure unless a different time frame is approved by the Agency.

A.13: Staff Training and Qualifications

Attachment J, A.13.e-f

MCNA ensures on an ongoing basis that all staff has the appropriate credentials, education, experience, and orientation to fulfill the requirements of their position. We provide initial and ongoing training to make sure all Iowa program staff are trained in the major components of this contract. As applicable, based on the scope of services provided under any such subcontract, MCNA will ensure all subcontractor staff are trained in accordance with this section. Staff training includes:

- Contract requirements and State and Federal requirements specific to job functions;
- Initial and ongoing training on identifying and handling quality of care concerns, including access to dental services as outlined in the contract;
- Cultural sensitivity training;
- Training on fraud and abuse and the False Claims Act;
- HIPAA training;
- Clinical protocol training for all clinical staff;
- Training regarding interpretation and application of UM guidelines for all UM staff;
- Training and education to understand abuse, neglect, exploitation, and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements; and
- Training specific to Iowa providers and non-Medicaid resources.

All training material shall be updated on a regular basis to reflect any program changes. MCNA will maintain documentation to confirm staff training, curriculum, schedules, and attendance. The Agency reserves the right as part of the standard remedy process to request that MCNA implement additional staff training in the event that performance issues are identified by the Agency.

A.14: Business Location

Attachment J, A.14.d

MCNA acknowledges and understands that we must set up and maintain a business office or work site within the State of Iowa. Our office will be located in Des Moines and we will have regionally located support staff who work under our telecommuting policies. We understand that all costs associated with the office will be the responsibility of MCNA. Further if any activities are approved by the Agency to be performed offsite, MCNA will provide toll-free communications with the Agency staff to conduct business operations. MCNA will provide meeting space to the Agency as requested when onsite at our office location. We acknowledge and will comply with all contractual requirements related to staffing and the local Iowa office.

A.15: Out of State Operations

MCNA will ensure the location of any staff or operational functions outside of the State of Iowa does not compromise the delivery of integrated services and a seamless experience for members and providers. Additionally, MCNA assures availability of personnel to the Agency to address out-of-state operations during normal Agency hours of operation. In accordance with 42 C.F.R. § 438.602(i), no claims paid by Contractor to a network provider, out-of-network provider, subcontractor, or financial institution located outside of the U.S. may be considered in the development of actuarially sound capitation rates.

A.16: Agency Meeting Requirements

We will comply with all meeting requirements established by the Agency, including, but not limited to, preparation, attendance, participation, and documentation. MCNA will have subject appropriate staff members attend onsite meetings as requested and required by the Agency. We understand that the Agency reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format, or add meetings to the schedule as it deems necessary.

A.17: Coordination with Other State Agencies and Program Contractors

Attachment J, A.17

MCNA agrees to reasonably cooperate with and work with the other dental plans, subcontractors, State agencies and third-party representatives and to support community-based efforts as requested by the Agency. [redacted]

A.18: Media Contacts

We will not provide the media or give media interviews without the express consent of the Agency. Any contacts by the media or other entity or individual not directly related to the DWP, the Hawki program, or the contract shall be referred to the Agency.

A.19: Written Policies and Procedures

MCNA maintains written policies and procedures for each functional area in a global Policies and Procedures Manual (the "PPM"), including, but not limited to the strategies, policies, procedures, descriptions, mechanisms, and the like identified in the contract to be included in the PPM. In drafting the PPM, MCNA will be guided by the scope of work of this contract. MCNA will submit a draft PPM to the Agency forty-five (45) days following execution of the contract, unless directed otherwise by the Agency.

A.20: Contractor Developed Materials

All materials we develop will be made available to the Agency. We agree to produce an archive of such materials in an electronic library to be made available to the Agency upon request. The archive will include all written policies, procedures, and all public-facing documents. The materials will be available to the Agency throughout the Contract term and transitioned to the Agency after the Contract term.

A.21: Participation in Readiness Reviews

Attachment J, A.21.a-b

Over 30 years of experience implementing dental benefit management services, coupled with our innovative technology talented Iowa team, and our experience as a dental plan for the Iowa Dental Wellness Plan since 2016, allows MCNA to "hit the ground running." We are committed to ensuring a **flawless go-live**, on the Contract effective date which is targeted for July 1, 2024.

We know a successful implementation requires a clear but flexible implementation plan, well-defined milestones and expectations, robust communication, ample financial and manpower resources, and a strong leadership team. Our Implementation Plan for Iowa has been developed based on our experience serving DWP members and providers since 2016, as well as our other Medicaid and CHIP programs across the country. This brief overview of our plan addresses each aspect of readiness requirements set forth in the RFP. Our implementation planning process is comprehensive and involves the leadership of every major operational unit of MCNA.

The hallmarks of MCNA's approach to dental plan operations include a dedicated resource library and supports, weekly internal team meetings, documentation of requirements, continuous risk management, and ongoing communication with the Agency throughout the process, starting from award date and moving through Readiness Review to post-implementation.

The level of planning inherent within MCNA's Implementation Plan and its exemplary execution by our highly skilled and dedicated staff will reassure the Agency of our system and operational readiness. We will conduct all activities necessary for a successful commencement of operations including provider network development, and end-to-end testing of management information system and administrative systems, care coordination planning. Furthermore, all activities needed to ensure the requirements described in the RFP, including the submission of a revised implementation plan as part of Readiness Review, will be achieved and accepted by the Agency within the timeframes specified in the RFP.

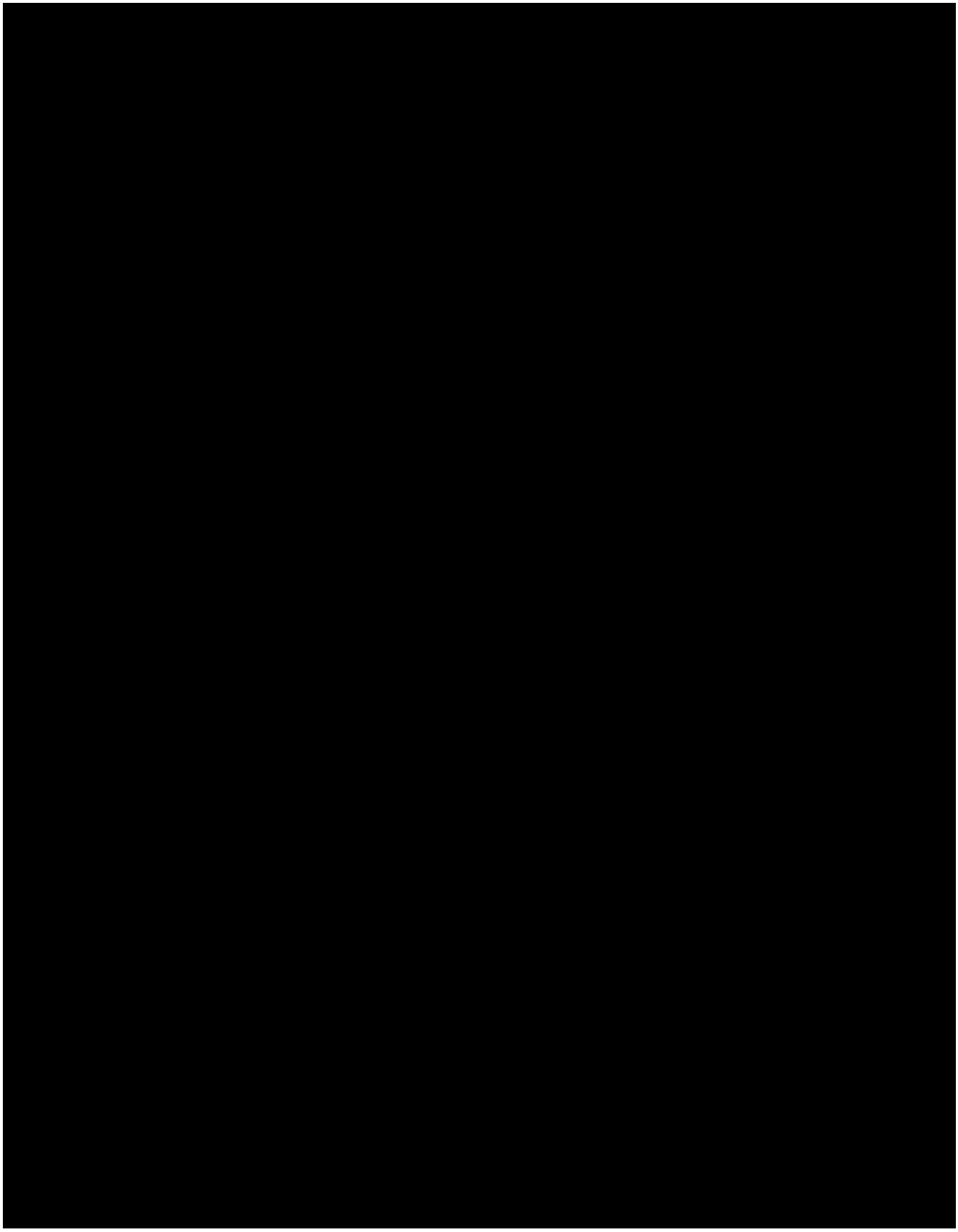
All member and provider educational materials such as member handbooks, provider directories, and provider manuals will be submitted to the Agency for approval prior to distribution. Our provider orientation training sessions, seminars, and webinars will follow an Agency-approved schedule.

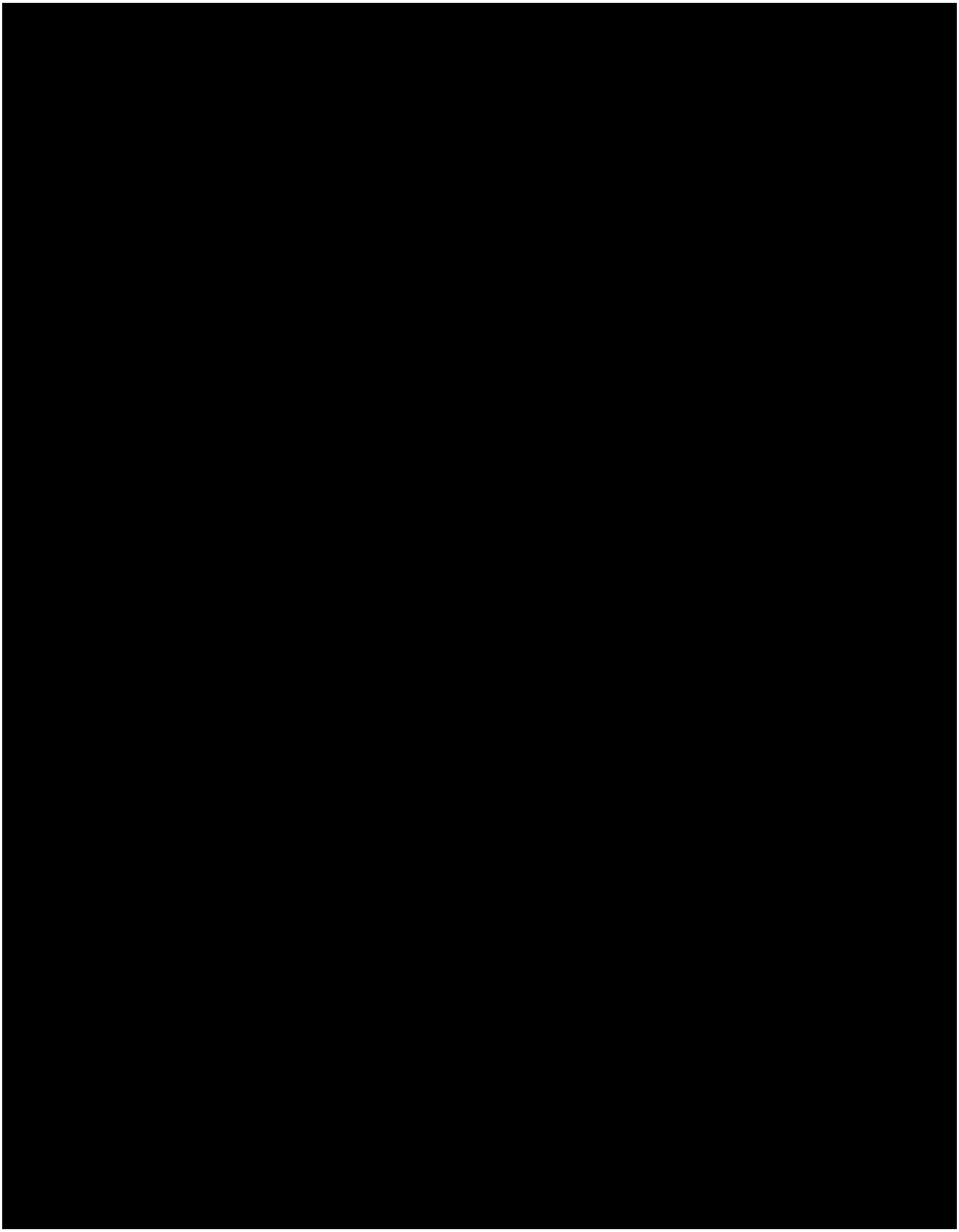
Implementation Plan

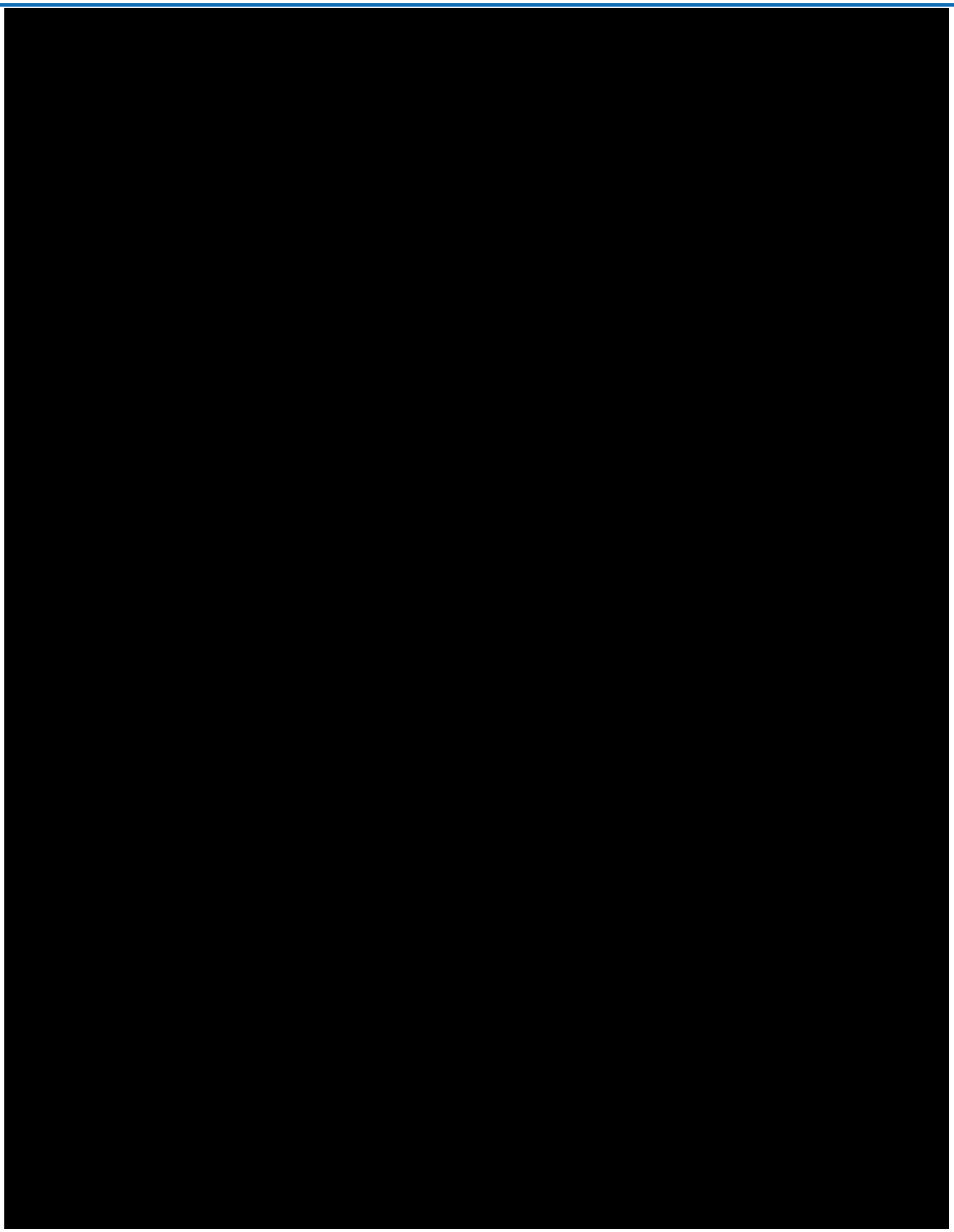
MCNA's proven track record of transitioning enrollees to our dental managed care plans demonstrates our qualifications and makes us the best choice for the State of Iowa. Factors that will be considered in the development of the plan include:

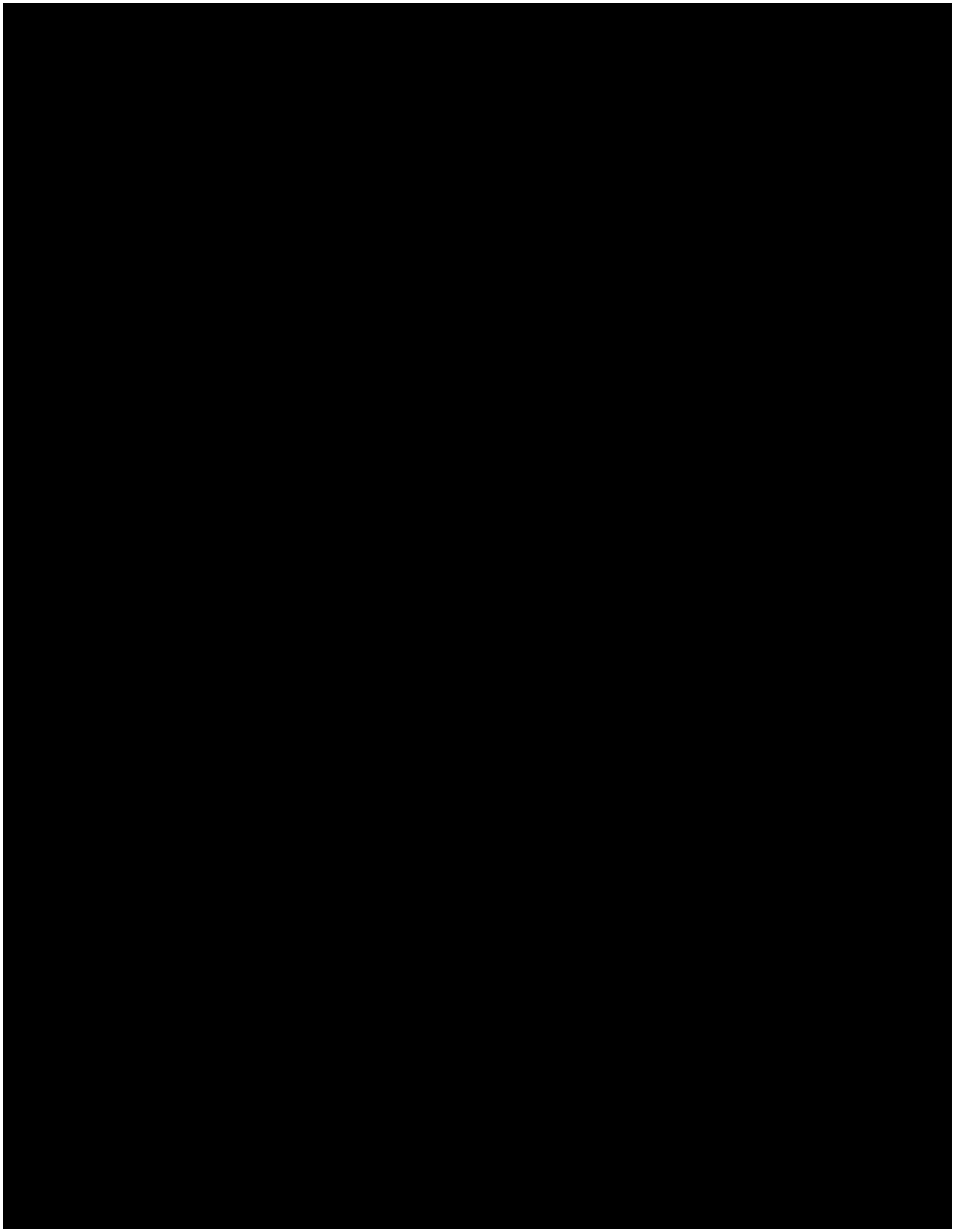
- Minimal disruption in the delivery of healthcare services to members during the transition to ensure that members' care is not affected.
- Timely data transfers conducted in accordance with Agency requirements.
- Coordination and defined communication protocols with the Agency and its contractors.

Using SmartSheet, a market-leading platform that allows us to collaborate, manage, and report our work in real-time, we have created an implementation plan, included below, that details a schedule of key milestones and activities that must be accomplished to meet RFP requirements before the contract start date and as part of Readiness Review. The plan keeps track of the baseline, all unique tasks associated with the implementation, the resources which are dedicated to it, all unique milestones that need to be achieved, the timeline allocated, task progress, fiscal status, scope creep, and Work Breakdown Structure. MCNA will revise the implementation plan as needed throughout the readiness review process and as requested by the Agency.









Readiness Review

We have successfully passed every readiness review and met every operational start date for the programs we have launched in every state we serve, including the Iowa Dental Wellness Plan in 2016 and the expansion for DWP Kids in 2021. MCNA provides Iowa with a turnkey solution that supports the improved quality of care and cost control objectives of the Medicaid and CHIP programs.

We understand that the Agency will complete a Readiness Review of MCNA prior to the contract start date in accordance with 42 CFR §438.66(c)-(d). Our Implementation Plan contains explicit controls for assessing the completion of activities required for Readiness Review. We will provide any materials required to complete the process by the dates established by the Agency.

MCNA confirms that we will revise the implementation plan and keep it updated throughout the readiness review process per Agency requirements.

Project Management Office (PMO)

MCNA's processes for ensuring contracted services begin upon the Contract effective date are underpinned by our proven Project Life Cycle framework for implementations, and our commitment to maintaining an open channel of communication with Agency staff assigned to monitor our transition. To this end, we have designated our Vice President of Business Operations and Strategy, Andrew Olson, to serve as the project leader. Mr. Olson and the PMO team will meet with Agency representatives and other state vendors as often as necessary to ensure consistent communication and support a smooth implementation process. Mr. Olson has extensive Project and Program Management experience in a variety of industries, including Pharmaceutical, Manufacturing and Healthcare. The PMO team members have years of experience with large-scale implementation projects such as our current Medicaid and CHIP dental programs in Iowa, Texas, Louisiana, Arkansas, Nebraska, Florida, Idaho, and Utah.

Under the expert leadership of Mr. Olson, our PMO is engaged in managing the activities of MCNA's dedicated operational teams to ensure flawless implementation. The PMO team is comprised of Project Managers (PMs), Subject Matter Experts (SMEs), and other key stakeholders with versatile and varied core strengths. The PMO is involved from the concept to the delivery stage, contributing to analyzing and responding to RFPs and their implementations. This level of involvement helps to ensure a consistent approach.

MCNA strives to be a lean company and constantly improves the efficiency of its processes and methodologies. Our processes are based on best practices, proven effective strategies, and global Project Management Institute (PMI) Community of Practice recommendations. The PMO team will solicit input from other staff as needed and meet regularly to continue to develop and refresh our Implementation Plan throughout Readiness Review. Our Project Life Cycle framework is based on strict standards and is handled with a tailored approach: Issue Identification, Assessment, Alternative Analysis and Resolution. Both change management and risk management activities are conducted on a regular basis to proactively identify and resolve such issues.

Communication Protocols

The collective knowledge and ability of our team ensures a well-managed project. We work diligently to ensure that all aspects of the project are well understood, well documented, and shared with all resources. Understanding that knowledge-sharing is key to the success of the project, we schedule regular checkpoint calls that include all stakeholders.

The PMO is directly involved during all implementation phases by reviewing the project status on a biweekly basis. The PMs provide an updated Project Plan, Action Plan, and Risk Register for review by the implementation team, which may include Agency personnel. During these reviews, subject matter experts are required to give a business and technical status report in relation to our progress. Each status report will contain updates on completed and pending deliverables, key milestones, upcoming activities, any items submitted for review and approval since the prior report, and identified risks to scheduled deliverables that could impact the project.

Risk Assessment and Mitigation

Proper risk management includes identification and mitigation and is one of the cornerstones of project management at MCNA. Our infrastructure limits exposure and minimizes the potential downtime and financial risk to MCNA, our members, and the Agency. Should a system outage or data breach occur, MCNA's proven best-in-class server operating systems and virtualization platforms support our environments and create a virtually unlimited redundant infrastructure. With multi-geographic distribution of all our servers, we minimize and mitigate the risk of service interruptions. MCNA also maintains a high degree of operational redundancy with call center operations, claims processing, and utilization management functions located in multiple states. The MCNA PMO consistently monitors for all issues and risks that may arise during implementation. The PMO utilizes a formal review and resolution process to prevent risks from being overlooked and causing project disruption.

Documenting and Classifying Risk

MCNA utilizes tools and processes to manage risks for all projects. Documenting risk in a well-designed Risk Register is the first step to managing it. Once the risk has been logged, its potential impact on the project and its likelihood of occurrence are ranked on a scale of High, Medium, or Low. This allows the team to identify the mitigation plan appropriate to address the risk. The key items identified in the Risk Register are addressed below.

1. **Identified Risk:** This area defines the risk and all its associated causes at any time before or during the implementation. The risks are identified in a multitude of ways, such as identifying when a deliverable is close to becoming untimely. The MCNA PMO is well versed in the identification of risks by using best practices and diligent monitoring.
2. **Potential Impact Rank:** Here, a High (H), Medium (M), or Low (L) rank is assigned to the risk based on how adversely it may affect the project and its delivery.
3. **Likelihood of Occurrence Rank:** Similar to the Impact Rank, the Likelihood of Occurrence is ranked on a High-to-Low scale based on the probability that it will occur and impact the project.
4. **Mitigation Plan:** The Mitigation Plan charts a series of steps and circumvention approaches that can be undertaken to eliminate or minimize the risk. Although all risks are given considerable attention, M/H and H/H ratios are scrutinized with extra care and a separate Mitigation Risk Plan is developed to deal with their impact. The Risk Plan consists of the top 3 reasons for occurrence, the top 3 risk management approaches for mitigation, transfer, or avoidance, the mitigation strategy, and the mitigation ownership.

Risk Management Strategy

MCNA's Risk Management approach does not stop after implementation. It includes the following processes for Risk Management throughout the life of the contract: planning, identification, analysis, monitoring, and control. MCNA recognizes that new risks can be identified at any time during the contract and processes may need to be updated accordingly. MCNA's objective is to decrease the probability and impact of developments that could adversely affect the project.

[redacted]

[redacted]

A.22: Response to State Inquiries & Requests for Information

We understand that the Agency may, at any time during the term of the Contract, request financial or other information from MCNA. We will ensure that our responses fully disclose all financial or other information requested. We acknowledge that information may be designated as confidential but may not be withheld from the Agency as proprietary, and that information designated as confidential may not be disclosed by the Agency without the prior written consent of MCNA except as required by law. If we believe the requested information is confidential and may not be disclosed to third parties, we will provide a detailed legal analysis to the Agency, setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

MCNA acknowledges that the Agency may directly receive inquiries and complaints from external entities, including but not limited to, providers, enrolled members, legislators, or other constituents which require our research, response, and resolution. We will comply with requests for response to all such inquiries and complaints. Responses will be provided in the timeframe specified by the Agency when the inquiry or complaint is forwarded to MCNA for resolution.

A.23: Stakeholder Education

MCNA currently maintains a formal process for the ongoing education of stakeholders prior to, during, and after contract implementation. We have found that our members, their families and caregivers, providers, and key stakeholders respond best to digital communication channels such as websites, portals, and social media.

Our dedicated Iowa website contains information about the program, enrollment instructions, news articles, and documentation such as handbooks, guides, forms, orientations, and state materials. To allow stakeholders to easily engage with us, we prominently feature contact information including our member and provider hotline numbers, TTY numbers, and secure email forms for a variety of topics. We also utilize our leading-edge Member and Provider Portals, as well as social media channels, to provide timely information to stakeholders and allow them to contact us as needed.

[redacted]

We also utilize our Iowa Member Advocate and Outreach Specialists to participate in health fairs and other local events to educate our members on a variety of oral health and oral hygiene topics, and to give members an opportunity to engage with our team face-to-face.

Our Provider Relations Representatives are dedicated to the Iowa program and can assist our providers with one-on-one training and education, topical webinars, and ad-hoc questions or concerns they may have. Training is also offered when a new provider or provider group joins our network. Our provider training includes information about how to access and use MCNA's Provider Portal, and we make additional training on Portal functionality available on demand 24/7 through our online YouTube educational video library and our Portal User Guide.

MCNA will submit a Stakeholder Education Plan to the Agency for review and approval in the timeframe and manner determined by the Agency.

A.24: Dissemination of Information

MCNA will distribute information prepared by the Agency or the federal government to its members and provider network as appropriate. We utilize a variety of distribution channels including website news articles, portal announcements, mass emails, outbound call campaigns, postal mail, and text messaging.

A.25: Future Program Guidance

MCNA understands that we shall operate in compliance with current and future program manuals, guidance, policies, and procedures at no additional cost to the Agency. Further, we recognize that future modifications that have a significant impact on our responsibilities, as set forth in this Contract, will be made through the Contract amendment process.

As an incumbent DWP dental plan, MCNA has enjoyed a close working relationship with the Agency and looks forward to continuing to improve the oral health of Iowans.

A.26: Material Change to Operations

Attachment J, A.26.a: Material Change to Operations

MCNA understands that a material change to operations is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of our membership or provider network and that a reasonable person would find to be a significant change. Prior to implementing a material change in operation, MCNA will notify the Agency as far in advance as possible. Notice will be delivered via email to the contract manager and will include all RFP-specified elements. Additionally, we will communicate all material changes to our enrolled members or providers at least thirty (30) days prior to the effective date of the change. We acknowledge that the Agency reserves the right to deny or require modification to proposed material changes if it is determined, at the sole discretion of the Agency, that such change will adversely impact quality or access.

A.27: Call Center Performance Metrics

MCNA has over 30 years of experience in managing member and provider hotlines. We track and trend a variety of metrics beyond service levels and abandonment rates to ensure a positive experience for our members and providers. [redacted]

Call Center Performance by Plan: May 2023				
Plan	**Answer Goal**	**Answer Rate**	**Abandonment Goal**	**Abandonment Rate**
Arkansas	[redacted]	[redacted]	[redacted]	[redacted]
Florida Medicaid	[redacted]	[redacted]	[redacted]	[redacted]
Florida CHIP	[redacted]	[redacted]	[redacted]	[redacted]
Iowa	[redacted]	[redacted]	[redacted]	[redacted]
Idaho	[redacted]	[redacted]	[redacted]	[redacted]
Louisiana	[redacted]	[redacted]	[redacted]	[redacted]
Nebraska	[redacted]	[redacted]	[redacted]	[redacted]
Texas	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]		
Utah	[redacted]	[redacted]	[redacted]	[redacted]

In addition to the performance metrics highlighted above, MCNA has experience meeting all the performance metrics outlined in section A.27 of this RFP. We are committed to meeting or exceeding all Iowa performance standards.

A.28: Quality of Responses and Deliverables to the Agency

MCNA will perform quality assurance reviews on all documentation and deliverables sent to the Agency. We ensure that at a minimum, the documents will be grammatically correct and in alignment with the Medicaid Program rule and regulation. All member materials are specifically screened and scored using the Flesch-Kincaid readability index to ensure compliance with the 6th grade reading level standard.

A.29: Coverage Area

MCNA agrees to continue providing DWP services to the entire State of Iowa and will provide Hawki services to the entire State of Iowa.

A.30: Periodic Reviews of Eligibility

We acknowledge that the Agency shall periodically conduct a review of each enrolled member's circumstances to establish the enrolled member's continued eligibility to participate in the DWP and Hawki dental programs.

A.31: Enrolled Member Engagement - A.32: Enrolled Member Education and Outreach

Since 2016, MCNA has been educating Iowa DWP members about the importance of achieving and maintaining good oral health, and the valuable benefits available to them in the State's dental program. We will continue to fulfill our commitment to Iowans enrolled in the DWP and Hawki programs by creating, producing, and distributing accurate and easy-to-understand educational materials. Population-specific, leading-edge outreach efforts are MCNA's specialty. We solicit member input to assist with targeted population outreach efforts for underserved groups to reduce health care disparities based on factors such as racial, ethnic, and socioeconomic status.

[redacted] These strategies educate members, their guardians, or authorized representatives about coordination of care, covered benefits and limitations, and how to access specialty dental services (See Section C for details on our Member outreach and engagement strategies).

We affirm that we will establish a process to analyze the data collected from the forthcoming Agency-approved Oral health Equity Self-Assessment Tool to create strategies to reduce the risk of negative dental outcomes of our members. Informed by our data analytics, MCNA will develop and deploy targeted outreach interventions to improve the oral health of members at high-risk for oral health disease.

MCNA engages our members in their care by leveraging educational materials and community resources to support member care needs. MCNA has a long history of reaching out to the underserved by cooperating with social and civic groups, resident associations, faith-based groups, and other community-based organizations. We call this approach **"locking arms with the caring community"** as it ensures coordinated care for our members. MCNA proactively utilizes Case Managers and Member Advocate and Outreach Specialists (MAOS) to educate families throughout the communities we serve about their benefits, how to access them, and to ensure coordinated care by linking them to medical health plans and key state agencies. We know that it is only when collaboration among these multiple stakeholders occurs that members experience continuity of care.

[redacted]

Sample Member Advocate Informational Flyer

Community-Based Member Advocate Outreach Specialists

MCNA employs experienced MAOS to provide assistance with oral health education and understanding plan benefits, scheduling dental appointments, and coordinating transportation as needed. Our MAOS collaborate with Medicaid medical health plans, community partners such as religious and civic organizations that serve our members, safety-net providers, and schools. We share information about the importance of preventive services with our collaborative partners so that they can also share a consistent message with members and the community.

[redacted]

[redacted]

[redacted]

Our Care Connections Team educates members about the importance of preventive care, assists members in scheduling appointments, and assists with arranging transportation if needed. If during these calls we identify any urgent dental needs, we work with the member to arrange necessary services as quickly as possible.

MCNA manages population health by engaging in targeted activities and interventions designed to improve oral health outcomes. Please see our response to Section G for additional details about our quality improvement strategy and successful Iowa results.

[redacted]

[redacted]

The results of this data analysis drive our comprehensive approach to member outreach, education, and communication.

[redacted]

MCNA evaluates the interventions we deploy using rigorous data analysis methods.

identify specific areas for improvement in our education and outreach programs. Please the following bilingual postcard we created to encourage fluoride use among our DWP members. MCNA looks forward to partnering on enhanced outreach to our Iowa members.

Sample Member Outreach Postcard

Section B: Enrollment and Disenrollment

MCNA has provided rigorous oversight of the enrollment and disenrollment process over the past 7 years, serving almost 284,000 members of the Iowa Dental Wellness Plan (DWP). We understand the issues and needs that surround enrolling and disenrolling members and monitor all major data transactions daily, assuring accurate and timely data reporting and exchange with the State.

The integrated capabilities of our proprietary management information system, DentalTrac™, allow MCNA to effortlessly process daily eligibility files and weekly reconciliation files from the State in the format specified in the Systems Companion Guide.

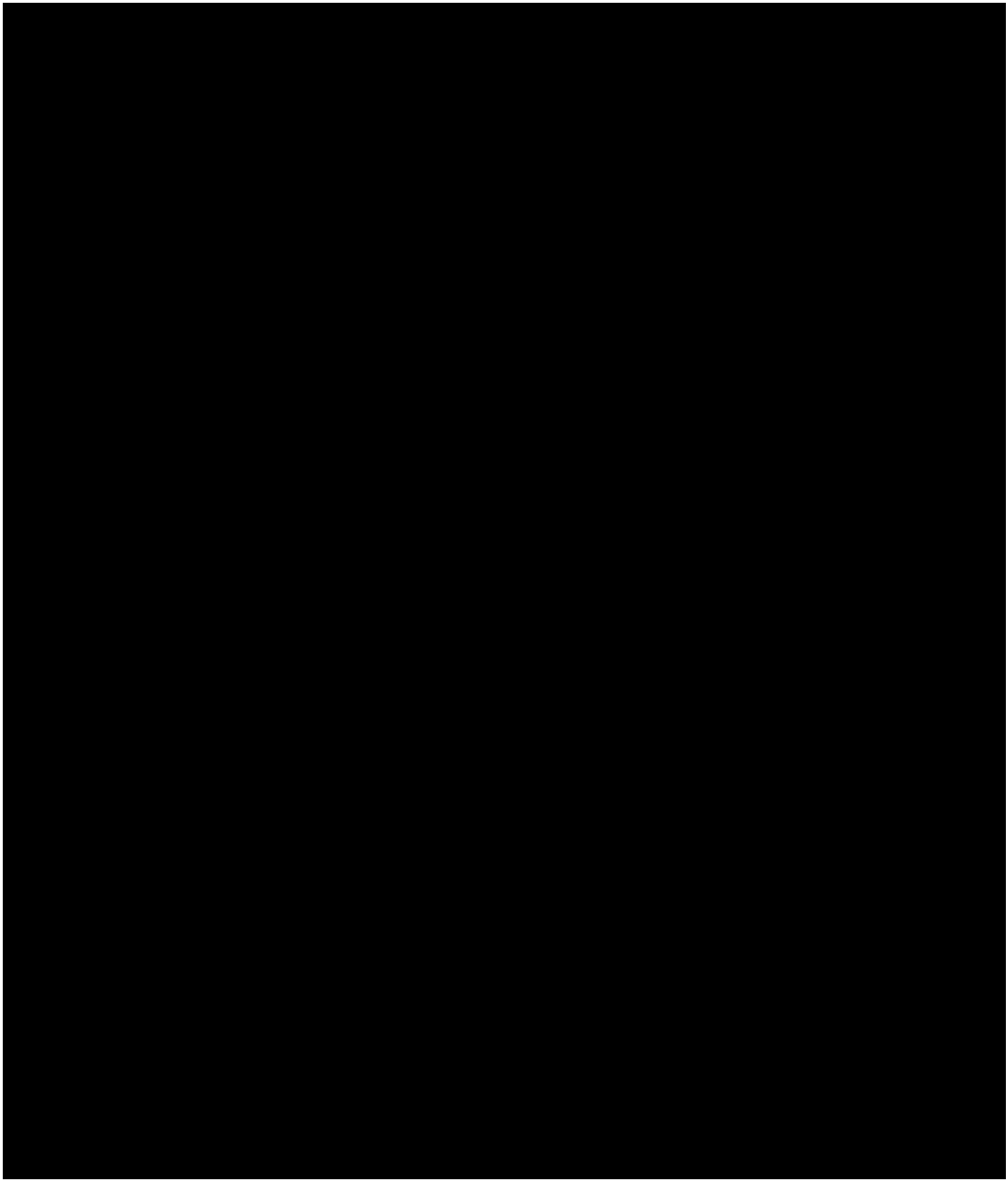
DentalTrac™'s comprehensive eligibility and enrollment module uses a sophisticated business rules engine to process benefit and enrollment data transmissions and to determine eligibility and benefits of members. Our system accepts outbound ANSI ASC X12 834 Benefit Enrollment & Maintenance from the State's enrollment broker daily and allows us to link member records that are associated with different Medicaid Program ID numbers and aid categories to a single member file. This capability allows us to ensure that only members eligible for benefits will be enrolled and excluded populations will not be eligible.

MCNA currently processes enrollment data daily and conducts reconciliation and reports errors to the State in accordance with Contract requirements. We confirm member eligibility information is current and accurate, that members are treated fairly and equally during enrollment, and that they have the greatest choice of providers available.

We make every effort to be a responsible partner to the State as it completes its responsibilities and look forward to continuing our successful relationship with State staff, the Iowa professional dental community, and key stakeholders across the state as we continue to improve the oral health of the members we serve.

We have read, understand, and will comply with Iowa Dental Wellness Plan and Hawki Dental PAHP RFP# MED-24-004. In our response below, we address key requirements from RFP Attachment F: Contract and Scope of Work Section B. Enrollment and Disenrollment B.01-B.7 and understand the responsibilities of the State outlined in these requirements as well.

Enrollment, Eligibility, and PDP Assignment Flowchart



MCNA's Enrollment Manager (EM) works directly with the State, maintaining an open line of communication to efficiently and effectively transfer member files. The EM is responsible for continuously monitoring the proper processing of daily and weekly eligibility and enrollment files and maintaining communication with the State if processing exemptions occur.

Upon processing eligibility and enrollment files, DentalTrac™ follows business rules that trigger multiple validation checks during the process and executes the necessary steps to satisfy contractual compliance.

The EM is responsible for:

- Ensuring that enrollment files received are processed within 24 hours from the time of receipt;
- Reconciling the enrollment data;
- Reviewing enrollments and disenrollments to identify potential issues, and ensuring each member's eligibility status is accurate;
- Notifying the State in the formats and methods specified by the State, within five (5) business days of receipt of the file transfer of any discrepancies in enrollment, including enrollees not eligible for the Dental Benefit Program; and
- Notifying the State via the Change Reporting System of any changes in demographic information or living arrangements for families or individual members within five (5) business days of identification, including changes in mailing address, residential address if outside Iowa, email address, telephone numbers, and insurance coverage.

B.01: Eligible for Enrollment

We agree to enroll any mandatory Medicaid beneficiary who selects MCNA or is assigned to MCNA and will accept new enrollment from individuals in the order in which they are submitted by the enrollment broker without restriction. MCNA serves all eligible members beginning on their date of enrollment regardless of pre-existing conditions, prior diagnosis, receipt of any prior dental health care services, or for any other reason, subject to State-prescribed benefit limitations. We understand the State determines eligibility for the qualifying populations noted in Special Contract Exhibit D. Submission to MCNA is received via electronic transactions submitted from the State and the Iowa Department of Health and Human Services (Agency) in contractually accepted formats. MCNA accepts the State's eligibility determination and agrees to acceptance of PAHP Enrollment as it is received.

B.02: PAHP Selection and Assignment

As the incumbent dental plan for DWP, our enrollment team has been working with the Agency since 2016 managing the member enrollment process, which includes enabling members to select the provider of their choice or implementing auto-assignment logic if a PDP choice is not made. We understand that enrollment with a PAHP may be the result of a member's selection of a particular Contractor or assignment by the Agency.

B.03: Effective Date of Contractor Enrollment

MCNA understands that assignments and changes to members' aid type are made retroactively for Medicaid reinstatements only. MCNA is not responsible for covering newly retroactive Medicaid eligibility periods, except for 1) babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth and 2) Hawki-enrolled members starting the month after the date of application.

B.04: Estate Recovery Notification

MCNA supports the State's estate recovery efforts as directed by the Agency. We understand the Iowa estate recovery law and process and recognize that those affected by the estate recovery policy include members who are 55 years of age or older, regardless of where they are living, or under age 55, and reside in a nursing facility, an intermediate care facility for persons with an intellectual disability, or a mental health institute, and cannot reasonably be expected to discharge and return home

As requested, we send Comm. 123, a State-approved form, to members over age 55 once a year. At the Agency's request, we produce documentation providing details of information sent to the member. We also assist with providing completed forms back to the State.

B.1: No Discrimination

B.1.01: Acceptance of New enrolled Members

MCNA complies with all Federal civil rights laws that relate to healthcare services and will comply with all Agency enrollment provisions. We will accept all new members in the order in which they apply without restriction, up to the limits set under the Contract.

B.1.02: Health Status & Need for Services

We do not discriminate against members on the basis of their health history, health status, need for health care services or adverse change in health status.

B.1.03: Other Discrimination Prohibited

We do not discriminate against members on the basis of age, religious belief, sex, gender, sexual orientation, gender identity, or disability.

B.1.04: Non-Discriminatory Policies

Furthermore, we will not develop or implement any policies or practices that in effect discriminate against enrollment-eligible individuals on the basis or race, color, national origin, sex, sexual orientation, gender identity, or disability. MCNA understands and acknowledges that we may be subject to monetary penalties and other sanctions if it is determined by the State that we have requested disenrollment for any of these prohibited reasons.

B.2: Choice of Doctor

B.2.01: Rural Residential Exceptions

MCNA understands and acknowledges that the Agency does not operate a rural residential exception for members enrolled in the DWP or the Hawki programs.

B.2.02: Free Choice of Provider

MCNA provides proactive education to our Iowa members on the importance of proper dental care and assists them with selecting a Primary Dental Provider (PDP). We inform members of their right to choose their own PDP. [redacted]

Our written policies and procedures document the processes for member selection of a PDP and auto-assignment. [redacted] hen a member selects or changes their PDP, we follow up by sending a letter and member ID card within two business days after selection to confirm their choice.

B.2.03: Member Choice

MCNA is committed to supporting member choice wherever possible, regardless of variations in reimbursement. If a member enrolls with MCNA and has a pre-existing relationship with a non-network provider, we will reach out to the provider first and make every reasonable effort to have the provider join the MCNA network, meeting the same qualifications as other network providers. If the provider declines to join, or if a member's PDP leaves MCNA's network, we send the member a letter notifying them of the change and providing them with information about selecting a new PDP.

B.3: Opt Out

B.3.01: Mandatory Enrollment

MCNA understands that the Agency may add delete, or otherwise change mandatory, voluntary opt-out, voluntary opt-in, and excluded population groups and amend the Contract as necessary. We agree to comply and coordinate with the Agency to ensure all eligible populations are covered when changes are made, and the contract is amended.

MCNA currently receives, processes, and updates the daily member enrollment file from the State using our powerful, fully integrated management information system, DentalTrac™. Once eligibility information is processed and available in our system, it is automatically available to providers for immediate verification of eligibility using one of several methods. Member eligibility verification resources for providers include:

- Free Online Provider Portal, available 24/7/365
- MCNA's Call Center
- MCNA's 24/7 automated eligibility Interactive Voice Response (IVR) system

We currently receive a full member enrollment file from the State on a monthly basis and use it to complete the reconciliation process with the member data housed within DentalTrac™'s Eligibility and Enrollment module. MCNA notifies the Agency in the event that any data inconsistencies are identified in the full member enrollment file.

B.4: Reenrollment

B.4.01: Auto-Reenrollment

MCNA understands and acknowledges that the Agency will reenroll members in the same dental plan they had prior to losing eligibility when the eligibility loss period is 2 months or less. We support the Agency in this effort to provide members with as little disruption in care as possible.

B.4.02: Auto Assignment

Further, we confirm that the Agency will auto-assign members who do not select a dental plan using their auto-assignment algorithm, which is designed to maintain existing member and provider relationships.

Like the Agency's algorithm, MCNA strives to maintain the member-provider relationship in our PDP assignment workflow. We assign every member to a PDP. If a member does not select a PDP, or when a member selects a PDP that has restrictions or limitations, we assign one in accordance with our State-approved automatic assignment methodology using our DentalTrac™ system. [redacted] Upon auto-assignment of a PDP, we send a letter and member ID card to the member informing them of their assigned PDP's contact information within seven business days. The letter also describes the member's ability to change their PDP at any time.

B.5: Disenrollment

MCNA is committed to ensuring all Iowa Medicaid members have full access to covered services for the duration that they are enrolled with us. We partner with social and civic groups, resident associations, and other community-based organizations to proactively outreach to our members and offer them information about and assistance with accessing dental care and services. Our approach to outreach is designed to connect with members in a positive manner to increase their satisfaction with the plan and reduce the occurrence of voluntary disenrollment requests. If a member is disenrolled from MCNA, we continue to provide covered services and all other services required under the Contract to that member up to 12:00 a.m. of the day after the effective date of disenrollment.

MCNA will continue to provide covered services to the member until the member is disenrolled by the enrollment broker. MCNA will work with the State and its enrollment broker to reconcile enrollment and/or disenrollment issues at the end of each month utilizing an agreed-upon procedure.

The integrated capabilities of our proprietary management information system, DentalTrac™, allow MCNA to effortlessly process all enrollment files received from the State's enrollment broker. We currently receive daily electronic media updates on beneficiaries newly enrolled in our plan in the format specified in the Systems Companion Guide. We maintain written policies and procedures for receiving these updates, incorporating them into DentalTrac™, and ensuring this information is available to our network providers. All policies and procedures are available as part of the readiness review process.

B.5.01: Contractor-Requested Disenrollment

We also understand and acknowledge that MCNA may request involuntary disenrollment of a member only for reasons specified in the contract, such as if his or her utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning their member ID card to another person to obtain services.

B.5.02: Prohibited Disenrollment Requests

MCNA will not request disenrollment because of an adverse change in physical or mental health status or because of the member's health diagnosis, utilization of medical services, diminished mental capacity, preexisting medical condition, refusal of medical care or diagnostic testing, attempt to exercise his or her rights under MCNA's grievance system, or attempt to exercise his or her right to change, for cause, the primary care provider that he or she has chosen or been assigned. MCNA will not request disenrollment because of a member's uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment seriously impairs our ability to furnish services to that member or another member.

B.5.03: Reasonable Steps Requirement

In such case that MCNA requests the involuntary disenrollment of a member under the circumstances allowed by contract, we will report the event to the State and the Medicaid Fraud Control Unit and will submit the disenrollment request to the enrollment broker in the format and manner to be determined by the State. All involuntary disenrollment documents will be maintained within the member's record in DentalTrac™. MCNA will document all education and support efforts to help the member understand proper behavior and will document the member's refusal to comply.

B. 5.04: Contractor Assurances

MCNA assures the Agency that it will not request disenrollment for any reasons other than those allowed under the DWP and Hawki contract.

B.5.05: Enrolled Member Rights – Timing

We understand and acknowledge that a member has the right to disenroll from MCNA for cause at any time. We understand and acknowledge that a member may request disenrollment from MCNA without cause only under the circumstances stated in the contract, including:

- 90 days after initial enrollment or during the 90 days following enrollment notification, whichever is later
- At least once every 12 months
- Upon reenrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period

MCNA understands the Agency makes all final determinations regarding enrollment and disenrollment.

B.5.07: Other Disenrollment Rights

MCNA's service area covers the entire state of Iowa and there are no covered services that MCNA does not cover because of moral or religious objections. A member may request disenrollment if they move out of the service area.

B.5.08: Enrolled Member Disenrollment – Related Services

If a member needs related services not available within the MCNA network, and the member's PDP or another MCNA provider determines that to receive the related services at a separate point in time would put the member at unnecessary risk, the member may be eligible for disenrollment.

B.5.10: Enrolled Member Disenrollment – Other Reasons

In addition to related services, reasons members may request disenrollment include, but are not limited to: poor quality of care, lack of access to covered services, or no access to providers experienced in the member's care needs.

B.5.11: Agency Initiated Disenrollment Requirements

When the State approves a request for involuntary disenrollment, MCNA will notify the member in writing in a notice that includes:

- The reason for the disenrollment;
- The effective date;
- An instruction that the member choose a new PAHP; and
- A statement that if the member disagrees with the decision to disenroll, the member has a right to submit a request for a State Fair Hearing.

B.6: Disenrollment Request Process

B.6.01: Oral or Written Requests

MCNA strives to work in partnership with all members and support their needs but acknowledges that a member may seek disenrollment. We educate members on the various ways to raise and address their concerns with MCNA, however, we understand that members may request disenrollment for a variety of reasons, and we respect their right to choose. We follow the Agency's policies and procedures for disenrollment, including enabling the member to provide written or oral requests through our grievance and appeals process and accepting the Agency's disenrollment decisions, including effective date.

B.6.02: Agency Disenrollment Decisions

If the member remains dissatisfied with the result of the MCNA grievance and appeals process, MCNA will direct the member to contact the Agency and request disenrollment. MCNA understands:

- The Agency will process and make a determination regarding all member disenrollment requests following completion of the grievance and appeals process.
- The effective date of an approved disenrollment will be no later than the first day of the second month following the month in which the member requests disenrollment or MCNA refers the request to the State.

- If the Agency fails to make a disenrollment determination within the specified time frame, the disenrollment is considered approved for the effective date that would have been established had the State made a determination in the specified timeframe.

B.6.03: Effective Date

In cases of member disenrollment, we understand that the State makes the determination of disenrollment as requested by the enrolled member and that the effective date of disenrollment will be no later than the first day of the second month after completion of our grievance process.

B.6.04: Deemed Approval

In the instance that the State does not provide a decision to MCNA within these timeframes, we accept the State's deemed approval. We acknowledge understanding and will adhere to this requirement.

B.7: Special Rules for American Indians

B.7.01: Restricting Enrollment of Indians

MCNA is not an Indian managed care entity, and as such will not restrict enrollment of those who identify as American Indian/Alaska Native (AI/AN) in the same manner as federal Indian health programs may restrict the delivery of services to this population.

B.7.02: IHCP PDPs

Enrolled members that self-identify as AI/AN for Medicaid, may enroll in the DWP program and continue receiving services and care with local Indian Health Services, tribes, tribal organizations, or urban Indian organizations. These providers can receive reimbursement for care at a negotiated rate that is no less than the reimbursement to a network provider for the same or similar care. MCNA understands that AI/AN are exempt from Medicaid premiums, enrollment fees, cost-sharing, and out-of-pocket expenses-in the Hawki program, and additional protections including the estate recovery requirements.

MCNA ensures any American Indian enrolled with us is permitted to select an IHCP as their PDP. MCNA understands this requirement and agrees to administer it accordingly. In addition, we believe it is critical for providers to have the knowledge, resources, and tools to offer culturally competent care to our diverse members, including AI/AN. Therefore, we provide cultural competency training for all network providers – upon joining our network, ongoing, and annually.

Section C: Beneficiary Notification

Since 2016, MCNA has been educating Iowans about the importance of achieving and maintaining good oral health, and the valuable benefits available to them in the State's dental program. We will continue to fulfill our commitment to Iowa Dental Wellness Plan (DWP) members and will extend it to Healthy and Well Kids in Iowa (Hawki) members by creating, producing, and distributing accurate and easy-to-understand educational materials. We recognize that every interaction with an MCNA member is an opportunity to share educational information about dental health and self-care and encourage them to improve their oral health and general wellbeing.

MCNA has read, understands, and will comply with Iowa DWP and Hawki Dental PAHP RFP# MED-24-004. In our response below, we address key requirements from RFP Attachment F: Contract and Scope of Work Section C Beneficiary Information C.1-C.11.

C.1: Language and Format

C.1.01: Information Easily Understood

[redacted]

These strategies educate members, their guardians, or authorized representatives about coordination of care, covered benefits and limitations, and how to access specialty dental services.

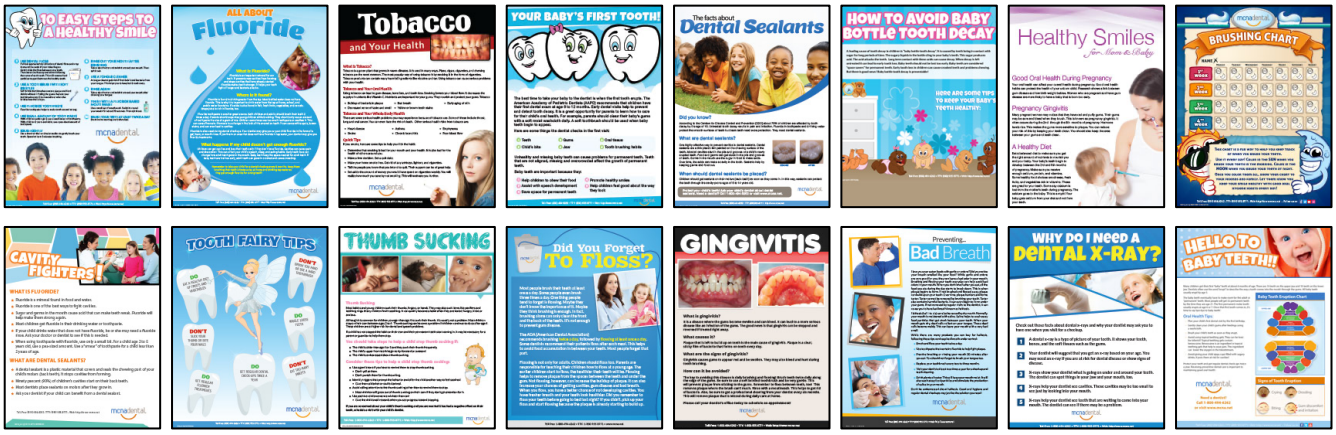
Recognizing that modes of learning differ among members, our methods are designed to be responsive to various needs, preferences, and ages with both general and targeted education campaigns. MCNA strives to ensure all member materials are consistent in style, language, and format, and are written using plain language that is focused on the essential information members need to understand.

All written materials for members and potential members are composed for ease of understanding (at or below a sixth grade reading level based on the Flesch Kincaid grade level calculation formula) and translated into Spanish. Upon request and as required by state or federal law, MCNA will prepare written member materials in any other languages spoken by 5% or more of the member population, or as required. We make written material available through auxiliary aids and services that take into consideration the special needs of members and potential members with disabilities or limited English proficiency (LEP) and inform them about our toll-free and TTY/TDY phone numbers should they need assistance accessing information in the written materials.

Oral Health Education Flyers

[redacted]

[redacted]



[redacted]

Information for potential members and their authorized representatives is developed by our Marketing Department and complies with all Agency, State, and federal requirements (see C.7 and C.10).

C.1.02: Information for Potential Enrolled Members

MCNA will treat all information requests from the Agency and its contracted affiliates for the development of information for potential members with the highest priority while adhering to our process standards and utilizing Agency-approved terminology in our printed and online communications.

C.1.03: New Member Communications

MCNA provides proactive education to members on the importance of proper dental care and assists them with selecting a Primary Dental Provider (PDP). [redacted]

[redacted] Members are notified of their right to request and receive the Welcome Packet at least once a year and that they will receive notification of any change that the Agency deems significant.

[redacted]

[redacted]

To ensure our members, their authorized representatives, their families, and the general public have access to resources and educational materials on our plan and DWP and Hawki PAHP benefits, our public website includes downloadable versions of our member handbooks; a searchable and printable Provider Directory; policies and procedures; and other helpful forms, tools, and resources with no login required.

Information provided to new enrolled members includes:

- MCNA's contact information, including address, telephone number, and Iowa-specific website (www.mcnaia.net)
- MCNA's office hours/days, including the availability of the fully integrated, toll-free Member Hotline and after-hours Hygienist Helpline
- Oral health risk assessment process
- Cost-sharing information and options for members to obtain additional information regarding cost-sharing obligations
- Procedures for obtaining out-of-network services and any special benefit provisions
- Information about standards and expectations for members for receiving preventive dental services (e.g., timely dental exams, sealants, fluoride applications)
- Criteria and procedures for changing health plans
- Grievances and appeals procedures and processes for recommending changes in policies and services
- Contact information for the Iowa Medicaid Enrollment Broker
- Alternative methods or formats of communication for members with visual and hearing impairments and non-English speaking members and how members can access accommodations at no expense
- Reporting suspected abuse and neglect, including the contact information (e.g., Agency Abuse Hotline at 1-800-362-2178)
- Role of the Office of the Ombudsman in the Iowa Legislature and contact information (e.g., phone, email, or fax)

Member Welcome Packets

MCNA's experience in Iowa and the other states we serve underscores our understanding of the importance of educating new members. Our Welcome Packet is mailed to new members within 7 business days after receipt of the enrollment file. [redacted] The packets include:

- Notification of enrollment
- ID cards, which are also made available via our Member Portal
- Informative, easy-to-understand, current Member Handbook detailing the information listed above
- Adult members receive a QR code to access the PreViser tool to complete their oral health risk assessment

MCNA will collaborate with the Agency as needed to ensure that the Oral Health Equity Self-Assessment Tool is distributed and completed by members per contractual requirements.

The Member Handbook, Provider Directory, and a searchable real-time Provider Directory are also available online via MCNA's dedicated Iowa website at www.mcnaia.net. [redacted] We are committed to ongoing and regular education, which includes distributing educational materials on preventive care, health promotion, access to care, and other relevant issues in dental care at least two times each year.

C.1.04: Health Education and Initiatives

[redacted] Our well-publicized DWP website provides members with 24x7 access to resources such as our Member Handbook, frequently asked questions, and plan contact information.

Member Portal

MCNA's online Member Portal is a direct link connecting our members to current program information, educational materials, and accurate data about their oral health. Our Member Portal has been designed to simplify complex information in order to enhance member understanding of their dental plan and benefits and help them make well-informed decisions about their dental care. It also provides the most current information about the DWP dental program and MCNA. As a cloud-based software solution, the Member Portal is fully interactive and available using a computer or mobile device, 24x7x365, and displays on all popular browsers. MCNA's easy-to-use Member Portal allows members to:

- Manage their profile
- See a list of most recent claims and check the status of each
- Check status of prior authorizations
- View covered benefits and copays
- Check eligibility
- Manage preferences for alerts, reminders, and e-mail subscription
- Search for in-network dentists
- See information about their assigned PDP
- Access the most recent version of the Member Handbook
- View information about filing grievances and appeals
- See a list of frequently asked questions and helpful answers
- Read and watch educational materials and videos on oral health
- Play oral health-themed games and puzzles Receive personalized oral health tips and Care Gap Alert reminders for Iowa Care for Kids program
- Request to speak with an MSR

Member Newsletter

MCNA produces member newsletters designed around seasonal topics of interest. Our *Tooth Tribune* is distributed via hard copy mailings, social media, and published on our member website. In the newsletter, we provide members with up-to-date information on maintaining good oral hygiene and health. We will offer Iowa-specific information relevant to the DWP, Hawki, and Care for Kids programs, as well as to relevant social resources and supports that impact oral health.

Member Advocate Outreach Specialists and Community Events

[redacted]

[redacted]

MCNA has organized and sponsored health fairs across the states we serve to provide community members with vital healthcare information and services. At MCNA, we not only focus on dental, but also on total body wellness. The health fairs we participate in, and sponsor include free services such as:

- Screenings (vision, dental, and hearing)
- Vouchers for free exams (mammograms, Well-Woman Checkups, and colonoscopies)
- Educational Information about community supports (food and diaper banks)

During outreach events, MCNA's MAOS conduct the following educational activities:

- Discuss techniques to help maintain good oral hygiene and encourage members to receive preventive services such as dental sealants and fluoride.
- Discuss the importance of having a PDP to provide treatment at an early age and encourage regular dental visits.
- Utilize age appropriate "hands-on" activities to teach children the proper way to brush and floss their teeth.
- Provide participants with dental kits that include a toothbrush, toothpaste, and dental floss, as well as informational flyers, water bottles, backpacks, hand sanitizer, and pencils.
- Provide information about Non-Emergency Medical Transportation (NEMT) for Medicaid members.
- Share information with participants about other organizations that provide services for little or no cost.

[redacted]

MCNA understands that we must conduct regularly scheduled and targeted outreach and education activities for all covered members. We work to proactively identify relevant community issues and the health promotion and education needs of our members and implement plans that are culturally appropriate to meet those identified needs. We have pioneered several innovative initiatives designed to improve the overall oral health literacy of our members and target populations who have historically underutilized preventive services such as timely dental exams, sealants, and fluoride applications. All of our education efforts are conducted with utmost respect for member privacy in an orderly, non-disruptive manner.

[redacted]

C.1.05: Cost and Quality Information

[redacted]

C.1.06: Explanation of Benefits

Explanation of Benefits (EOBs) provide members with information about the services they received and costs. MCNA will provide DWP and Hawki members with EOB statements in accordance with requirements in 42 C.F.R. § 433.116(e) and (f). EOBs are made available in the required format and with required information to all members through our Member Portal or mailed to members if that is their communication preference.

C.1.07: Quality Information

[redacted]

[redacted]

MCNA will make available quality information about its network providers to members based on their preferred mode of communications including, but not limited to, electronic communication, website, and paper copies and in English and Spanish.

C.1.08: Mechanisms to Aid Understanding

In addition to electronic and print materials available in various easy to access and understand formats, our members have the option to review plan requirements and benefits and obtain verbal answers to their questions by contacting one of our qualified MSRs. [redacted]

All of our education efforts are conducted with utmost respect for member privacy in an orderly, non-disruptive manner. MCNA will provide members with at least 30 days' advance written notice of significant changes as defined by the Agency prior to implementation of the change.

C.1.09: Implementation Support

MCNA will ensure widespread publication of options and processes for members to obtain information and submit inquiries about program implementation, including options for contacting the Office of the Ombudsman in the Iowa Legislature and MCNA's fully integrated, toll-free Member Hotline. We have delivered quality services for the DWP program since 2016. Upon expanding service delivery to the Hawki population, we will employ these same best practices to ensure that these members can obtain support and ask questions during program implementation.

C.1.10: Integration of Service Lines

MCNA operates one fully integrated, toll-free Member Hotline based in San Antonio, Texas, and Fort Lauderdale, Florida, to assist DWP members with any questions related to the DWP and Hawki programs. Our highly responsive MSRs assist our members during normal business hours from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday, excluding state-approved holidays. For after-hours calls, including weekends and state-approved holidays, our members can access MCNA's toll-free, Interactive Voice Response (IVR) system. The IVR system informs callers of our operating hours and what to do in case of a dental emergency, and it also allows callers to leave messages. Our staff monitors the message queues and returns all calls by close of business the following day. We will not have separate Member Hotline numbers for DWP and Hawki membership. All members, regardless of program enrollment, will use the same Hotline number to reach MCNA and address their needs.

C.1.11: Member Services Helpline

MCNA operates a fully integrated, toll-free Member Hotline based in San Antonio, Texas, and Fort Lauderdale, Florida, to assist members with any questions related to the DWP. Our highly responsive MSRs assist our members during normal business hours from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday, excluding state-approved holidays.

For after-hours calls, including weekends and state-approved holidays, our members can access MCNA's toll-free, IVR system. The IVR system answers calls within one ring and offers a series of prompts to ensure calls are routed correctly.

[redacted]

The IVR system informs callers of our operating hours and what to do in case of a dental emergency, and it also allows callers to leave messages. Our staff monitors the message queues and returns all calls by close of business the following day.

Our MSRs assist our members with issues including:

- Receiving benefit information and dental benefit program policies and procedures
- Inquiring about prior-authorizations, referrals, or claims
- Identifying how to access services and providers such as provider location
- Choosing a primary dental provider or specialist
- Submitting and resolving complaints, grievances, or appeals
- Receiving benefits information

[redacted]

A TTY/TDD line is also available for members who are deaf, hard of hearing, or speech impaired. [redacted]

Monitoring Call Quality and the Accuracy of Information

At MCNA, we understand that call handling has a significant impact on customer satisfaction. We strive to increase member and provider satisfaction by promptly responding to calls and providing a pleasant and informative interaction. Our MSRs are thoroughly trained on dental benefits, policies and procedures, customer service, issue resolution, and call handling skills. Our system records all member and provider calls for quality assurance purposes.

[redacted]

[redacted]

To track performance and trends, MCNA collects call center data on an ongoing basis and analyzes it monthly to ensure services are provided accurately and timely, assess staffing level adequacy, identify trends and variations in call volumes to inform staffing schedules, and identify opportunities for improvement. [redacted] We will submit our Hotline policies and procedures and performance standards, as well as hold time messages and call handling scripts, to Agency for approval prior to implementation.

MCNA employs multiple mechanisms to gather member feedback on quality, availability, and accessibility of care. [redacted]

C.1.12: Member Services Helpline Performance Metric

Call Center Staffing and Performance

[redacted] Our MSRs are at the forefront of our commitment to ensure that all our members receive accurate and timely information needed to access dental care and are responsible for answering all inbound calls from MCNA's members.

[redacted] We acknowledge that Agency reserves the right to require specific staffing ratios should performance issues occur. [redacted]

Monitoring and Ensuring Adherence to Performance Standards

[redacted]

[redacted]

C.1.13: Availability for All Callers

[redacted] Members can reach MCNA via a dedicated toll-free Member Hotline from 7:00 am to 7:00 pm Central Time, Monday through Friday, excluding Iowa state holidays. [redacted]

A TTY/TDD line is also available for members who are deaf, hard of hearing, or speech impaired. [redacted]

C.1.14: Helpline Staff and Knowledge

[redacted]

MSRs answering member calls are trained and equipped to efficiently respond to member concerns including but not limited to:

- How to access dental health care services and dentists accepting new members who provide those services
- Identification or explanation of covered services
- Procedures for submitting a Grievance or Appeal
- Reporting fraud or abuse
- Locating a provider or specialist
- Dental health crises
- Balance billing issues
- Cost-sharing inquiries
- Selecting and changing a PDP
- Identifying how to access services and providers such as provider location
- Incentive programs
- Receiving benefit information and dental benefit program policies and procedures
- Inquiring about prior authorizations, referrals, and claims,
- Providing service authorization decisions

- Providing general information about the program in response to inquiries
- Accurately responding to questions regarding covered services
- Assisting with billing issues
- Handling member/provider inquiries, grievances, appeals, and requests for reconsideration

Staff Education and Training

[redacted]

MCNA's comprehensive training program sets a solid foundation for success for our staff. [redacted]

[redacted]

Cultural Competency

[redacted]

[redacted]

C.1.15: Backup System

[redacted] MCNA currently provides data backup in accordance with RFP requirements, and our backup policy and procedures. We currently provide, and will continue to provide, the Agency with a list of all backup files, in what locations they are housed, and how frequently these files are updated.

[redacted]

C.1.16: Tracking and Reporting

[redacted] Our MSRs assist our members with issues including:

- Receiving benefit information and dental benefit program policies and procedures
- Inquiring about prior authorizations, referrals, and claims,
- Identifying how to access services and providers such as provider location
- Choosing a PDP or specialist
- Submitting and resolving complaints, grievances, or appeals
- Providing service authorization decisions
- Providing technical and clinical support functions for providers and members who request assistance on how to complete the functions described under this RFP
- Providing general information about the program in response to inquiries
- Assisting members with locating a participating dental provider
- Accurately responding to questions regarding covered services
- Assisting with billing issues
- Handling member/provider inquiries, grievances, appeals, and requests for reconsideration

[redacted]

[redacted] As described here and in C.1.11-C.1.12, MCNA will monitor its Member Hotline and report its telephone service level performance to the Agency in the timeframes and according to the specifications described in the Reporting Manual.

C.1.17: Dental Call Line

[redacted]

C.1.18: Redetermination Assistance

MCNA provides redetermination assistance to all members, referring all questions and calls to the Agency's Enrollment Broker. MCNA confirms that we do not engage in any of the following activities when assisting the member:

- Discriminate against members, including particularly high-cost members or members that have indicated a desire to change dental PAHP plans
- Talk to members about changing dental PAHP plans
- Provide any indication as to whether the member will be eligible, as this decision is at the sole discretion of the Agency
- Engage in or support fraudulent activity in association with helping the member complete the redetermination process
- Sign the member's redetermination form
- Complete or send redetermination materials to the Agency on behalf of the member

C.1.19: Prevalent Non-English Languages

We make every effort to inform and assist our members with written materials that are critical to obtaining services. MCNA educates our members via the Member Handbooks, Appeal and Grievance Notices, and denial and termination notices, and any other materials as required by State or federal law, regulation, and guidance.

Our Member Handbook details the entire process, including the applicable timeframes for filing member grievances and appeals and for MCNA to respond, availability of member assistance with filing, members rights including their right to a State Fair Hearing in the case of an adverse determination. The Member Handbook and all written notifications are provided in the member's primary language and are written to ensure ease of understanding. The handbook is also available in alternative formats such as Braille, audio, and large print upon request.

We provide additional resources for members with disabilities and those requiring linguistic and translation services by utilizing the following:

- Toll free numbers that have TTY/TDD line capability for hearing impaired members
- MSRs who speak English, Spanish, and other prevalent non-English languages
- Free translation services available in over 200 languages
- Large print or Braille materials for members with impaired sight
- Additional accommodations for members with special health care needs

All member materials will be translated into other prevalent languages as needed.

C.1.20: Formats and Taglines

Leveraging our robust multilingual staff resources, we promote our translation and interpretation resources through taglines in printed materials. Website users may easily select the appropriate tab at the top of the home page to choose the language they wish to view. A TTY/TDD line is also available for members who are deaf, hard of hearing, or speech impaired. Auxiliary aids such as American Sign Language and other services are also provided at the member's request.

MCNA's written materials will:

- Be available in alternative formats upon request of the potential member or member at no cost
- Include taglines in the prevalent non-English languages in the State, and in a conspicuously visible font size, explaining the availability of written translation or oral interpretation to understand the information provided
- Include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size that provide information on how to request auxiliary aids and services
- Include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size that provide the toll-free and TTY/TDY telephone number of the MCNA Member Services Hotline

C.1.21: Language Requirements

[redacted] We have multiple processes in place to ensure that only the most accurate and up-to-date information is available. [redacted]

[redacted] All written member materials are composed for ease of understanding (at or below a sixth-grade reading level based on the Flesch Kincaid grade level calculation formula) and translated into Spanish. Upon request and as required by state or federal law, MCNA will prepare written member materials in any other languages spoken by 5% or more of the member population, or as required in any of our service areas.

Please see below our Agency-approved "Healthy Smile for Life" reminder postcard to our DWP members about the importance of seeing their dentist on a regular basis as an example of our ongoing bilingual Iowa mailings.

Sample Member Outreach Postcard

C.1.22: Auxiliary Aids & Services

MCNA makes auxiliary aids and services available to members and their authorized representatives upon request. Auxiliary aids such as American Sign Language, materials in large print or Braille materials for members with impaired sight and other services are also provided at the request of the member. Members who are unable to push telephone buttons are prompted to remain on the line while the call is routed to an MSR. This rich set of translation resources allow us to make oral interpretation services available as needed to assist members in understanding member materials or to facilitate an appointment with a provider.

C.1.23: Interpretive Services

MSRs include individuals who speak a variety of languages including English, Spanish, Haitian Creole, French Creole, Vietnamese, and French. Any languages not spoken by our help line staff are quickly made available through a three-party call with our new translation vendor, Translations.com, for real-time interpretation for members and providers. With this new service, members and providers do not need to arrange for interpretation ahead of their appointments; instead, we offer immediate interpretation when and where they need it. Translations.com has a network of over 5,000 native speakers who are accredited by translation and interpretation industry organizations such as the Institute of Translation and Interpreting and the American Translators Association. This translation service is free to MCNA members and providers.

A TTY/TDD line is also available for members who are deaf, hard of hearing, or speech impaired. Auxiliary aids and services such as American Sign Language interpretation and other services are also provided at the request of the member. Members who are unable to push telephone buttons are prompted to remain on the line while the call is routed to an MSR. This rich set of translation resources allow us to make oral interpretation services available as needed to assist members in understanding member materials or to facilitate an appointment with a provider.

C.1.24: Notifications of Translations and Aids

MCNA will continue to notify members via our member materials, including the Member Handbook, MCNA Website, Member Portal about the translation and aids we offer them, including:

- Oral interpretation is available for any language, and how to access those services.
- Written translation is available in prevalent languages, and how to access those services.
- Auxiliary aids and services are available upon request at no cost for members with disabilities, and how to access those services.

C.1.25: Easily Understood Standard

MCNA agrees to provide all written materials for potential members and enrolled members in an easily understood language and format.

C.1.26: Patient Language Preference

MCNA will continue to utilize information, such as primary language details provided by the Agency to ensure communication materials are distributed in the language appropriate and preferred by the member and their authorized representatives.

C.1.27: Written Materials Formatting

Our dedicated Creative Services Department develops culturally and linguistically appropriate materials to accommodate each of the enrolled target populations. These educational materials are available to our DWP members in readable, easy-to-understand formats. A description of how to access materials in alternative formats and the availability of oral/written interpretation is featured in MCNA's Member Handbook and on our Iowa Member Website.

MCNA currently and will continue to:

- Provide all written materials for potential members and enrolled members in a font size no smaller than 12 point
- Make written materials for potential members and enrolled members available in alternative formats in an appropriate manner that takes into consideration the special needs of potential members and enrolled members with disabilities or LEP
- Make written materials for potential members and enrolled members available through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of potential members and enrolled members with disabilities or LEP

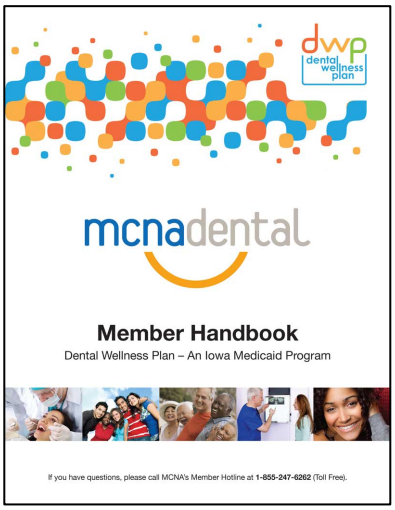
C.2: Member Handbook

C.2.01: State-Developed Handbook

MCNA maintains and distributes a Member Handbook to our current DWP members that adheres to the requirements in 42 C.F.R. § 438.10(c)(4)(ii) and state-developed model Enrolled Member handbook. In similar fashion, we will develop, maintain, and distribute a Member Handbook for the Hawki program upon award of this contract. Prior to disseminating the handbook to our members, we will conduct a quality check and ensure that all materials are consistent with the Contract and State and federal requirements prior to submitting materials for review and approval by the Agency.

C.2.02: Obligation to Provide Handbook

We recognize our obligation to provide members and their authorized representatives with the MCNA Member Handbook specific to the Iowa dental program in which they are enrolled. MCNA will provide each member and their authorized representative a Member Handbook, which serves as a summary of benefits and coverage, within a reasonable time after receiving notice of their enrollment.



MCNA acknowledges each newly enrolled or re-enrolled member after receipt of the member enrollment file from Agency and provides each member with all required materials, including our printed Member Handbook, as part of our comprehensive Welcome Packet.

Member Welcome Packets

MCNA's experience in Iowa and the other states we serve underscores our understanding of the importance of educating new members. Our Welcome Packet is mailed to new members within 7 business days after receipt of the enrollment file. The packets include the following information:

- MCNA's contact information, including address, telephone number, web site
- MCNA's office hours/days, including the availability of our Member Hotline and After-Hours Hotline
- A description of how to complete an initial oral health risk assessment
- If applicable, any cost-sharing information, and contact information where the member can ask questions regarding their cost-sharing obligations
- Procedures for obtaining out-of-network services and any special benefit provisions (for example, co-payments, limits or rejections of claims) that may apply to services obtained outside the MCNA network
- Standards and expectations for receiving preventive dental services
- Procedures for changing contractors and circumstances under which this is possible
- Procedures for making complaints and recommending changes in policies and services
- Information on how to contact the Iowa Medicaid Enrollment Broker
- Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking embers and how members can access those methods or formats at no expense
- Information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect
- Contact information and description of the role of the Ombudsman

MCNA ensures that all new member materials will be reviewed and approved by the Agency prior to distribution.

C.2.03: Content of Handbook

MCNA's Member Handbook is the cornerstone of our Welcome Packet and contains easy-to-understand program information designed to break down barriers in oral health literacy for our members. The Member Handbook helps our members understand medically necessary covered dental services, the importance of a primary care dental home, and how to effectively use the program to meet their needs.

C.2.04: Information Requirements in Handbook

MCNA will continue to utilize the model Member Handbook, developed by the State, that includes information:

The MCNA DWP Member Handbook includes the following required information:

- Welcome, including important contact information and ID cards

- Covered benefits and services including benefits, services not covered, annual benefit maximum, and Iowa Care for Kids EPSDT benefits and how to access them
- Going to the dentist including freedom of choice in selecting and changing a dentist, going to the dentist, and prior authorizations
- How and where to access any benefits provided by the State, including Care for Kids benefits delivered outside of MCNA such as care coordination through the I-Smiles program or transportation services
- Payment for services, including information on cost sharing on any benefits provided by the State
- Emergency services, including after-hours services
- Grievance, appeal, and State Fair Hearing procedures and timeframes
- Members' Rights and Responsibilities, including how to access auxiliary aids and services including information in alternative formats and languages
- Fraud, Waste, and Abuse reporting process
- Notice of Privacy Practices
- Glossary of Terms

C.2.05: Information Requirements – Moral or Religious Objections

MCNA is not opposed to providing any services because of an objection on moral or religious grounds. Our Member Handbook is based on the State Model Enrollee Member Handbook and includes required details about counselling and referral services. We acknowledge some providers may not perform certain services based on religious and moral beliefs. In those cases, MCNA will arrange for the appropriate services with another network provider based on member needs.

C.2.06: Amount, Duration & Scope

Per Contract, MCNA utilizes our DWP Member Handbook to provide members with information regarding:

- The amount, duration, and scope of benefits available and to which they are entitled.
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care.

C.2.07: After-Hours Care

MCNA ensures members receive the right care, in the right place, at the right time. We understand that emergency department use for non-traumatic dental care is a core focus area for states looking to control cost and increase dental care utilization in appropriate settings. Our written policies and procedures describe how members can obtain urgent coverage and emergency services after business hours and on weekends, including the provision of direct contact with qualified dental professionals.

Members are educated about after-hours access to care through the MCNA Member Handbook. Our Member Handbook thoroughly describes the extent to which, and how, after-hours care is provided. MCNA's toll-free Member and Provider Hotlines are available 24 hours a day, 7 days a week, and staffed Monday through Friday between the hours of 7:00 a.m. to 7:00 p.m. Central Time, excluding State holidays. For after-hours calls, MCNA's IVR system answers calls within one ring and offers a series of prompts in the essential languages of the markets we serve to ensure calls are routed correctly. The IVR informs callers of our operating hours and what to do in cases of a dental emergency or natural disaster and allows callers to leave messages. Our staff monitors the message queue and returns all calls within one business day of receipt.

Our goal is to ensure the dental office setting is used for all non-trauma related dental services, and that the emergency department is a last resort for our members. We monitor member utilization of emergency dental services to ensure members have properly addressed their chief concern.

C.2.08: Emergency Care Information

In accordance with Section 1852(d)(2) of the Act and 42 C.F.R. §§ 438.114(b), 422.113(c), 438.114(d), and 438.114(e), MCNA will cover and pay for emergency and post-stabilization care services. While MCNA aims to reduce potentially preventable emergency department visits through the provision of timely and high-quality preventive care, we understand that emergencies may occur. We ensure that our members have access to emergency care without the need to obtain prior authorization and can receive services through any emergency facility or provider, regardless of whether the facility is in or out-of-network.

The Member Handbook defines what constitutes an emergency dental condition and outlines covered emergency dental services, i.e.,

- Problem-focused exams
- Pulp vitality test
- Tooth removal/oral surgery
- Tooth reimplantation/stabilization
- Biopsy
- Surgical incision and drainage
- Anesthesia
- Palliative treatment
- Periapical/panoramic x-ray
- Pulpal debridement and pulpotomy
- Office after regularly scheduled hours

[redacted]

C.2.09: Information Requirements – Restrictions

MCNA will continue to utilize the model Member Handbook developed by the State that complies with any restrictions on the member's freedom of choice among providers.

C.2.11: Information Requirements – Cost Sharing

To ensure compliance with State requirements regarding cost-sharing, MCNA will utilize the model Enrolled Member handbook developed by the State and include pertinent information in our Member Handbook. We make it easy for network providers to be informed of any cost sharing requirements. [redacted]

C.2.12: Information Requirements – Enrolled Member Rights and Responsibilities

Based on the model Enrolled Member Handbook, MCNA includes information about member rights and responsibilities, including members' right to:

- Receive information on beneficiary and plan information.
- Be treated with respect and with due consideration for his or her dignity and privacy.

- Receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of their medical records at no cost and request that they be amended or corrected.

Our Member Handbook states these and additional **Member Rights** as follows:

- To be treated with respect and with due consideration for your dignity and privacy
- To be able to request and receive a copy of your medical records (one copy free of charge) and to request that they be amended or corrected
- To be free from any form of restraint or seclusion used as a mean of coercion, discipline, convenience, or retaliation, as specified in the federal regulations on the use of restraints and seclusion
- To receive care regardless of race, color, nationality, disability, sex, religion, or age
- To get accurate, easy-to-understand information to help make good choices about a dentist and other providers
- To receive information on grievance, appeal, and State Fair Hearing procedures
- To know how MCNA decides about whether a service is covered and/ or medically necessary
- To know about the people in MCNA's office who decide those things
- To know the names of the dentists and other providers enrolled with MCNA and their addresses
- To pick from a list of dentists that is large enough so that members can get the right kind of care when needed
- To take part in all the choices about dental care, including the right to refuse treatment
- To get information on all treatment options and alternatives
- To speak for themselves in all treatment choices
- To get a second opinion from another dentist enrolled with MCNA about what kind of treatment is needed
- To be treated fairly by MCNA, dentists, and other providers.
- To talk to dentists and other providers in private, and to have dental records kept private
- To look over and copy personal dental records and to ask for changes to those records.
- To know that dentists, hospitals, and others can advise you about health status, medical care, and treatment.
- To know that they are not responsible for paying for covered services.
- To receive information in other forms (Spanish, Braille, larger font, etc.)
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To get information on the managed care program and plan
- To recommend changes in policies and services under the DWP

Member Responsibilities are stated in the Member Handbook as follows:

- Must present own MCNA issued DWP member ID card when getting services from dentist.
- Must try to follow healthy habits, such as exercising, staying away from tobacco, and eating a healthy diet
- Must become involved in the dentist's decisions about treatments
- Must work together with MCNA's dentists and other providers to pick treatments for that member and providers have all agreed upon
- If there is a disagreement with MCNA must try first to resolve the disagreement using MCNA's grievance process
- Must learn about what MCNA does and does not cover
- Must read Member Handbook to understand how the rules work
- If there is an appointment, must try to get to the dentist's office on time or call to cancel the appointment
- Must report misuse by dental and health care providers, other members, MCNA, or other dental or medical health plans
- Must let the dentist know as soon as possible any reasons your treatment cannot be followed. Members who think they have been treated unfairly or discriminated against, are instructed to call the U.S. Department of Health and

Human Services (HHS) toll-free at 1-800-368-1019 and/or can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

C.2.13: Information Requirements – Available and Accessible Care

Per the model Enrolled Member handbook developed by the State, MCNA includes information about Members' rights to obtain available and accessible health care services covered under the DWP program and our contract with the State.

C.2.14: Information Requirements – Selecting a PCP

The Member Handbook, based on the model Enrolled Member handbook, informs members about how they can locate a list of dentists in their area by utilizing MCNA's Provider Directory (online and printed). MCNA's Online Provider Directory is prominently displayed on our Iowa website (https://www.mcnaia.net/) and is available 24x7x365 so our members can easily access it without having to obtain a member login. The directory also provides information about each dentist such as:

- Office location and office hours
- The languages the office staff and dentist speak, as well as linguistic capabilities
- If the dentist is accepting new patients and any limitations of member populations served

The handbook informs members who need help finding a PDP that they may call MCNA's toll-free Member Hotline or to go to MCNA's Iowa website (https://locator.mcna.net) to find a dentist using our DWP Online Provider Directory. Members can search for a dentist by:

- Dentist or office name
- Type of dentist (Specialty)
- Male or female dentist
- The language that the dentist or office speaks
- Dentists that are accepting new patients
- Office city and ZIP code

Members can obtain a printed copy of MCNA's Provider Directory by calling the toll-free Member Hotline to request it or printing a copy from our online Dental Wellness Plan Provider Directory at any time. MCNA ensures the most current printed dental Provider Directory is available to participants upon request.

The handbook informs MCNA members that they may change their PDP at any time and lets them know that if they are dissatisfied with a particular provider, we can assist them with selecting another conveniently located PDP and securing an appointment as soon as possible.

The Member Handbook explains the difference between in-network and out-of-network dentists, and members' obligation to pay for any out-of-network services not authorized by MCNA (with the exception of emergency care).

C.2.15: Information Requirements – Grievance and Appeals Procedures & Timeframes

In full compliance with the model Enrolled Member handbook, MCNA's Member Handbook includes thorough information about how to effectively navigate the grievance and appeals G&A system inclusive of covering the State Fair Hearing procedures and timeframes (See Tab 3 Section H for a robust description our G&A system which is fully compliant with all Agency and Centers for Medicare & Medicaid Services (CMS) requirements. The Member Handbook promotes ease of access for members, including those with disabilities and non-English speakers, and informs them about how we can members and their authorized representatives in accessing the grievances and appeals process. The Member Handbook details our processes, including the timeframes applicable for filing member grievances and appeals. The handbook and all written notifications are provided in the member's primary language and are written to ensure ease of understanding. The handbook is also available in alternative formats such as Braille and audio upon request.

Members can use the handbook to learn how to connect with MCNA's highly trained and dedicated staff who can assist members and their representatives in fully understanding, accessing, and navigating the grievance and appeal processes.

[redacted]

C.2.16: Information Requirements – Enrolled Member Rights Regarding Grievances & Appeals

MCNA's Member Handbook includes all required information concerning member rights regarding grievance and appeals. This includes:

- Member's right to file grievances and appeals.
- Requirements and timeframes for filing a grievance or appeal
- Information on the availability of assistance in the filing process for grievances
- Information on the availability of assistance in the filing process for appeals
- Member's right to request a State Fair Hearing after MCNA has made an adverse determination
- Specifies that, when requested by the Member, benefits that MCNA seeks to reduce or terminate will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing, and that the member may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State Fair Hearing is pending if the final decision is adverse to the member

C.2.18: Information Requirements – Auxiliary Aids

MCNA makes auxiliary aids and services available upon request. Auxiliary aids such as materials in large print format, Braille, American Sign Language, and other services are also provided at the request of the member. Members who are unable to push telephone buttons are prompted to remain on the line while the call is routed to an MSR. This rich set of translation resources allow us to make oral interpretation services available as needed to assist members in understanding member materials or to facilitate an appointment with a provider.

C.2.19: Notice of Significant Changes

We understand that the Agency may request a significant change, as defined by the Agency, in the information included in our Member Handbook at any time. When this occurs, we will provide our members with a notice of significant change within 30 days before the intended effective date of change. We value our relationship with the Agency and will treat such requests with the highest priority while adhering to our process standards.

C.2.20: Significant Change

MCNA understands and will adhere to the Agency's definition of "significant change," defined in the Contract and SOW as any change that may impact member accessibility to services and benefits, in:

- Restrictions on the member's freedom of choice among providers;
- Member rights and protections;
- Grievance and fair hearing procedures;
- Amount, duration and scope of benefits available;
- Procedures for obtaining benefits, including authorization requirements;
- The extent to which, and how, members may obtain benefits from out-of-network providers;
- The extent to which and how after-hours and emergency coverage are provided;

- Policy on referrals for specialty care and for other benefits not furnished by the member's PDP; or
- Cost sharing.

C.2.21: Transition of Care Policies

MCNA utilizes the model Enrolled Member handbook developed by the State and notices that describe the transition of care policies for enrolled members and potential enrolled members. Currently, our Member Handbook informs members and potential member that if they have been on a different dental plan or seeing a dentist that is not part of our provider network, we will help them find a dentist. The handbook states that during this transition, the member can continue to see their current dental provider for a period of time (up to 90 days) if a provider is not available or your health is at risk. We let members know that we will work with them and the office to get their dental records sent to their new provider and that they can request assistance by calling our Member Hotline.

C.3: Member Handbook Dissemination

C.3.01: Dissemination of Member Handbook

MCNA knows that our members depend on timely, comprehensive, and easy to understand information, inclusive of a summary of their benefits and coverage, in the MCNA's Member Handbook to access the oral health services they need. We make sure to deliver printed copies of the Member Handbook as part of the Welcome Packet we mail to members within 7 business days of enrollment. We also make the handbook available through various other methods including offering a downloadable copy via our Member Website (https://www.mcnaia.net/#resources), as well as posting the required information within our Member Portal (https://member.mcna.net).

C.4: Network Provider Directory

C.4.01: Network Provider Information

To support members in making informed choices about the providers they see, we offer detailed information in our online and printed Provider Directories. MCNA's Online Provider Directory is prominently displayed on our Iowa website (https://www.mcnaia.net/) and is available 24x7x365 so our members can easily access it without having to obtain a member login. The directory is mobile-friendly and is searchable in its machine-readable file and format. [redacted] As a result, members always have access to up-to-date information from MCNA, including:

- Dentist name and group affiliation, if applicable
- Office name, street address and location, telephone numbers, office hours, and website URLs (when possible)
- Specialty credentials and certifications
- Linguistic capabilities (including American Sign Language) offered by a provider or interpreter and completion of cultural competence training
- Ability to accept new patients and limitations such as age of member
- Ability to treat special needs members and accommodations for people with physical disabilities, including offices, exam rooms, and equipment
- A statement that some providers may choose not to perform certain services based on religious or moral beliefs
- Miles from the ZIP code requested

- Performance indicators

[redacted]

C.4.02.a-b: Forms Available

[redacted]

C.4.03: Availability on Website

MCNA's DWP Online Provider Directory is available on our website in a machine-readable file and format as specified by the Secretary.

C.6: Provider Terminations and Incentives

C.6.01: Provider Terminations – Timeline

In instances of provider termination, MCNA will conduct data analysis to determine the roster of members who selected the provider as their PDP, or who received care on a regular basis from the provider. We will make a good faith effort to give written notice of the termination within 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.

C.6.02: Information Regarding PIPs

We attest that we will make information about incentive payments available upon request. In accordance with E.8, we do not have arrangements that provide any incentive to deny or reduce services. In addition, we do not have incentive arrangements that place providers at financial risk.

C.6.03: Performance-Based Incentive System for Providers

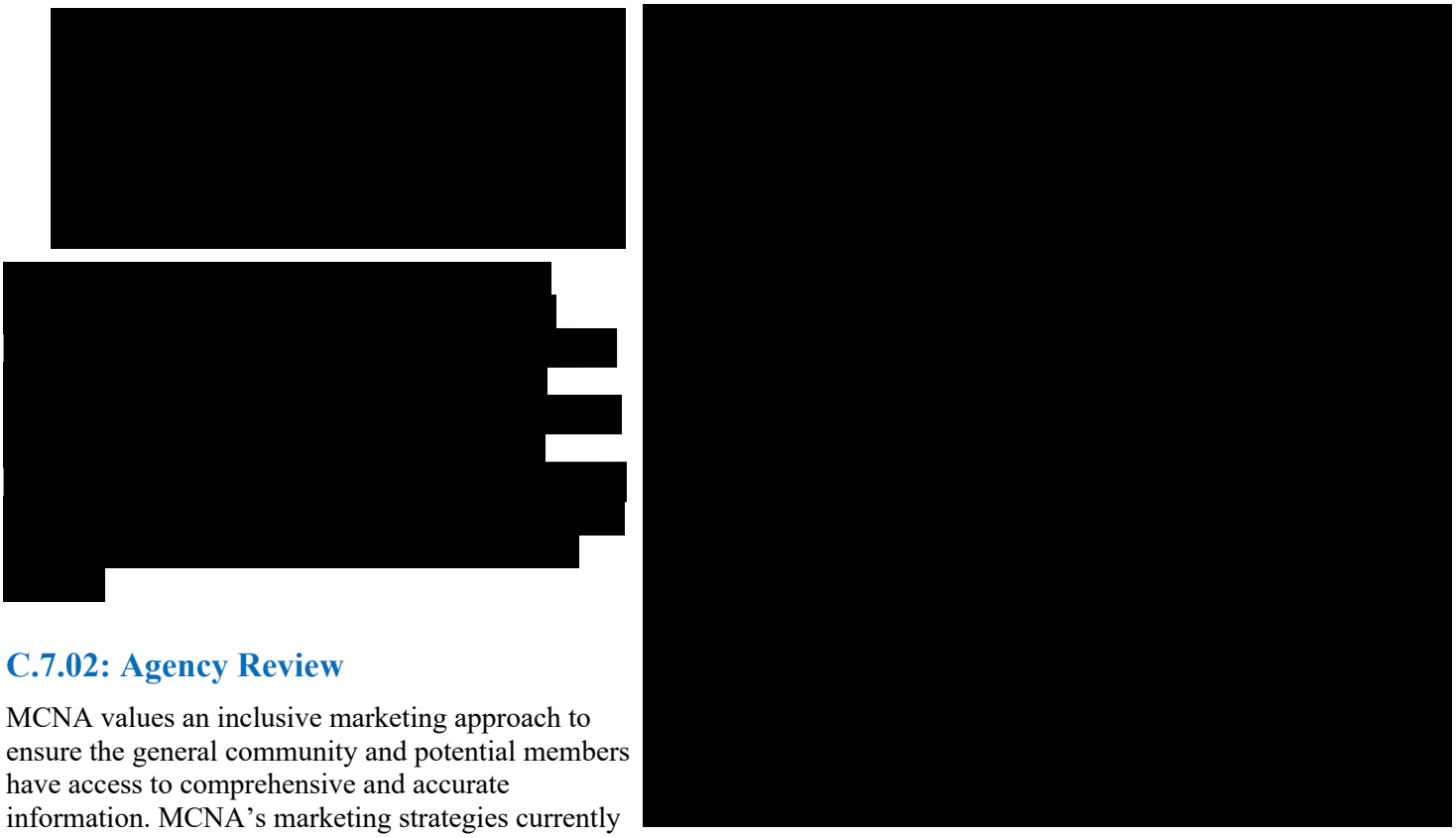
As a leader in Medicaid and CHIP dental managed care, MCNA is experienced in the design and implementation of incentives to increase engagement and improve quality. Our dental home and continuity of care incentives have resulted in improvements in Iowa as detailed in the response to E.8. We attest that we will obtain Agency approval prior to implementing or modifying any provider incentives. We will also provide information concerning provider incentive plan to members upon request and include information in marketing materials pursuant to federal disclosure requirements.

C.7: Marketing

C.7.01: Marketing Restrictions

[redacted] MCNA fully complies with and adheres to the marketing requirements, policies, and procedures as set forth by the Agency and the federal government. MCNA will not distribute marketing materials without first obtaining State approval and will not seek to influence member enrollment in conjunction with the sale or offering of any private insurance. Furthermore, MCNA will not directly or indirectly engage in door-to-door, telephone, e-mail, texting, or other cold-call Marketing activities.

[redacted]



C.7.02: Agency Review

MCNA values an inclusive marketing approach to ensure the general community and potential members have access to comprehensive and accurate information. MCNA's marketing strategies currently and will continue to comply with all applicable laws and regulations regarding marketing by health insurance issuers. All marketing activities shall be provided at no additional cost to the Agency. MCNA will submit all marketing materials to the Agency at least 30 Days or within the timeframe requested by the State, prior to distribution.

C.7.03: Permissible Marketing Activities

MCNA acts in compliance with all law and policy guidance regarding inducements in the Medicaid program, including marketing provisions provided for in 42 C.F.R. § 438.104.

Preventive care is vital to MCNA's philosophy of cultivating and maintaining good oral health outcomes. We are committed to communication and education as we believe these are the most important tools we have to influence member behaviors. We seek to empower communities and members and their caregivers to take responsibility for their oral health by engaging them through age-appropriate, inviting materials which we distribute at community events.

We use various modes of delivery including in-person, written, text messaging, and online so that our messages are delivered in the formats most meaningful to our members. Our content is supplemented by our Iowa Member Advocate Outreach Specialists (MAOS), who provide tailored outreach and education at health fairs and community events to help members achieve their dental health goals. Through this multifaceted approach, MCNA enhances oral health literacy and helps members make well-informed decisions about their own dental care.

C.7.04: Marketing Obligations

MCNA is a responsible partner in improving access to dental services across Iowa. As such, we will comply with all marketing obligations. We will not mislead, confuse, or defraud the marketing recipients or the State nor assert or state (neither in writing or orally) that MCNA is endorsed by the Centers for Medicare and Medicaid Services (CMS), the Federal or Iowa State government, or a similar entity.

C.8: General Information Requirements

C.8.01: General

MCNA values timely, transparent, and inclusive communication practices to promote informed decision-making among members and their authorized representatives. Member-facing information and materials (e.g., Member Handbook) are provided in multiple formats that are readily accessible and easy to understand. All MCNA materials with required information and that receive Agency approval are linked on the homepage of the MCNA Iowa (https://www.mcnaia.net) and are available in electronic formats that can be download and printed. All current information and materials comply with content (e.g., term definitions) and language requirements, and we commit to the same requirements and processes for all future communications for DWP and the Hawki populations. MCNA will notify members and their authorized representatives that information and materials are available in paper form without charge upon request and will be sent within the required five business days.

C.8.02: Leveraging Electronic Communication

Regarding communications with members and their authorized representatives, MCNA ensures that members opt into a communication pathway (e.g., regular mail, email, text) and sends members a confirmation via regular mail along with instructions on how to change their selection if desired. MCNA maintains both a physical address and email address as listed in the Member Handbook to receive and respond to communication from members.

MCNA is committed to transparency and timely access to accurate information for members and their authorized representatives, providers, and other parties. To this end, MCNA hosts and maintains an accessible, Iowa-specific website (https://www.mcnaia.net). In addition, MCNA operates a fully functional and continuously available secure email system for communication both within our company as well as with the Agency, dental network providers, members, and other external entities. The system is capable of attaching and sending documents created using software compatible with the State's installed version of Microsoft Office and any subsequent upgrades.

[redacted] We can establish a VPN with Agency for communications as required.

C.8.03: Website and Mobile Applications

MCNA's Iowa DWP website (https://www.mcnaia.net) is designed to comply with accessibility standards to achieve the highest degree of usability. In addition to being cross-browser compatible and compliant with the World Wide Web Consortium's validation standards, the site meets the guidelines set by Section 508 of the US Rehabilitation Act that address accessibility for people who are visually impaired, deaf, or hard of hearing. The site is designed with clear and resizable fonts, direct navigation, and vibrant colors, and is authored to meet sixth-grade reading-level standards. No special browsers or plug-ins are necessary to access essential site functionality. The site is mobile-friendly, enabling members to access it on a mobile device, as well as tablets and computers.

MCNA provides an Iowa-specific website where members, their authorized representatives, and others can easily find plan information in both English and Spanish. [redacted]

Members and their authorized representatives can access all materials made available to newly enrolled members (e.g., Member Handbook, Provider Directory, ID cards) via the MCNA Iowa website under "Member Resources." Our Provider Network Directory, accessible via the Member website, is searchable and updated, at minimum, every two (2) weeks.

We review all website materials and submit these materials to the Agency for review and approval prior to posting.

Recognizing that social network or blog sites are visited by 75% of online consumers, we use social media for outreach and oral health education to our members, including Facebook, Twitter, Instagram, and YouTube. Our social media mission is to reach members where they spend their Internet and cell phone time with educational materials and reminders to make appointments to see their health care providers.

C.8.06: Information About Moral or Religious Objections

MCNA will provide, reimburse for, or provide coverage of all counseling and referral services covered under the Contract. MCNA has no objection to any services outlined in the proposal on moral or religious grounds. We will notify members and their authorized representatives in the event we adopt a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least 30 days prior to the effective date of the policy for any particular service.

C.8.07: Definitions of Terms

MCNA will use and promote Agency-approved definitions for the following terms: appeal; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; grievance; habilitation services and services; home health care; hospice services; hospitalization; hospital outpatient care; physician services; prescription drug coverage; prescription drugs; primary care physician; PCP; rehabilitation services and devices; skilled nursing care; and specialist.

C.8.08: Additional Definitions

MCNA will use and promote Agency-approved definitions for the following terms: co-payment; excluded services; health insurance; medically necessary; network; non-participating provider; plan; preauthorization; participating provider; premium; provider; urgent care.

C.8.09: Exclusions

MCNA understands and acknowledges that we will not be held financially responsible for excluded services listed in the RFP Special Contract Exhibit D, Table D.02.

C.8.10: Dissemination of Practice Guidelines

MCNA has a robust and holistic oral health population management program inclusive of clinical pathways developed to detect, monitor, and evaluate for under-utilization, over-utilization, and inappropriate utilization. Our clinical pathways are based upon evidence-based clinical practice guidelines (CPGs) from sources such as the American Dental Association, the American Academy of Pediatric Dentistry, and other dental specialty boards falling under the American Dental Association. The CPG methods developed by MCNA, in concert with the Iowa provider community, represent the most advanced practice standards in dental health care.

MCNA makes our CPGs available to providers, members, and potential members at their request. The clinical criteria are disseminated via Provider manuals, during new provider orientation, and in the online Provider Portal, Provider newsletters, the MCNA website, and mailings upon request.

C.8.11: State-Developed Notices

MCNA uses and will continue to use and disseminate all State-developed notices to members in a timely fashion to ensure transparency and informed healthcare decision-making for all members, their authorized representatives, providers, and our community partners.

C.8.12: State Fair Hearing Timely Notice

Our Grievances and Appeals (G&A) Department provides a fair, thorough, timely investigation and resolution of all grievances and appeals lodged by our members and providers acting on a member's behalf with written consent. MCNA's G&A system includes our grievance process, appeal process, and access to the state fair hearing process, is fully compliant with all State and Centers for Medicare & Medicaid Services (CMS) requirements, and promotes ease of access for members, including those with disabilities and non-English speakers. Administration of our G&A system includes comprehensive maintenance of all information related to grievances or appeals filed by members. Such records meet the conditions of record keeping as outlined in 42 CFR §438.416(b) and are made available to CMS and the State, or their authorized designee upon request.

Once a member exhausts MCNA's internal appeal process, our G&A Department sends an appeal resolution letter advising the member of their right to request a State Fair Hearing. We inform members of their rights to request a state fair hearing if they disagree with MCNA's appeal decision of the member's adverse benefit determination. We provide these members with a Notice of Adverse Benefit Determination, delivered via mail within at least 10 days before the date of action that explains their right to request a State Fair Hearing, if adverse benefit determination is upheld. Additionally, we provide written appeal resolution letter that includes information about the right to request a State Fair Hearing; how to request a State Fair Hearing; the right to request and receive benefits pending a hearing; how to request a continuation of benefits; and a notice that the member may be liable for the cost of any continued benefits if MCNA's Adverse Benefit Determination is upheld in the state fair hearing. We inform the member they have no less than 90 calendar days and no more than 120 calendar days to from the notice of resolution to request a State Fair Hearing (42 CFR §438.408).

Our staff works with Agency throughout the state fair hearing process to ensure that all required information is readily available to those reviewing the case. We submit an evidence packet to both Agency and the member upon receipt of hearing notification. Upon notification of the State Fair Hearing request, MCNA will provide notice of Adverse Benefit Determination and appeal resolution letter to Agency using MCNA's dedicated email address for state fair hearing communications. Staff are made available to attend the hearings, or arrangements are made by MCNA to assure the appropriate witnesses attend to provide testimony. MCNA complies with all orders issued by the administrative law judge. MCNA further adheres to all State Fair Hearing processes, including the continuation of benefits requirements. MCNA does not create barriers to timely due process; we understand that we will be subject to penalties if it is determined by the Agency that MCNA has failed to meet due process requirements. We never take punitive action against a member or provider who chooses to exercise their rights to file a grievance, appeal, or state fair hearing.

C.10: State Member Communication Approval

C.10.01: Agency Approval of Enrolled Member Communications

MCNA actively produces and distributes member materials in accordance with the requirements outlined in this RFP to be used in our member communication activities. These materials encourage our members to utilize their covered benefits and educate them about the importance of good oral health. All our existing DWP member materials have been submitted and approved by the Agency prior to publication and dissemination, and we will submit any new DWP and Hawki member materials to the Agency for review and approval within the required timeframes prior to publication and dissemination. We will submit any previously approved DWP materials with substantive changes to the Agency for review and approval at least 30 days or within the timeframe requested by the Agency. This includes, but is not limited to,

print, television, and radio advertisements; handbooks and provider directories; website screen shots; promotional items; brochures; letters and mass mailings; and emails. We will comply with Agency processes to facilitate the submission and approval of materials, including when the Agency requests that the materials include state name and logos. When using state name and logos, we acknowledge approval is always limited to the specific approved use. All MCNA's materials are available in English and Spanish and MCNA will prepare written member materials in any other prevalent languages spoken by 5% or more of the member population. We will make our brochures available in full color, tri-fold, and in 8½ x 11 inches front and back format.

We understand and will accommodate instances in which the Agency may request a modification or addition of content to our Iowa-specific website (www.mcnaia.net), print materials, electronic materials, or directory at any time. We value our relationship with the Agency and will treat such requests with the highest priority while adhering to our process standards. MCNA understands the importance of consistency of information provided to members and will continue to utilize Agency-approved terminology in our printed and online communications. Our written materials, telephonic, electronic, and face-to-face communication strategy clearly explains our members' rights and responsibilities.

MCNA maintains a current Iowa DWP Member Handbook that adheres to the requirements in 42 CFR §438.10(g) and will use the state developed model member handbook for each of the covered populations as specified in this RFP. We will conduct a quality check and ensure that all materials are consistent with the contract and state and federal requirements prior to submitting materials for review by the Agency.

C.11: Value-Added Services

C.11.01: Value Added Services

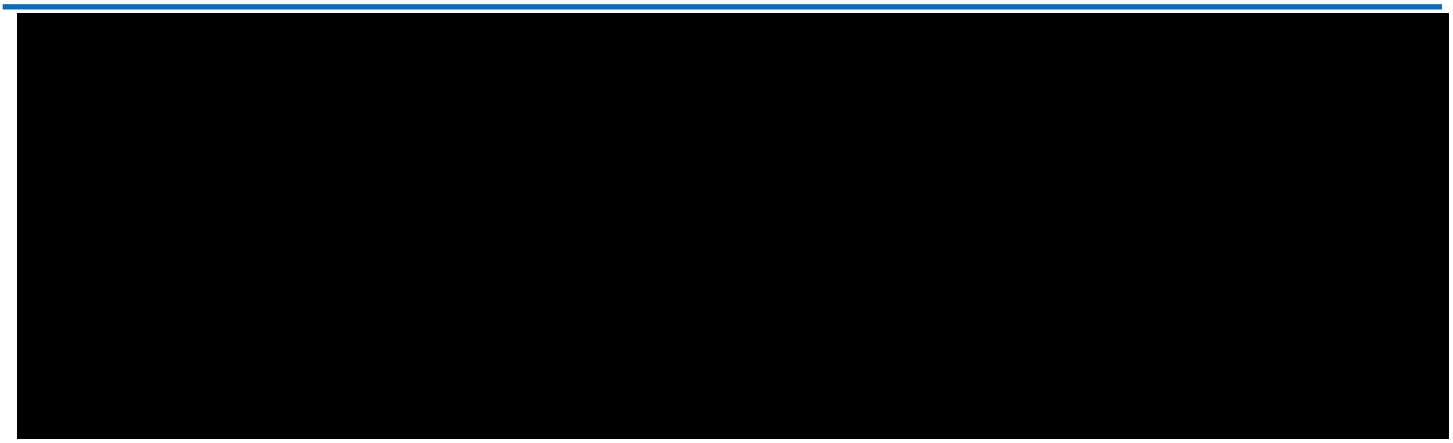
[redacted]

We acknowledge and understand that MCNA will not receive additional compensation for value-added services and may not report the costs of value-added services as allowable dental or administrative costs. MCNA will provide all Agency-approved value-added services during the initial contract term. Any changes to the proposed services described below will be submitted to Agency for approval at least 90 calendar days in advance.

Attachment J, C.11: MCNA Proposed Value-Added Services in Iowa

MCNA proposes to implement, administer, and track, pending State approval, the following value-added services:

[redacted]



C.11.02: Applicability

MCNA will work collaboratively with the Agency and submit to the State all proposed value-added services for evaluation prior to implementation. In addition, all proposed changes to any value-added services will be submitted to the Agency for evaluation. Prior to implementing any Agency-approved value-added service we have and continue to ensure the legality of the service.

C.11.03: Costs

MCNA acknowledges and understands value-added services are not reportable as allowable medical or administrative expenses. Further, we acknowledge and understand that the cost of value-added services should not and cannot be passed on to providers. All value-added services will be fully described – scope of services, criteria for participation or utilization, etc. – in our marketing materials and communication materials targeting members.

C.11.04: Program Description

MCNA works diligently to maintain up-to-date materials, such as the Policies and Procedures Manual, with full, easy-to-understand descriptions of all programs and services. To foster awareness and participation among members, MCNA will ensure that any limitations, restrictions, or conditions specific to the value-added services are fully described in the Policies and Procedures Manual in multiple formats to meet members' accessibility needs. In addition, the Policies and Procedures Manual will clearly state the providers delivering value-added services and how the MCNA will identify value-added services in administrative data to ensure proper accounting. MCNA will notify providers and members about the availability of such value-added services in accordance with the federal marketing requirements. With our continued focus on improving members' health outcomes, awareness, and personal agency in healthcare decision-making, we will include in all member-facing marketing and programmatic materials (e.g., Member Handbook, Member website, member-facing newsletters) how a member can obtain or access the value-added services outlined in C.11.01 (pending approval by the Agency).

C.11.05: Approval & Implementation of Value-Added Services

To ensure our value-added services are meeting members' needs and positively impacting their oral health, we will clearly identify and track members receiving a value-added service and track outcomes related to the intent of the value-added service in order to evaluate effectiveness. For each value-added service, we establish standards and dental health status targets, and we use these metrics to evaluate the effectiveness of our value-added service program. by maintaining the mailing and distribution lists for all adult and child members who receive the educational or preventative service intervention.

Section D: Payment

D.1: General

D.1.01: General

MCNA acknowledges that the capitation rates are set forth in separate Iowa Dental Wellness Plan (DWP) and Healthy and Well Kids Iowa (Hawki) RFP Special Contract Exhibits, which represent the separate rate periods. The final capitation rates are identified and developed, and payment is made in accordance with 42 C.F.R. § 438.3(c). See: 42 C.F.R. § 438.3(c)(1)(i); 42 C.F.R. § 457.1201(c).

D.1.02: Medicaid-Eligibility Requirement

Capitation Payments may only be made by the State and retained by MCNA for Medicaid-eligible enrolled members in accordance with 42 C.F.R. § 438.3(c)(2); 42 C.F.R. § 457.1201(c). As an incumbent plan for the DWP program, we currently reconcile with the Agency any capitation found to be paid for members who are later learned to be deceased or incarcerated.

D.1.03: Risk-Sharing Mechanisms

We acknowledge and understand that all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, are described in this contract. See: 42 C.F.R. § 438.6(b)(1). In relation to CHIP rates, we recognize that the rates are based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at 42 C.F.R. § 457.10. 42 C.F.R. § 457.1203(a).

D.1.07: Delivery System and Payment Initiatives

MCNA understands that all delivery system and payment initiatives at the State's option as outlined in 42 C.F.R. § 438.6(c) are included in this Contract so long as the initiative has been approved prior to the implementation of the contract and is described consistently with the approval of that initiative under separate cover. Should MCNA wish to enter into future payment initiatives, we will seek Agency approval.

D.1.12: Mandatory Rates

For DWP program, MCNA reimburses in-network dental providers at a rate that is equal to or exceeds the Agency defined Iowa Medicaid fee for service rate, or as otherwise mutually agreed upon by MCNA and the provider.

For the Hawki program, MCNA reimburses in-network dental providers at a rate that is mutually agreed upon by the contractor and the provider, no greater than usual and customary provider rates, or as otherwise directed by the Agency. We acknowledge that at any point, the Agency may provide a fee schedule defining rates for the Hawki program. MCNA will then reimburse in-network Hawki dental providers at a rate that is equal to or exceeds the Agency defined rates, or as otherwise mutually agreed upon by MCNA and the provider.

MCNA agree to share our reimbursement rates and/or fee schedules upon Agency request, and at a minimum annually. These rates and/or fee schedules are not considered as proprietary information to MCNA. MCNA currently publishes our Agency-approved fee schedules along with our Provider Manual on our public-facing website at www.mcnaia.net.

D.1.13: Risk Assessment Platform

MCNA understands that we are required to utilize the Agency-Approved Oral Health Equity Self-Assessment Tool to meet the requirements of 42 CFR § 438.208. We have a current contract in place with PreViser.

D.2: Incentive Arrangements

D.2.01: General

MCNA understands that under this Contract, the Agency does not use any incentive arrangements but rather uses an actuarially sound withhold arrangement in accordance with 42 C.F.R. § 438.6(b)(2)(i).

D.3: Withhold Arrangements

D.3.01: Withhold Arrangement

MCNA understands that the Agency will implement a withhold arrangement to reward MCNA's efforts to improve quality and outcomes as described in the relevant rate certification. We understand that the Agency has established a set of pay for performance measures for the dental plans selected under this RFP.

D.3.02: General

MCNA acknowledges that for all withhold arrangements authorized by this contract:

a) The arrangement is for a fixed period of time.
b) That performance is measured during the rating period under the contract in which the withhold arrangement is applied.
c) The arrangement is not to be renewed automatically.
d) The arrangement is made available to both public and private dental plans under the same terms of performance.
e) The arrangement does not condition plan participation in the withhold arrangement on the plan entering into or adhering to intergovernmental transfer agreements.
f) The arrangement is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's dental quality strategy.

D.4: Medical Loss Ratio

D.4.01: Medical Loss Ratio Applicability

MCNA acknowledges the MLR definitions included under this contract. As a current dental plan serving the Iowa DWP membership, MCNA submits our medical loss ratio (MLR) in accordance with MLR standards and the Agency's instructions. We will report separate MLRs for the Title XIX and Title XXI populations and aggregate across both populations for minimum MLR application.

D.4.02: Medical Loss Ratio Definitions

MCNA acknowledges and will continue to adhere to the defined MLR terms.

D.4.03: Medical Loss Ratio Requirement

MCNA understands and acknowledges that the Agency expects a minimum MLR of 88% to be reported for each MLR reporting year.

D.4.04: Calculation of the Medical Loss Ratio (MLR) Requirement

MCNA understands that the MLR is the ratio of the numerator to the denominator and may be increased by a credibility adjustment.

D.4.05: Numerator

We will continue to apply the Agency definitions for all components of the MLR numerator including the meaning of incurred claims, activities that improve health care quality, and fraud reduction activities.

D.4.06: Incurred Claims

MCNA ensures compliance with the Incurred Claims requirements outlined in the RFP through the following:

- Including:
  - Direct claims paid to providers
  - Unpaid claims liabilities
  - Withholds from payments
  - Recoverable claims for coordination of benefits
  - Subrogation recoveries
  - Incurred but not reported claims
  - Changes in other claims-related reserves
  - Reserves for contingent benefits and lawsuits
  - Amounts paid above a member's Annual Benefit Maximum (ABM)
- Deducting:
  - Premiums and overpayment recoveries
- Expenditures included in incurred claims:
  - Incentive and bonus payments to network providers
  - Claims payments recovered through fraud reduction efforts (up to the amount of fraud reduction expenses)
- Excluding:
  - Non-claims costs, including payments to third-party vendors
  - Fines and penalties assessed by regulatory authorities
  - Remittance payments to the agency
  - Payments to network providers specified under 42 C.F.R. § 438.6(d)

D.4.07: Activities that Improve Health Care Quality

MCNA agrees to categorize activities that improve health care quality in one of the following categories:

- Activities that meet the requirements of 45 C.F.R. § 158.150(b) and are not excluded under 45 C.F.R. § 158.150(c).
- Activities related to any EQR-related activity as described in 42 C.F.R. § 438.358(b) and (c).

- Expenditures that are related to Health Information Technology and meaningful use, meet the requirements placed on issuers found in 45 C.F.R. § 158.151, and are not considered incurred Claims.

D.4.08: Fraud Prevention Activities

MCNA adheres to the requirements regarding contractor expenditures on activities related to fraud prevention, as adopted for the private market under 45 C.F.R. part 158. We ensure strict compliance by excluding expenses for fraud reduction efforts from the expenditures reported under this section.

D.4.09: Denominator

The denominator for the MLR calculation is equal to the adjusted premium revenue. The adjusted premium revenue is MCNA's premium revenue minus our Federal, State, and local taxes, licensing and regulatory fees, and if applicable, community benefit expense. The revenue used in the MLR calculation will consist of both capitation and risk corridor revenue.

D.4.10: Premium Revenue

MCNA ensures compliance with the Premium revenue requirements for the MLR reporting year as follows:

- We include Agency Capitation Payments, developed in accordance with 42 C.F.R. § 438.4, to MCNA for all members under a Risk Contract approved under 42 C.F.R. § 438.3(a), excluding payments made under 42 C.F.R. § 438.6(d).
- We incorporate Agency-developed one-time payments for specific life events of members.
- We include other payments to MCNA that are approved under 42 C.F.R. § 438.6(b)(3).
- We account for unpaid cost-sharing amounts that MCNA could have collected from members under the Contract, except for those amounts where MCNA can demonstrate a reasonable, but unsuccessful, effort to collect.
- We consider all changes to unearned premium reserves.
- We include net payments or receipts related to risk sharing mechanisms developed in accordance with 42 C.F.R. § 438.5 or 42 C.F.R. § 438.6.

D.4.11: Federal, State, and Local Taxes and Licensing and Regulatory Fees

MCNA will continue to comply with the Federal, State, and local taxes and licensing and regulatory fees for the MLR reporting year.

D.4.12: Denominator when Contractor is Assumed

MCNA recognizes that if we are later assumed by another entity, the total amount of our denominator must be reported by the assuming MCO, PIHP, or PAHP for the entire MLR reporting year and no amount under this section for that year may be reported by MCNA.

D.4.13: Allocation of Expense

We include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense is pro-rated between types of expenses. MCNA ensures that and expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

D.4.14: Methods used to Allocate Expenses

We make allocations to a particular category based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of Claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

D.4.15: Credibility Adjustment

MCNA acknowledges and commits to complying with the requirements regarding the Credibility Adjustment for the calculated MLR.

D.4.16: Aggregation of Data

MCNA will aggregate data for all Medicaid eligibility groups covered under the contract with the Agency and will aggregate data for all Title XXI eligibility groups covered under the contract with the Agency consistent with the requirement to report the two populations separately. We will aggregate data for the Title XIX and Title XXI populations for application of the minimum MLR of 88%.

D.4.17: Remittance to the Agency if MLR is Not Met

MCNA will remit to the Agency the delta between the achieved MLR and the 88% Agency threshold within 90 days of submission of the MLR report.

D.4.18: Reporting Requirements

We report the annual MLR in accordance with all standards and Agency instructions and attest to the accuracy of the report. Additionally, MCNA performs recalculations as needed due to retroactive Agency changes.

D.4.19: Newer Experience

MCNA understands and acknowledges that the Agency may exclude a Contractor that is newly contracted with the Agency from the requirements in this section for the first year of the Contractor’s operation.

D.4.20: Recalculation of MLR

MCNA acknowledges and commits to complying with the requirement regarding retroactive changes to capitation payments made by the Agency for previously submitted MLR reports. If the Agency makes a retroactive change to the Capitation Payments for a specific MLR reporting year, we understand that it is our responsibility to re-calculate the MLR for all affected MLR reporting years. We will ensure that the recalculated MLR meets the requirements set forth in this section. Subsequently, we will submit a new report to the Agency, incorporating the revised MLR calculations and providing all necessary information as specified in the guidelines.

D.4.21: Attestation

MCNA acknowledges and will comply with the requirement to attest to the accuracy of the MLR calculation in accordance with the provisions of this section. We are committed to ensuring the integrity and precision of our MLR report submission, adhering to the prescribed guidelines and using accurate data.

D.4.22: Medical Loss Ratio Guarantee

MCNA acknowledges the Target Medical Loss Ratio of eighty-eight percent (88%) as set by the regulatory requirements. If the calculated Medical Loss Ratio falls below the Target Medical Loss Ratio, MCNA will refund to the State an amount equivalent to the difference between the two ratios, multiplied by the Coverage Year Revenue.

D.4.23: Revenue

MCNA acknowledges and confirms our commitment to comply with the requirements stated regarding the revenue components used in the MLR calculation.

D.4.24: Benefit Expense

We acknowledge and agree to comply with the guidelines outlined for determining Benefit Expense as specified by the Agency.

D.4.25: Data Submission

We submit data to the Agency, in the form and manner prescribed by the Agency in the contract. MCNA submits information to the State within thirty (30) days following the six (6) month claims run-out period.

D.4.26: Medical Loss Ratio Calculation and Payment

Within 90 days following data submission, the Agency calculates the MLR by dividing the benefit expense by the revenue. MCNA then has 60 days to review the Agency's calculation. MCNA acknowledges that the Agency and MCNA will have the right to review all data and methodologies used to calculate the Medical Loss Ratio. Any payments due to the Agency are due and payable by MCNA within 15 days of the end of the third calendar quarter of each Coverage Year.

D.4.27: Coverage Year

We acknowledge and agree that the Coverage Year will be considered a 12-month period. For the purpose of preparing the MLR Calculation, we understand that all available data from the Coverage Year will be utilized, including Incurred But Not Paid (IBNP) Claims and a six month run-out period for Benefit Expense. We will ensure that the necessary data is collected and accurately included in the calculation to comply with the requirements of the MLR Calculation.

D.4.28: Risk Corridor

MCNA understands and agrees to the application of the risk corridor as described in the contract.

D.4.29: Overview

We acknowledge that the Risk Corridor settlement is determined by comparing the actual MLR to the risk sharing corridor percentages outlined in the provided table. The actual MLR is calculated as the ratio of total adjusted medical expenditures to the total capitation revenue for all populations.

D.4.30: Total Capitation Revenue

We acknowledge that the Total Capitation Revenue represents the capitation rates paid by the State to the MCNA for the contract period and will exclude:

- Taxes and fees explicitly built into the capitation rates,

- Revenue associated with directed payments that are implemented by the State and are not included in regular monthly capitation rates for the contract period.
- Any unearned withhold amounts will not be included within the capitation revenue for purposes of the Risk Corridor calculation.
- Payments to MCNA including any amounts due from the State to the Contractor for the fiscal year associated with services carved-out of capitation.

D.4.31: Total Adjusted Medical Expenditures

We agree that the Agency may audit claims expenditures. For purposes of the risk corridor in the DWP program, the State may limit the overall level of reimbursement to 105% of the Medicaid fee schedule and will sample the submitted encounter data to ensure compliance with the Medicaid fee schedule. Reimbursement associated with incentives and value-based purchasing arrangements are not included in the 105% requirement.

The data used by the State and its actuaries for the risk corridor settlement will be the accepted MMIS encounter data and financial data submitted by MCNA. We agree to make a good faith effort to reconcile any identified differences between claims expenditures as reflected in the encounter data and our submitted financial data before the calculation of the final settlement.

D.4.32: Risk Corridor Percentage

MCNA understands that the Risk Corridor Percentage is calculated as the total adjusted medical expenditures divided by the total capitation revenue for all populations and that the State will determine the specific Risk Corridor percentages prospectively for each Contract year and communicate the percentages to the MCNA through annual Contract amendments.

D.4.33: Timelines

Within 230 days following the end of the contract period, MCNA will provide the Agency with a complete and accurate report of actual medical expenditures for our members, by category of service, based on claims incurred for the contract period including six months of claims run-out, and our best estimate of any claims incurred but not reported (IBNR) for claims run-out beyond six months, and any applicable IBNR completion factors.

We understand that prior to nine months following contract period, the Agency will provide MCNA with a final settlement under the risk share program for the contract period. Any balance due will be paid within 60 days of receiving the final reconciliation from the Agency. We acknowledge that these timelines may be modified at the Agency's discretion.

D.5: Payment for Indian Health Care Providers (IHCP)

D.5.01: Timely Payment Obligation

MCNA meets all timely payment requirements for payments made to all Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) providers in our network. This includes paying:

- ninety percent (90%) of all clean claims from practitioners within 14 days of the date of receipt
- ninety-five percent (95%) of all clean claims from practitioners within 21 days of the date of receipt
- ninety-nine percent (99%) of all clean claims from practitioners within 90 days of receipt

D.5.02: Payment Obligations When IHCP is an FQHC

MCNA adheres to all IHCP payment requirements and is pleased to provide Iowa with a robust network which already includes a significant number of contracted and credentialed ICHPs. For IHCPs enrolled in Medicaid as an FQHC but which are not part of MCNA's network, we pay an amount equal to the amount that we would pay a participating FQHC, including any supplemental payment from the State to make up the difference between the amount paid by MCNA and what the IHCP FQHC would have received under Fee for Service (FFS) Medicaid.

D.5.03: Payment Obligations When IHCP is Not an FQHC

When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it is in MCNA's network, the IHCP has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS), or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State Plan's FFS payment methodology.

D.6: Timely Payment

D.6.01: Timely Payment Obligation

MCNA adheres to the Agency's definition of a "clean claim" and meets the requirements of FFS timely payment, including the paying of 90% of all clean claims from practitioners within 14 days of the date of receipt; paying 95% of all clean claims within 21 days of the date of receipt; and paying 99%of all clean claims from practitioners within 90 days of the date of receipt. We recognize that this obligation for timely payment will be met at both an aggregate and provider type level (e.g., dentist, orthodontist, screening and maternal health centers, FQHCs, etc.), and that final provider type levels will be determined by the Agency.

D.6.02: Claims Reprocessing and Adjustments

We will accurately adjudicate ninety percent (90%) of all clean identified adjustments including reprocessed claims within 30 business days of receipt and ninety-nine percent (99%) of all clean identified adjustments including reprocessed claims within 90 business days of receipt. MCNA will also reprocess all claims processed in error within thirty (30) business days of identification of the error or upon a scheduled approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when MCNA identifies, or is made aware of the error, and has received all necessary information to validate the error; identification of the error could be brought forward by a provider, the Agency, or our internal staff. If MCNA requests clarification from the Agency regarding a claim reprocessing project, the time for reprocessing will begin to run on the day we receive all information necessary to accurately reprocess the claims. We will reprocess mass adjustments of claims upon a jointly approved schedule.

D.6.03: Additional Claims Payment Timeliness Obligations

MCNA acknowledges that a "clean claim" is one in which all information required for processing is present and that if a clean claim is denied, the claim notice will specifically describe all information and supporting documentation needed to evaluate the claim for processing. As provided in 42 C.F.R. § 447.46(c)(2), MCNA may, by mutual agreement, establish an alternative payment schedule with in-network providers.

D.6.04: Timing

For claims payment purposes, the date of receipt is the date the MCNA receives the claim, as indicated by its date stamp on the claim, and the date of payment is the date of the check or other form of payment.

D.7: Pass-Through Payments

D.7.01: Pass-Through Payments

MCNA will not make any pass-through payments to providers under this Contract even if such payments are permissible pursuant to 42 C.F.R. § 438.6(d).

Section E: Providers and Provider Network

MCNA has partnered with Iowa providers to deliver high quality care to our Iowa Dental Wellness Plan (DWP) and members since 2016. [redacted]

We have read, understand, and will comply with Iowa Dental Wellness Plan and Hawki Dental RFP# MED-24-004. In our response below, we address key requirements from RFP Attachment F: Contract and Scope of Work Section E. Providers and Provider Network E.1-E.9. Per Attachment J, we outline in the corresponding sections how we will establish written agreements with all Network Providers, explain our Provider Credentialing Performance Metric, and how we will adhere to all requirements set forth in Special Contract Exhibit C.

E.01: Provider Relations and Communication

[redacted]

Proactive Provider Relations and Communications Strategy

[redacted]

E.02: Provider Services Helpline - E.03: Performance Metrics

Since we began serving Iowa DWP members in 2016, MCNA has maintained a skilled and responsive Provider Hotline to serve the needs of our Iowa network. [redacted] Our dedicated Iowa Provider Hotline is staffed Monday through Friday from 7 a.m. to 7 p.m. Central Time, excluding State-approved holidays, exceeding contractual requirements. To accommodate providers who need assistance outside normal business hours, our hotline is answered by the automated Interactive Voice Response (IVR) system which informs providers of our Hotline's normal operating hours and allows callers to leave a message that will be returned the following business day. [redacted]

E.04: Provider Training

At MCNA, we believe the key to our success is the strong relationships we have built with our provider communities. Experience has taught us the most effective way to build relationships is by first establishing trust. MCNA establishes trust with our provider communities using the following five essential elements:

- **Mutual Concern:** MCNA demonstrates shared concern with our providers about the oral health of our members.
- **Keeping Commitments:** MCNA exhibits integrity, ability, and character in keeping commitments to our providers and members.
- **Open Communication:** MCNA fosters an open communication environment among employees, providers, and members.
- **Active Collaboration:** MCNA actively collaborates with community partners, providers, and members to promote good oral health.
- **Long-Term Perspective:** MCNA invests in provider education and training to contribute to overall provider and member satisfaction.

Building and maintaining relationships with the Iowa provider community is always our top network development priority. With this long-term perspective in mind, MCNA conducts initial and ongoing provider orientations and online training seminars and offers a wealth of supporting information through our Provider Portal and Provider Manual. In Iowa, we provide training to providers and staff about the program, covered services and benefits, special needs of our members, and requirements of the contract upon a provider or provider group joining our network. This training includes how to access MCNA's Provider Portal. Additional training regarding Provider Portal functionality is also available 24/7 through our online YouTube educational video library and our Portal User Guide.

The following work plan ensures that the concerns and needs of the Iowa dental community are met by offering ample training opportunities throughout the year and upon request. Training will include, but not be limited to:

- Unique needs of and benefits for different member populations
- Responding to urgent and emergent member needs
- Timely information on policy and procedure changes and updates
- Presumptive eligibility and qualified entity details as applicable
- Trends and issues of interest to or impacting providers
- Provider enrollment including common errors during enrollment and credentialing in order to avoid delays
- Information about the annual benefit maximum (ABM) and applicable impacts on services and costs for members
- Coordinating transportation assistance and facilitating continuity of care with IA Health Link MCOs

[redacted]

Provider Education Opportunities			
Type of Education	**Audience and Focus**	**Frequency**	**Method**
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

E.1: Network Adequacy

E.1.01: Network Adequacy Obligations

Prior to the Operational Start Date, network Providers will be contracted and credentialed, trained on program policies, covered services, benefit maximums, billing guidelines, record keeping, quality initiatives, and other important elements of Provider participation. On an ongoing basis, MCNA will monitor network adequacy and access.

MCNA maintains a sufficient number, mix, and geographic distribution of providers, including providers who are accepting new Medicaid patients, to provide adequate access to all services covered under the contract pursuant to the Agency's access standards. We will continue to provide 24-hour availability of information, referral, and treatment for dental emergencies. MCNA will continue to submit a weekly provider network file of all participating providers to the Agency or its agent with sufficient evidence that we have the capacity to provide covered services to all members. We will provide this information at any time upon the request of the Agency.

E.1.02: Communication Review and Approval

[redacted] To ensure the Agency has sufficient time to review and to comply with the requirements of Section E.1.02, we submit the materials to the agency at least 30 days prior to expected distribution. Similarly, any substantial changes to previously approved communications will be sent to the Agency at least 30 days prior to expected distribution. We will comply with any Agency processes implemented to facilitate submission and approval of materials. Additionally, any approval we receive to use a state agency name or logo will be understood to be only for that instance and will not be a blanket approval. We will include the state program logo in provider communications when requested by the Agency.

E.1.03: Provider Manual

MCNA maintains an Agency-approved Provider Manual to educate our network providers on a wide range of topics, including a complete user guide explaining the functionality of our Provider Portal. Our Iowa Provider Manual complies with state and federal requirements and outlines how to submit prior authorizations, complaints, and appeals, and lists important telephone numbers such as the Provider Hotline and the Fraud, Waste, and Abuse Hotline as well as Agency contact information. Other information in the manual includes:

- A description of MCNA and covered benefits and services including benefit limitations
- Claims submission standards and instructions for submission, including samples of clean and complete claims
- Medical necessity standards, practice protocols and guidelines, including for complex and chronic conditions, and procedures governing prior authorization and referrals
- Cost sharing requirements
- Urgent and emergency dental service responsibilities
- Member rights
- Provider rights and responsibilities including advocating on behalf of patients
- Provider non-discrimination information
- Information on the provider and member grievance and appeal processes
- Primary Dental Provider (PDP) responsibilities
- Claims payment policies and prompt pay requirements
- Quality performance requirements and dental records standards

The Provider Manual is available online and is provided in hard copy, free of charge, within five business days of request by a provider. MCNA sends written notification to all providers that describes how to obtain the Provider Manual from MCNA’s website and the process for requesting a hard-copy manual. Notice of changes to the Provider Manual are disseminated 30 days in advance through our provider bulletins and *Dental Details* newsletter. Changes may also be discussed during webinars or other training opportunities. MCNA understands that the Agency must approve our Provider Manual and any revisions prior to publication.

E.1.04: Provider Website

MCNA offers our Iowa providers access to a wide range of up-to-date resources on the programs through our public website at https://www.mcnaia.net/dentists, and via our secure HIPAA-compliant Provider Portal to help them make the best treatment decisions for our members. Our website includes all forms needed to contract with and be credentialed by MCNA. It also contains useful provider forms, the Provider Manual, and a section for frequently asked questions (FAQs). The Provider Portal is accessible and functional on a mobile phone.

[redacted] This easy-to-use online portal allows providers to:

- Access the Provider Manual, provider training materials, newsletters, program announcements, and relevant Agency bulletins and updates
- View upcoming trainings and access workshop materials
- Obtain information on the provider complaint system and processes for obtaining information and referrals
- Perform operational activities, including the ability to submit and view the status of claims, appeals, authorizations, and referrals
- Obtain information on how to contact MCNA's Provider Relations Representatives
- Verify member eligibility and the member's dental treatment history
- Print Remittance Advices (RAs)
- View a member roster and create an appointment book
- View and update demographic information, manage fee schedules, and view scorecards and provider profile reports

[redacted] CNA will submit Portal and website updates to the Agency for review and approval within 30 days of contract signing, and annually thereafter. We comply with Section 508 of the Americans with Disabilities Act (ADA) and meet all standards for ensuring accessibility for individuals with visual impairments and disabilities.

Attachment J, E.1.06: Establishing Agreements

E.1.05: Written Agreements - E.1.06: Provider Agreements

MCNA enters into written, signed, and dated Provider Agreements with our network dentists. Our Agency-approved Provider Agreement complies with all state and federal regulations. Prior to contracting with a network provider or paying a provider's claim, MCNA ensures that the provider has a valid National Provider Identifier (NPI) Number, has a valid license or certification to perform services, has not been excluded or barred from participation in Medicare, Medicaid, or CHIP, and has obtained a Medicaid provider number from the Agency upon implementation of appropriate systems.

Our Provider Agreement complies with all contractual requirements included in Section 6.6 of this RFP. Nothing limits communication between members and providers regarding patient care and treatment options. All access and availability standards and details regarding covered services are outlined in MCNA's Provider Manual which is incorporated into our Provider Agreement. Our manual also informs all providers at the time they enter into a provider agreement about members' rights to file grievances and appeals, and request State Fair Hearings as specified in 42 CFR § 438.400 through 42 CFR § 438.424.

MCNA complies with all sanctions imposed by the State on network providers, including enrollment revocation, termination, and mandatory exclusions in a timely manner. Our Provider Agreement requires at least 90 days' notice prior to voluntary provider termination.

[redacted]

[redacted] If MCNA declines participation to an individual or group of providers, we will provide written notice of the reason for this decision to the provider or group within 14 calendar days of the decision.

[redacted] We understand that MCNA may limit provider participation to the extent necessary to meet the needs of our members and that we may use payment amounts that are greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty.

[redacted]

E.1.14: Federally Qualified Health Centers

MCNA recognizes that safety net providers play an essential role in ensuring access to appropriate dental services. [redacted] Payment to an FQHC requires receipt of a clean claim. We reimburse FQHCs the Prospective Payment System (PPS) rate in effect on the date of service for each encounter. MCNA understands that if we do not enter into a provider agreement with the FQHCs within the geographic services area and within the time and distance travel standards of the primary dental care provider, MCNA is not required to reimburse for out-of-network services unless the services provided were considered emergency services.

E.1.16: Maternal Health Centers and Screening Centers and Public Health Providers

MCNA supports the mission of the Iowa Department of Public Health Oral Health Center. The center advances important population health goals by supporting screening and treatment services in schools, maternal and child health agencies, public dental health clinics, and other community-based settings. We attest that we will offer to contract with, at a minimum, the Screening and Maternal Health Centers and Public Health providers, as part of our strategy to improve health equity for all Iowans. [redacted]

We will approach our contracting strategy under this contract provision based on our successful recruitment methodology outlined in the response to E.1.05-06 above.

We understand some providers may not be experienced with contracting under a Medicaid dental plan, so we are prepared to provide all necessary support to ensure successful implementation and a positive experience for providers and members. [redacted]

E.1.18: Other Safety Net Providers and Community Partners

[redacted]

Our PPM also covers how we work with hospitals and urgent care centers to make sure they know how to refer members who present with an urgent or emergent dental concern.

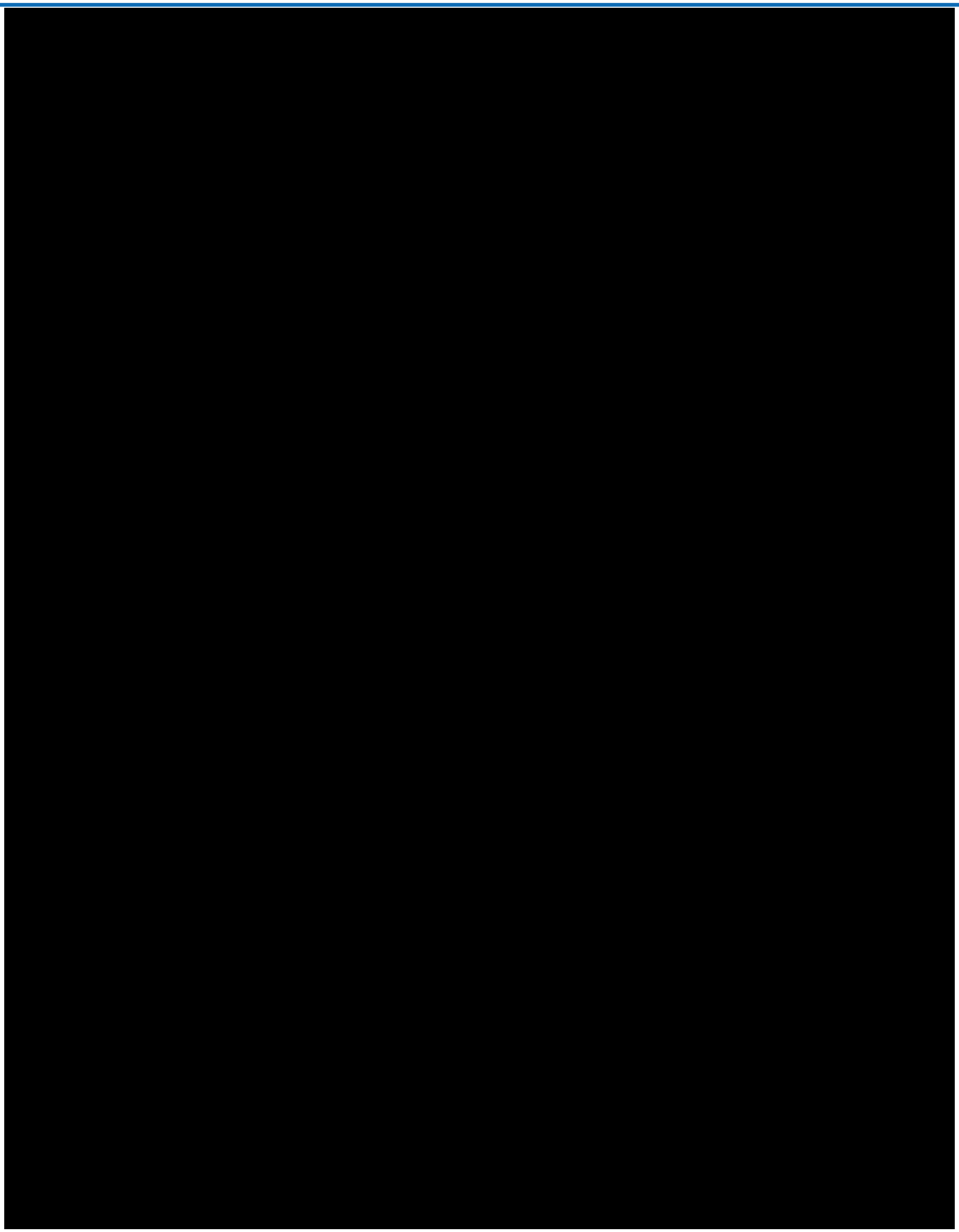
[redacted]

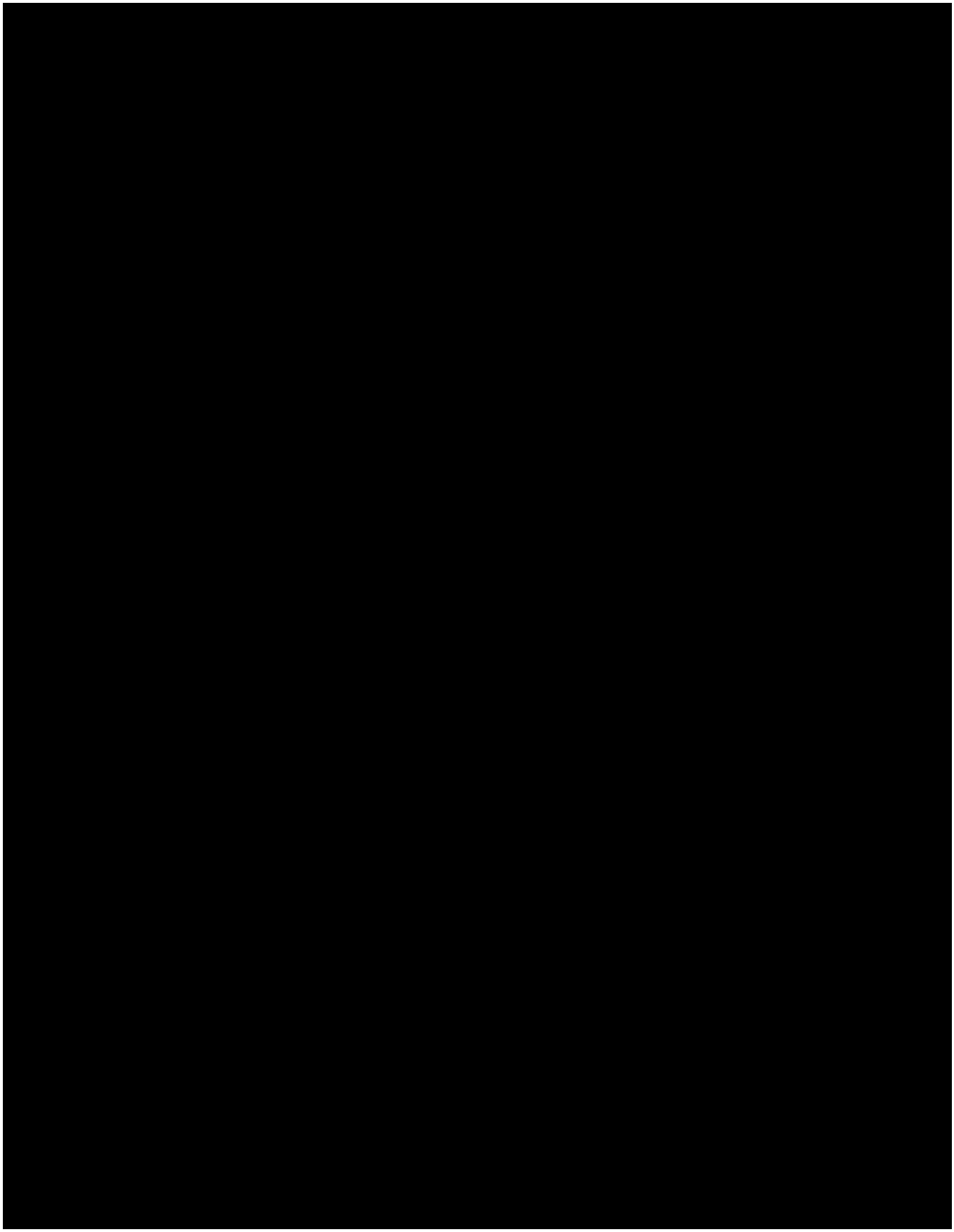
[redacted]

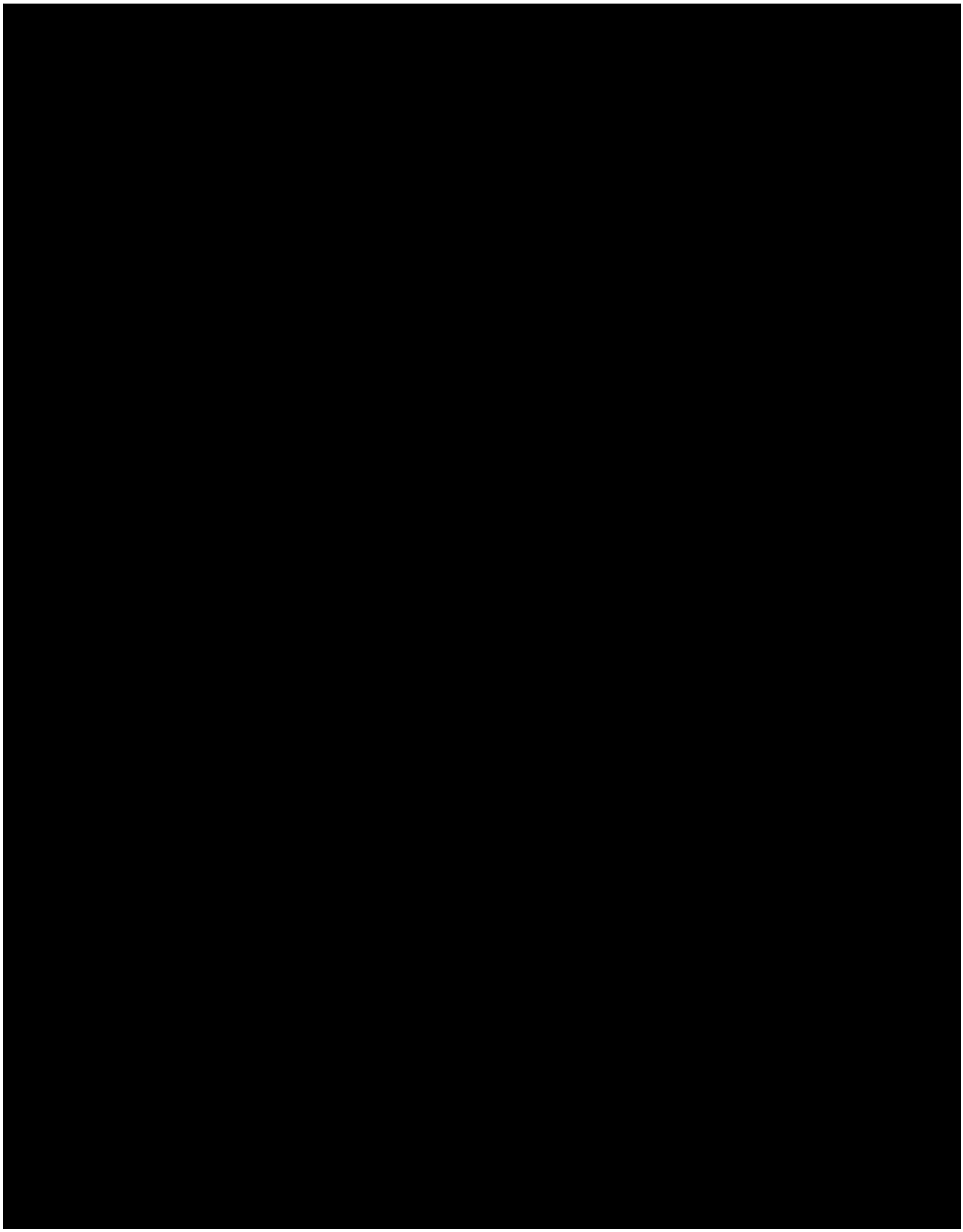
E.1.20: Access to Medical, Dental, and Financial Records

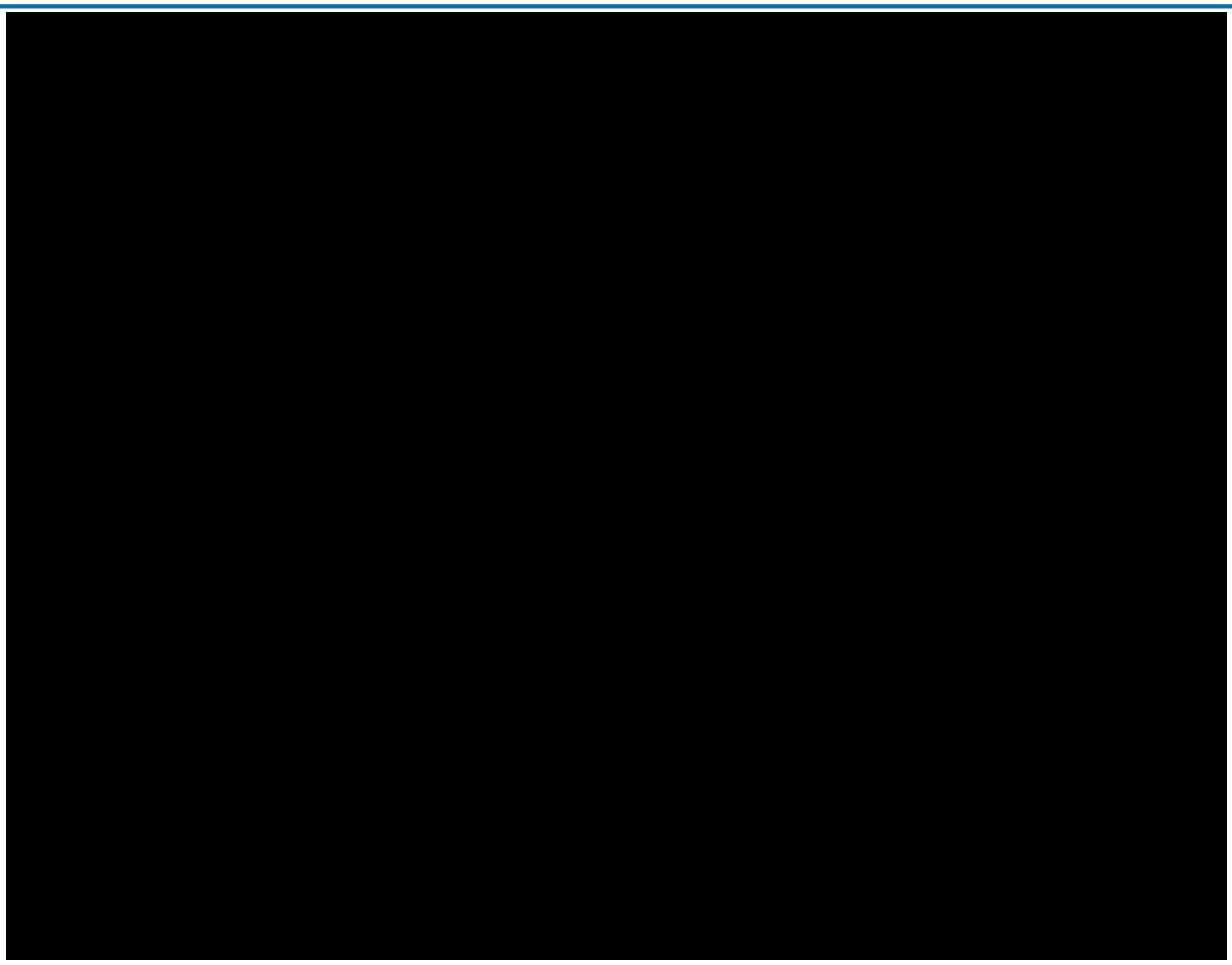
MCNA Provider Agreements stipulate they must make member records available to MCNA, representatives from the Agency, and other authorized entities for the purposes of monitoring compliance with record keeping, quality of care, financial record, or other reasons important to program administration. Each year we review a representative sample of member records from 25% of network providers to identify any issues and follow up with training as needed.

[redacted]









E.1.21: Adequate Access

MCNA ensures our members, including those with limited English proficiency (LEP) or physical or other disabilities, have access to comprehensive statewide provider networks in all states we serve. [redacted]

[redacted]

Attachment J, E.1.22: Adhering to Special Contract Exhibit C Requirements

E.1.22: Compliance with Access Requirements

MCNA's Iowa DWP provider network complies with timely access standards as specified in the contract, and we will continue to meet access and appointment availability requirements for DWP and Hawki in accordance with Exhibit C of Attachment F (General Access Standards). We educate our providers about appointment standards in our Provider Manual which is incorporated into our Participation Agreement. We also educate providers about these standards in our Provider Orientation training materials. Our members receive timely care and referrals to care in accordance with the following standards:

- **Primary Dental Care:** Members have a choice of PDPs within 30 minutes or 30 miles from their residence. Appointment availability is not to exceed 4 to 6 weeks from a request for a routine appointment, 48 hours for persistent symptoms, and urgent care within 1 day.
- **Specialty Care:** MCNA attests that 75% of members have a choice of specialists within 60 minutes or 60 miles of their residence, and all members have a choice of specialists within 90 minutes or 90 miles from their residence. Appointment availability is not to exceed 30 days for routine care or 1 day for urgent care.
- **Emergency and Post-Stabilization Services:** Members in need of emergency and post-stabilization services have a choice of any emergency care provider, at the nearest facility available, regardless of whether the facility or provider is under contract with MCNA. Post-stabilization services will be available to members in a timely manner to prevent re-hospitalization or presenting at the emergency room. MCNA coordinates these for the member, upon notification from the member, MCO, hospital, physician, or dentist who referred the member.

[redacted]

If a member is determined to need a course of treatment or regular care monitoring, MCNA allows the member to directly access a specialist as appropriate for their condition. We ensure that our Iowa network providers have an appointment system for covered dental benefits and services that are in accordance with prevailing dental community standards. Any Agency changes to appointment availability requirements will be communicated to our in-network providers via the MCNA Provider Manual.

MCNA maintains and updates an emergency/contingency plan to assure timely access to needed services in the event a large provider of services collapses or is otherwise unable to provide services to members.

E.1.24: Capacity – Assurances

[redacted]

[redacted] These reports include such information as the numbers and types of providers who furnish Medicaid covered dental benefits and services, the number of providers who are not accepting new patients, and a geographic analysis of providers and members, considering distance, travel time, and whether the location provides physical access for members with disabilities.

E.1.25: Contractor Closing Network

We understand that once we meet network adequacy standards that we can require all our enrolled members to seek covered services from in-network providers only if closure would not burden a group of members. [redacted]

E.1.26: Appropriate Range of Services

MCNA provides an appropriate range of primary care, specialty, and preventative services that is adequate for the anticipated number of enrolled members in the service area. We will submit this documentation in the format and frequency specified by the State. We are fully prepared to continue providing these benefits with no disruption in services for members or providers. In the event the Agency adds or changes any services over the course of the contract, we will work closely with our network of providers to promptly and efficiently implement these changes to ensure our members continue to receive all covered benefits. This includes all services in the DWP and Hawki plans.

E.1.27: Appropriate Provider Mix

MCNA will submit documentation in the format specified by the State to demonstrates we maintain a network of providers, who are accepting new patients, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

E.1.28: Provider Network

[redacted] We will continue to submit all required information about our provider network adequacy upon contract execution, monthly thereafter, and when is a significant change in operations that may impact services. As described in E.1.22, we meet the accessibility standards set forth in Special Contract Exhibit C.

Attachment J, E.1.29: Provider Credentialing and Performance Metric

E.1.29: Provider Credentialing - E.1.30: Recredentialing Performance Metrics

Credentialing is a critical component of our network development approach that ensures members have access to a qualified continuum of providers. **MCNA has been NCQA accredited for credentialing and recredentialing since 2011, and URAC accredited since 2014.** MCNA's procedures for reviewing, approving the credentials of all participating dental providers, and terminating or suspending providers are in compliance with all RFP requirements. For initial credentialing, we meet or exceed the Agency requirement to credential 85% of providers within 30 days of the provider's

formal request to participate in our network, and 98% within 45 days, and 100% within 60 days. [redacted] ur written credentialing and re-credentialing process complies with the RFP and governs our review of all licensed providers with whom we contract or employ.

[redacted]

[redacted]

E.1.31: Rural Considerations

MCNA deploys multiple strategies to expand available access points in rural and Dental Health Professional Shortage Areas (HPSAs). Some of our key strategies include expanding the network to include providers in bordering states, collaborating with the dental schools to retain newly trained dentists within the hardest areas of reach, pursuing out-of-network arrangements, and expanding the scope of services routinely offered by primary care dental homes such as extractions that may have otherwise been referred to an oral surgeon. We will continue to monitor across the state, particularly in rural areas. When we detect the need for increased access of services, we will submit an action plan to the state.

[redacted]

Successful Out of Network Arrangements

MCNA strives to contract with every available, high-quality, dentist within the states we serve. We do understand however, that not all dentists or specialty dentists are willing to participate for a variety of reasons, including maximum panel capacity or patient mix status. In these instances, our network development team will attempt an agreement with the provider to see our members on a case-by-case basis when a gap in access occurs.

[redacted]

[redacted]

E.1.32: Network Adequacy

In accordance with 42 CFR § 438.207, MCNA will submit documentation demonstrating the adequacy of capacity and services we provide to our Iowa members in the format and intervals specified by the Agency, but no less frequently than (1) when the contract begins, (2) annually, and (3) any time there has been a significant change in MCNA's operations that would impact the adequacy of capacity and services.

E.2: No Discrimination

E.2.01: Provider Discrimination

Our network development methods are designed to ensure that our network includes a diverse array of providers to care for the population served. MCNA recruits providers who value diversity and are committed to serving people of racial and ethnic minorities and those with disabilities. Our provider selection policies and procedures do not discriminate against providers serving high-risk populations or those who specialize in conditions requiring complex and costly treatment. We do not discriminate against a Provider who is acting within the scope of their license solely based on that licensure or certification.

E.3: Provider Selection

E.3.01: Declining Enrollment – Written Notice

If a Medicaid provider requests participation in our network, MCNA makes a good faith effort to execute a Provider Agreement if the provider meets our terms and conditions for participation as established in our NCQA accredited credentialing process and agree to our terms of participation and reimbursement in our Provider Agreement and Provider Manual. If MCNA declines participation to an individual or group of providers, we will provide written notice of the reason for this decision to the provider or group within 14 calendar days of the decision.

E.3.02: Policies and Procedures

MCNA has written policies and procedures for the selection and retention of network providers. As mentioned in E.1.25, **MCNA maintains an open network policy**. New providers are invited to participate in MCNA's network so long as they meet all requirements for participation.

[redacted]

[redacted]

E.3.03: Credentialing Policies and Procedures

MCNA has been NCQA accredited for credentialing and recredentialing since 2011, and URAC accredited since 2014. MCNA reviews, approves, and periodically recertifies the credentials of all participating dental providers at least every 36 months through a process that updates information obtained in initial credentialing, considers performance indicators such as those collected through the Quality Improvement (QI) program; the Utilization Management (UM) program; complaints, grievances, appeals, and State Fair Hearings; member satisfaction surveys; and other pertinent information.

Our accredited credentialing process has been in place in Iowa since 2016. MCNA's credentialing and re-credentialing policies and procedures detail the process for approval of new providers, and termination or suspension of providers. We encourage board certification as applicable. Our written credentialing and re-credentialing process complies with 42 CFR §455.436, §438.12, §438.206, §438.214, §438.224, §438.230, and §432.602(b), and governs our review of all licensed providers with whom we contract or employ. Any annual changes to our process will be submitted to the Agency for review and approval prior to implementation.

E.3.04: Uniform Credentialing and Recredentialing Policy

MCNA follows the State's uniform Credentialing and Recredentialing policy regarding acute, primary, behavioral, substance use disorder, and LTSS providers, as appropriate. We embed this content into our credentialing and recredentialing policy, which we describe in detail above in E.3.03. Our credentialing and recredentialing program provides the structure through which we can ensure providers meet the standards of both MCNA and the state. Providers must complete the uniform credentialing application to join MCNA's network.

E.3.05: Credentialing and Recredentialing Requirements

MCNA's credentialing and re-credentialing process for all contracted providers meets the guidelines and standards of NCQA and URAC and is in compliance with all State and Federal rules and regulations.

E.3.06: Licensed and Non-Licensed Providers

A key part of MCNA's Iowa credentialing process is making sure providers meet all State requirements. We determine that providers possess the licenses and credentials necessary to render dental services under State law (MCNA obtains information from the National Practitioner Data Bank, the Iowa Dental Board, any equivalent licensing boards for providers located out of state who are in our network, and any other applicable licensing entities). We check the Dental License, DEA License, Controlled Substance Registration, and Sedation Permits at initial and re-credentialing time, and whenever the license expires mid-cycle. Providers are also required to submit their professional liability insurance face

sheet, work history, Board Certificate or evidence of adequate training, a completed W-9, and signed copies of the provider application and provider contract. When individuals providing services are not required to be licensed, accredited or certified, MCNA ensures, based on applicable State licensure rules and/or Program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

E.3.07: Facility Requirements

As part of our initial credentialing process and as part of recredentialing, we make sure facilities, including hospitals and dental offices, are licensed and in good standing as required by Iowa state law. We keep track of when each applicable dental license expires, and we follow up if the expiration date falls before required re-credentialing.

E.3.09: Obligation to Follow Documented Processes

MCNA follows a documented process for credentialing and recredentialing of network providers, which we describe above in E.1.29-30. This process is described in our policies and procedures, provider agreements, and provider manual which is part of our provider agreement.

MCNA complies with all sanctions imposed by the State on network providers, including enrollment revocation, termination, and mandatory exclusions in a timely manner. Our Provider Agreement requires at least 90 days' notice prior to voluntary provider termination.

E.3.10: Non-Discrimination

Our network development methods are designed to ensure that our network includes a diverse array of providers to care for the population served. MCNA recruits providers who value diversity and are committed to serving people of racial and ethnic minorities and those with disabilities. Our provider selection policies and procedures do not discriminate against providers serving high-risk populations or those who specialize in conditions requiring complex and costly treatment, as mentioned in section E.2.01.

See section 3.13 from our Iowa Provider Agreement below:

> **Section 3.13 – Nondiscrimination by MCNA.** Provider will provide services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of payor, source of payment, physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991 (the "ADA"). Provider recognizes that as a governmental contractor, MCNA is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors.

We reinforce this in our provider and staff training, provider manual, and provider agreements.

E.3.11: Provider Selection Obligations

MCNA attests our Provider Agreements will be kept up to date with any additional provider selection requirements the State may establish.

E.3.12: Contractor Limitations on Provider Network

We do not close or limit provider panels unless the request is made by the provider; our network is always open to new providers willing to meet MCNA's terms and conditions. Unlike many of our competitors who limit the size of the

provider network by closing their dental panels, MCNA maintains an open network policy, which we elaborate on in section E.1.25 above.

E.3.13: Varying Reimbursements

MCNA acknowledges that we are not precluded from having different reimbursement amounts for different specialties and different providers within a specialty.

E.3.14: Maintaining Quality and Cost Controls

MCNA understands that we are not precluded from establishing measure that are designed to maintain quality of services and control costs, consistent with our responsibilities to members. MCNA recognizes that Alternative Payment Models (APMs) or value-based payments (VBPs) are a means of incentivizing providers to innovate their practices and achieve higher quality outcomes and cost effectiveness.

E.3.15: Credentialing Obligation

All of our network providers are credentialed as required under 42 C.F.R. § 438.214. This is demonstrated through our ongoing EQRO audits and Agency reporting requirements. Credentialed providers are loaded into DentalTrac™ and available through our member-facing Provider Directory.

Our online Provider Directory allows users to filter a search using a preferred language. This information is gathered from the practitioner's initial credentialing application and updated as the status is changed by the practitioner. MCNA verifies this information at the time of initial credentialing and annually thereafter. Our website and directories are available in English and Spanish.

E.3.16: Restriction on Non-Compete Provider Arrangements

MCNA does not restrict our providers from contracting with other Iowa DWP and Hawki Program Contractor, which we outline in our provider agreement.

E.3.18: Iowa Medicaid Providers

As an incumbent to the Iowa DWP program since 2016, we do not close or limit provider panels; our network is always open to new providers willing to meet MCNA's terms and conditions.

E.3.19: Written Notice Obligation

If a Medicaid provider requests participation in our network, MCNA makes a good faith effort to execute a Provider Agreement if the provider meets our terms and conditions for participation as established in our NCQA accredited credentialing process. If MCNA declines participation to an individual or group of providers, we will provide written notice of the reason for this decision to the provider or group within 14 calendar days of the decision.

E.4: Anti-Gag

E.4.01: Anti-Gag Obligation

MCNA does not and will not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding:

- The member's health status, medical/dental care, or treatment options, including any alternative treatment that may be self-administered
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

We ensure that providers are aware of this policy by including it in our provider agreements and provider manual.

E.4.02: No Punitive Action

We never take punitive action against a provider who exercises their right to request an expedited resolution or supports a member's appeal.

E.5: Network Adequacy Standards

E.5.01: Adequacy

MCNA understands and will comply with network adequacy standards outlined in 42 C.F.R. § 438.206(c)(1)(i) - (vi); 42 C.F.R. § 457.1230(a).

MCNA continually monitors our providers and overall plan performance metrics including access standards to ensure all services are provided timely and in compliance with applicable contract requirements. [redacted]

Timely Access to Care and Services

MCNA's provider network for Iowa complies with timely access standards as specified in the contract. We educate our providers about appointment standards in our Provider Manual which is incorporated into our Participation Agreement. We also educate providers about these standards in our Provider Orientation training materials. Our members receive timely care and referrals to care in accordance with the following standards outlined in Special Contract Exhibit C:

- **Primary Dental Care** – within 4 to 6 weeks from the member's request for a routine appointment and within 48 hours for persistent symptoms and within 1 day for urgent symptoms
- **Specialty Dental Care** – within 30 days for routine care and 1 day for urgent care

Hours of Operation

We will ensure that hours of operation for Iowa members are not less than the hours available to commercial patients or Medicaid fee-for-service hours if the provider serves only Medicaid recipients. MCNA will maintain a robust network of Iowa providers who offer after-hours care. After-hours care access is a key component of the model we promote to ensure members receive the right care, in the right place, at the right time. We understand that emergency department use for non-traumatic dental care is a core focus area for states looking to control cost and increase dental care utilization in appropriate settings. Our goal is to ensure the dental office setting is used for all non-trauma related dental services, and that the emergency department is a last resort for our members. As part of our network capacity building strategy, we educate and encourage providers to offer extended office hours. Our Network Development and Provider Relations teams are available to work with providers who offer extended hours to better meet members' needs by assisting them in identifying strategies to improve their after-hours availability. With extended office hours and appointment availability, members have increased access to their provider and more opportunities to manage their care.

24/7 Access When Medically Necessary

MCNA is committed to ensuring that dental services are available 24 hours per day, 7 days per week (24/7) consistent with medical necessity needs. MCNA has clear written guidelines for our network providers regarding access standards outlined in the SOW including:

- 24/7 access to emergency services
- PDP medically appointment for persistent symptoms within 48 hours, urgent care within 1 day, and routine appointments within 4 to 6 weeks
- Specialist appointments within 30 days for routine care, urgent care within 1 day

If a member is determined to need a course of treatment or regular care monitoring, MCNA allows the member to directly access a specialist as appropriate for their condition. We ensure that our Iowa network providers have an appointment system for covered dental benefits and services that is in accordance with prevailing dental community standards. Any changes to appointment standard policies and procedures will be communicated to our in-network providers and our enrollees prior to implementing the changes.

To further support timely access, our written policies and procedures describe how members can obtain urgent coverage and emergency services after business hours and on weekends, including the provision of direct contact with qualified dental professionals. Members are educated about after-hours access to care through the MCNA Member Handbook. Our goal is to ensure the dental office setting is used for all non-trauma related dental services, and that the emergency department is a last resort for our members. We monitor member utilization of emergency dental services to ensure members have properly addressed their chief concern.

[redacted]

[redacted]

Monitoring of Network Provider Access

MCNA continually monitors our providers and overall plan performance metrics including access standards to ensure all services are provided timely and in compliance with applicable contract requirements. [redacted]

E.5.02: Access Obligations

MCNA expects our providers to demonstrate cultural sensitivity to individuals with physical and mental disabilities and providing physical access, reasonable accommodations, and accessible equipment is a contracting requirement. All providers must comply with the Americans with Disabilities Act (ADA), and each member may choose among participating providers. MCNA performs ongoing monitoring, including secret shopper activities, to ensure provider compliance with access requirements. Member complaints are also monitored for any allegation of discrimination by a network provider. We ensure that providers comply with these requirements and will take corrective action as needed.

E.5.03: Quantitative Network Adequacy – Provider Type and Geographic Area Requirement

MCNA has procedures in place to ensure that all relevant provider types listed in SOW E.5.03 meet the state's network adequacy standards outlined in Special Contract Exhibit C. As mentioned in E.1.25, we do not close or limit provider panels; our network is always open to new providers willing to meet MCNA's terms and conditions. See section E.1 Network Adequacy above for more details.

[redacted]

E.5.08: Exceptions

We acknowledge that the state has developed exceptions to the Provider Network adequacy obligation. We will request exceptions as needed in areas where access is unavailable.

E.6: Provider Notification of Grievance and Appeals Rights

E.6.01: Enrolled Member Appeal Rights Notice

Providers receive detailed information about grievances, appeals, and State Fair Hearings upon contracting with MCNA. We provide the information through multiple highly accessible avenues. This includes our detailed Provider Manual, our Provider Portal, and the required orientation. In addition, these important member rights and associated timeframes are covered in ongoing educational videos, newsletters, and webinars. Providers may also request ad hoc training at any time.

Because MCNA does not engage subcontractors to perform any of the Scope of Work, our response speaks exclusively to how we work with our network providers to ensure they understand and abide by all requirements related to member rights regarding grievances and appeals and State Fair Hearings.

Grievances

MCNA makes our Provider Manual accessible on our Iowa website at www.mcnaia.net. The manual is part of our Participating Provider Agreement and explains that member grievances can be filed at any time by a member or a person acting on behalf of a member. A grievance can be about any aspect of MCNA's operation, quality of care, rudeness of an employee, or failure to respect a member's rights. We notify providers that grievances can be filed verbally, in writing, or in person. With written consent of the member, a provider can file a grievance on their behalf. Providers may file grievances on behalf of members via the Member Hotline or by mail to the Grievances and Appeals Department.

MCNA acknowledges receipt of a grievance within five calendar days of receipt. We resolve and provide written resolution of all member grievances within 30 days from the date of receipt. [redacted]

Appeals

The Provider Manual also covers the process and timeframes for appeals of adverse determinations. Adverse determinations include:

- Denial or limited authorization of a requested service, including the type or level of service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, for payment of a service
- Failure to provide services in a timely manner, as defined by the Agency
- Failure of MCNA or the Agency to act within required timeframes
- For rural area members, denial of the right to obtain services outside the provider network
- Denial of a member's request to dispute a financial liability

Any of these adverse determinations can be appealed by a member or by a network provider. As with grievances, when filing an appeal on behalf of a member or a member's representative, the provider must obtain written consent of the member. An appeal may be filed verbally or in writing within 60 days of receiving the Notice of Action Letter outlining the adverse determination. MCNA acknowledges receipt within five calendar days. We resolve and provide written resolution within 30 days of receipt. If the member requests an extension of the timeframe or more information is needed, we may extend the timeframe for resolution by up to 14 days. If the extension is due to MCNA's need for more

information, we notify the member in writing of the reason for the extension. [redacted]

Expedited Appeals

[redacted]

In accordance with applicable statue and regulations, MCNA provides for an expedited appeal process in instances where the standard appeals timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. An expedited review request may be submitted verbally or in writing. MCNA will resolve an expedited review request no later than 72 hours after receiving the request. If MCNA denies a request for expedited resolution of an appeal, the appeal will be transferred to the standard appeals process and be resolved within 30 calendar days. MCNA immediately contacts the member by telephone if our decision is to deny an expedited resolution. We follow up with a written notice indicating our denial of the request within two calendar days.

MCNA never takes punitive action against any provider who requests an expedited resolution or supports an enrollee's appeal, or who files any grievance or appeal on behalf of a member.

Additional Educational Opportunities

[redacted]

[redacted]

E.6.02: State Fair Hearing Rights Notice

We inform providers that members (or a provider under certain circumstances) can request a State Fair Hearing after a decision on a standard or expedited appeal. After exhausting MCNA's appeals process, a member can file for a State Fair Hearing no less than 90 and no more than 120 calendar days from the date of MCNA's Notice of Action or Notice of Appeal Resolution. If the Agency permits a provider to act as a member's authorized representative, the provider may also request a State Fair Hearing. State Fair Hearings can be requested through the MCNA Member Hotline or by contacting the Agency. We provide complete contact information in our Provider Manual, Member Handbook, and on our website.

[redacted]

During the hearing, a member may represent himself or herself, or be represented by any authorized individual, such as a friend, relative, dentist, legal counsel, or anyone the member names to speak on their behalf. The Agency will typically reach their decision within 90 days of the hearing or appeal request date. [redacted]

E.6.03: Continuation of Benefits

Our Provider Manual and all related materials also inform providers of continuation of benefits requirements. Unless a member loses program eligibility, we do not end the benefits while the appeal is under review. If the appeal concerns services the member is currently receiving, and the member wishes to continue receiving services in the meantime, the member (or provider with written authorization from the member) must submit a written authorization request.

A Continuation of Benefits may be requested when all the following are true:

- The appeal is filed within 60 days of receiving notice of the adverse determination
- The appeal involves the termination, suspension, or reduction of a previously authorized service
- The services were ordered by an authorized provider
- The authorization period, if applicable, has not expired
- The request for Continuation of Benefits is filed on or before the later of:
    - Ten days of receipt of the adverse benefit determination, or
    - The intended effective date of the processed adverse benefit determination

The written appeal must clearly state that the member wishes to continue receiving the services. Services may be continued until the appeal decision is made. If the appeal decision aligns with MCNA's denial, the member may be liable to pay for the services received during the continuation period.

E.6.04: Payment Disputes

MCNA attests that our Provider Manual which is part of our Participating Provider Agreement clearly state that providers do not have the right to request a State Fair Hearing in resolve a payment dispute between the provider and MCNA after services have been rendered.

E.7: Balance Billing

MCNA does not allow billing of medically necessary covered dental services without a benefit limit for Medicaid members. [redacted]

E.8: Provider Incentive Plan

E.8.01: Restriction on Reducing or Limiting Services

MCNA attests that we do not operate any incentive programs that encourage, either by means of payment or other means, providers or provider groups to reduce, limit, or deny medically necessary services to members.

E.8.02: Stop-Loss Protection

MCNA attests that we do not operate any payment arrangements that put any providers or provider groups at substantial financial risk for service provided by other providers or similar entities.

E.8.03: Value-Based Purchasing Arrangements

MCNA recognizes that VBP arrangements are an important means of incentivizing providers to innovate their practices and achieve higher quality outcomes and cost effectiveness. [redacted]

In implementing incentive programs and VBPs, we will consider State goals and seek and receive State approval prior to implementation. In addition, we do not enroll Iowa providers in any VBP or incentive program without their explicit agreement. [redacted]

MCNA agrees to abide with all State monitoring protocols for our VBPs, whether semiannually or more frequently. Data we will share with the State will include, at a minimum, claims data and lists of members who are attributed to providers participating in VBP arrangements. We will report Agency-approved quality metrics and cost of care measures to document population dental health outcomes.

[redacted]

MCNA understands that for providers to participate and succeed in VBP arrangements, they must have a complete and accurate understanding of the population attributed to them. [redacted]

[redacted]

[redacted]

E.8.04: Value-Based Purchasing Compliance

MCNA attests that we will comply with all federal requirements for VBP arrangements found in 42 CFR. § 438.6(c). With Agency approval, we will only implement arrangements where payment is tied to utilization and delivery of services. Moreover, for any class of providers participating in the arrangement, the same incentives and same terms of performance will apply. All arrangements will advance one or more of the goals and objectives in the quality strategy found at 42 CFR § 438.340. All VBP arrangements will have an evaluation strategy that measures progress in meeting goals and objectives. MCNA will never require providers to participate in intergovernmental transfer arrangements in order to be part of a VBP arrangement, and no VBP arrangement will be constructed to be renewed automatically.

E.9: Network Requirements Involving Indians, Indian Health Care Providers (IHCPs), and Indian Managed Care Entities (IMCEs)

E.9.01: IHCPs – Timely Access

MCNA is committed to working with Iowa Medicaid, our Indian Health Care Providers (IHCP), and the American Indian Health Commission (AIHC) to ensure our members from tribal communities receive superior services and support in a respectful manner that recognizes their heritage and cultural history. We understand that American Indians and Alaska Natives experience poorer outcomes than any other population in Iowa, and we are excited about the opportunity to implement oral health initiatives we have successfully used in other states to improve services and outcomes for populations experiencing similar health care disparities.

MCNA fully complies with the requirement to demonstrate that there are sufficient IHCPs in our network to ensure timely access to care as outlined in Section E.9.01. [redacted]

[redacted]

[redacted]

E.9.02: IHCPs – Payment Obligations

In accordance this provision, we reimburse IHCPs, whether participating in our network or not, for covered services provided to American Indian/Alaska Native members at a negotiated rate, or, in the absence of a negotiated rate, at a rate no less that would be paid to a participating provider that is not an IHCP. All payments are made in a timely manner.

E.9.03: Out-of-Network Obligation

MCNA permits any enrolled American Indian/Alaska Native member to choose an IHCP as his or her primary care provider. American Indian/Alaska Native members can obtain services covered under the contract from out-of-network IHCPs where the member is otherwise eligible to receive such services. In addition, American Indian/Alaska Native members are permitted to access out-of-state IHCPs as needed.

E.9.04: Out-of-Network Referrals

MCNA permits any out-of-network IHCP to refer an Indian enrolled member to a network provider.

Section F: Coverage

F.01: Covered Populations

MCNA will continue to provide dental services on a statewide basis for all covered populations as specified in the contract. Services will be on a statewide basis without any regional coverage variations.

F.02: Excluded Populations

We acknowledge that populations excluded from coverage are set forth in Special Contract Exhibit D, Table D.02.

F.1: Emergency and Post-Stabilization Services

Attachment J, F.1.a: Emergency and Post-Stabilization Services

While MCNA aims to reduce potentially preventable emergency department visits through the provision of timely and high-quality preventive care, we understand that emergencies may occur. We ensure that our members have access to emergency care without the need to obtain prior authorization and can receive services through any emergency facility or provider, regardless of whether the facility is in- or out-of-network.

MCNA's Member Handbook contains easy-to-understand program information for our members designed to break down barriers in oral health literacy. The Member Handbook informs the member on the services that are available to them as a member during an emergency dental situation. The Member Handbook clearly states that a member does not need to get pre-authorization from MCNA and can use out-of-network providers for emergency dental services.

[redacted]

F.1.01: Payment Obligations

MCNA covers and pays for all emergency services and post-stabilization care services.

F.1.02: Review of Emergency Claims

MCNA will pay for emergency and post-stabilization services as defined in F.1.01. We do not reimburse providers for non-emergency services for treatment of conditions that do not meet the prudent layperson standard. MCNA does not limit what constitutes an emergency dental condition on the basis of lists of diagnoses or symptoms and may not deny or pay less than the allowed amount for the Current Dental Terminology (CDT) code on the claim without a clinical record review to determine if the prudent layperson standard was met. MCNA bases coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services where the presenting symptoms are of sufficient severity to constitute an emergency dental condition in the judgment of a prudent layperson,

even if the condition turned out to be non-emergency in nature. The prudent layperson review will be conducted by an MCNA staff member who does not have dental training. We do not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard. In addition to using the prudent layperson standard, MCNA endeavors to incorporate emergency dental condition as defined by the American Dental Association Emergency Dental Condition Guidelines into our review of emergency claims.

F.1.03: Obligation to Pay for Screening

If an emergency dental screening or examination leads to a clinical determination that an actual dentally-related emergency medical condition exists, MCNA will pay for both the services involved in the dental screening examination and the services required to stabilize the member. We acknowledge that we are required to pay for all emergency services which are medically necessary until the dentally-related or caused emergency is stabilized.

F.1.04: Non-Contracted Provider Payment Obligation

MCNA pays non-contracted and/or non-Iowa Medicaid Enrolled providers for emergency services at the amount that would have been paid if the service had been provided under the Agency's fee-for-service Medicaid program.

F.1.05: Payment Obligations

MCNA covers and pays for emergency services regardless of whether the provider that furnishes the services is Iowa Medicaid enrolled or has a contract with MCNA. We do not deny payment for treatment obtained when a member had a dentally-related emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, nor in situations where a member obtains dental treatment after being instructed by a representative of MCNA to seek emergency services. We follow State guidance for non-Medicaid enrolled providers to assure payment for services meets Medicaid provider enrollment screening guidelines.

F.1.06: Restriction on Limiting and Refusing Coverage

Additionally, MCNA does not limit what constitutes a dentally-related emergency medical condition on the basis of lists of diagnoses or symptoms, nor do we refuse to cover emergency services based on the emergency room, the provider, facility, hospital, or fiscal agent not notifying the member's PCP, MCNA, or applicable state entity of the member's screening and treatment within ten (10) days of presentation for emergency services.

F.1.07: Restriction on Holding Patient Liable

MCNA does not hold members liable for payment in relation to subsequent screening and treatment needed to diagnose or stabilize the specific, dentally-related Emergency Medical Condition

F.1.08: Emergency and Post-Stabilization Care Services

MCNA provides emergency services without requiring prior authorization or PCP referral, regardless of whether these services are provided by a contracted or non-contracted provider. We provide Post-Stabilization Care Services in accordance with 42 C.F.R. § 438.114.

F.1.09: Payment Through Stabilization

We are responsible for coverage and payment of services until the attending emergency physician, or the provider treating the member, determines that the member is sufficiently stabilized for transfer or discharge. The determination of the attending emergency physician, or the provider treating the member, of when the member is sufficiently stabilized for transfer or discharge is binding on MCNA and the Agency for coverage and payment of emergency and post-stabilization services.

F.1.10: Post-Stabilization Care Coverage

We cover Post-Stabilization Care Services:

a) Obtained within or outside our network that are:
    a. Pre-approved by an MCNA provider or representative.
    b. Not pre-approved by an MCNA provider or representative, but administered to maintain the member's stabilized condition within one (1) hour of a request to MCNA for pre-approval of further post-stabilization care services.
b) Administered to maintain, improve, or resolve the member's stabilized condition without preauthorization, and regardless of whether the member obtains the services within MCNA's network when MCNA:
    a. Did not respond to a request for pre-approval within one (1) hour.
    b. Could not be contacted.
    c. Representative and the treating physician or dentist could not reach agreement concerning the member's care and an MCNA physician was not available for consultation.

F.1.11: Post-Stabilization Services

MCNA is responsible for all medical and dental services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the member's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility.

F.1.13: Financial Responsibility

Charges to members for post-stabilization care services are limited by MCNA to an amount no greater than what we would charge the member if the member obtained the services through MCNA. MCNA's financial responsibility for post-stabilization care services if they have not been pre-approved ends when:

a) An MCNA provider with privileges at the treating hospital assumes responsibility for the member's care.
b) An MCNA provider assumes responsibility for the member's care through transfer.
c) An MCNA representative and the treating dentist/physician reach an agreement concerning the member's care.
d) The member is discharged.

F.4: Delivery Network

[redacted]

We support the successful onboarding of providers into our network with training and education. Ongoing network maintenance includes verification of credentials within the required contractual timeframes, contracting, performance monitoring, and corrective action as needed. These are integral components of our approach to ensure a network that complies with all contractual and program requirements.

All MCNA providers must maintain accurate, current medical records for members. [redacted] MCNA network PDPs are contractually required to ensure members have access to information on emergency dental care 24 hours per day, 7 days per week. [redacted]

Additional key contract provisions include a prohibition against balance billing, fraud and abuse prevention standards, dental record keeping requirements, and a requirement to ensure that MCNA members receive appointments within the timeframes required by the Agency. [redacted]

F.4.02: Second Opinions

MCNA provides for a second opinion from a network provider, or we will arrange for the member to obtain a second opinion outside the network, at no cost. If a network provider is unable to provide necessary medical services covered under the contract to a member, MCNA will cover the services out of network, for as long as our network is unable to provide them.

F.4.03: Out-of-Network Provision of Care

Circumstances may arise where it will be necessary for a member to obtain treatment from a non-participating (non-par) provider. The need to see a non-par provider can also occur when a member requires exceptional services that address uncommon and unique dental needs. To address these challenges, our Provider Relations Department monitors the performance of our network on at least a monthly basis to ensure that our members have access to an adequate number of providers accepting new Medicaid patients and a database of non-par providers for when such services are required.

[redacted]

F.4.04: Out of Network Providers

Once a suitable non-par provider is identified and contacted, our Credentialing Department performs a thorough background check of their credentials to ensure our member will receive the highest quality of treatment. MCNA collects enough detail about the out-of-network provider to screen for any exclusions, debarments, or licensure actions that would prevent the provider from being able to provide services to the member. If the non-par provider satisfies our credentialing requirements and there is mutual agreement with respect to the reimbursement rate for the services, an SCA is executed between MCNA and the provider, and the services may commence at no cost to the member.

The SCA sets forth the terms of payment and includes a provision against balance billing to ensure that the cost of care for the member is no greater than if the provider was in-network. The provider's NPI, tax ID number, and other details are loaded into our DentalTrac™ management information system to ensure accurate payment and enable the generation of a 1099 for tax purposes. Additionally, MCNA will offer the provider the opportunity to become part of our network as part of our long-term intervention to address gaps.

For situations requiring out-of-network care, MCNA coordinates care and transfers appropriate dental records to the provider to facilitate the completion of the treatment plan. All health care providers are encouraged to enroll in Iowa Medicaid to receive payment and may be denied payment if the required criteria are not met.

F.4.05: Out of Network Care for Duals

Generally, when a member is a "dual eligible" (having both Medicaid and Medicare coverage) and requires services that are covered under the contract but are not covered by Medicare, and the services are ordered by a Medicare provider who is an out-of-network provider, MCNA will pay for the ordered, medically necessary service if provided by an in-network provider. However, under the following circumstances, MCNA may require that the ordering physician be contracted and in-network:

a) The ordered service requires prior authorization;
b) Dually eligible members have been clearly informed of the contracted provider requirement and instructed in how to obtain assistance identifying and making an appointment with a contracted provider; and
c) MCNA assists the member in obtaining a timely appointment with an in-network provider upon request of the member or upon receipt of an order from an out-of-network provider.

F.4.06: Out-of-Network Coordination of Payment

MCNA coordinates payment with out-of-network providers and ensures the cost to the member is no greater than it would be if the services were furnished within the network.

F.4.07: Limitation on Out-of-Network Coordination of Payment

With the exception of SCAs and other arrangements established with out-of-network providers, we pay out-of-network providers no less than 80% of the rate paid to in-network providers.

F.4.08: Provider Restriction on Billing

We do not allow providers to bill a member for all or any part of the cost of a treatment service, except as allowed for cost sharing under this contract.

F.5: Services Not Covered Based on Moral Objections

F.5.01: Information Requirements – When Applying for Contract

MCNA will provide all services covered under this contract and does not have any moral objections to the any aspect of the scope of work.

F.5.02: Information Requirements – When Policies Change

We acknowledge that if MCNA elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, we must furnish information about the services we do not cover to the Agency with our application for a Medicaid contract or when such a policy change is adopted.

F.5.03: Advance Notice Requirement

MCNA will notify the Agency thirty (30) days before implementing any such restriction on services and provide information on such restricted services to all members at a minimum of ninety (90) days before implementing the policy for any particular service.

F.6: Amount, Duration, and Scope

The guiding principle for our UM Program is that UM decisions must be made by licensed dentists and specialists. In this way, professionals who understand the unique needs of the members, providers, and program sponsors in each state make UM decisions on a peer-to-peer basis. Our dedicated Iowa team is led by an Iowa-licensed dentist who has been providing clinical review services under our current contract with the Agency. Having a trusted, local leader is important to gaining provider "buy in" to MCNA's approach. Provider confidence and satisfaction with MCNA's UM Program is essential to guaranteeing that members have access to appropriate care on a timely basis.

MCNA will always consider the appropriateness of a specific dental treatment for which PA is sought on its own merit based on the radiographs, narratives, and other supporting documentation submitted with the request. Our Clinical Reviewers have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by MCNA's licensed Clinical Reviewers. Our Dental Director and all Clinical Reviewers are required to attest that no adverse determinations will be made regarding any dental procedure or service outside of the scope of their expertise. In accordance with 42 CFR §438.210(e), MCNA ensures that compensation to individuals conducting UM activities is not structured to provide any incentives for denying, limiting, or discontinuing medically necessary dental services to any Iowa member.

MCNA will educate our Clinical Reviewers on both the terminology and qualifying criteria defining the amount, duration, and scope of treatment specified in this RFP and the Model Contract. The Clinical Reviewers are trained to examine cases utilizing their experience as dental practitioners in addition to relating the existing conditions to the qualifying criteria to determine whether the requested service should be approved. The result of our comprehensive training is that services that should be approved will be approved.

[redacted]

F.6.01: General

MCNA acknowledges that this contract identifies, defines, and specifies the amount, duration, and scope of each service we are required to offer.

F.6.02: Fee-For-Service Equivalence Requirement

MCNA acknowledges that each service shall be furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under fee-for-service (FFS) Medicaid, unless otherwise specified in an approved State Plan waiver.

F.6.03: FFS Equivalence Requirement – Under Twenty-One (21)

MCNA provides services for members under the age of twenty-one to the same extent that services are furnished to individuals under the age of twenty-one under FFS Medicaid or, if applicable CHIP.

F.6.04: Sufficiency of Services

MCNA ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

F.6.05: Prohibition on Reducing Services

MCNA will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member.

F.6.06: Appropriate Limits on Services

We acknowledge that MCNA may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan (MSP), the CHIP State Plan, as applicable, and/or the Iowa Administrative Code, such as medical necessity or as otherwise permitted under an approved State Plan waiver.

F.6.07: Medical Necessity Determinations

MCNA makes all medical necessity determinations in accordance with contractual, State, and federal requirements and on a case-by-case basis. We do not employ and do not permit others acting on our behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history.

F.6.08: Licensed Professionals – UM

MCNA uses appropriate licensed professionals to supervise all medical necessity decisions and we specify the type of personnel responsible for each level of UM, including prior authorization and decision making.

[redacted]

Each service identified as requiring prior authorization has defined UM criteria based on the nationally accepted clinical guidelines referenced above, as well as Agency guidelines. The criteria are continuously evaluated in terms of appropriateness for the program benefits.

On an annual basis, our UM Criteria and Guidelines are reviewed to ensure they are current with industry best practice standards and comply with our contractual agreements. [redacted] Our approach is consistent with our URAC Dental Plan Accreditation standards. In addition, our oral health Clinical Practice Guidelines and practices meet all requirements pursuant to 42 C.F.R. § 438.236.

F.6.09: Appropriate Limits on Services

MCNA recognizes that we may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose.

F.6.10: Prior Authorizations

At any point that the Agency redistributes membership within the Iowa Dental Wellness Plan and Hawki Dental program or following open Enrollment, MCNA will honor existing authorizations for covered benefits for a minimum of ninety (90) days, without regard to whether such services are being provided by in or out-of-network providers, when a member transitions to MCNA from another source of coverage. We will honor existing exceptions to policy granted by the Director for the scope and duration designated.

At all other times outside of Agency member redistribution and following open enrollment, MCNA will honor existing authorizations for a minimum of thirty (30) days when a member transitions to our plan from another source of coverage, without regard to whether services are being provided by in or out-of-network providers. We will obtain Agency approval for policies and procedures to identify existing prior authorizations at the time of enrollment. MCNA implements and adheres to the Agency-approved policies and procedures. Additionally, when a member transitions to another dental plan, MCNA will provide the receiving entity with information on any current service authorizations, utilization data, and other applicable clinical information such as disease management or care coordination notes.

F.6.11: Transition of New Members

MCNA provides for the continuation of medically necessary covered services to newly enrolled members transitioning to MCNA's plan regardless of prior authorization or referral requirements.

F.6.12: Chronic Conditions & LTSS – Need for Services

We acknowledge that MCNA may place appropriate limits on a service for utilization control, provided the services supporting individuals with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports.

F.6.15: Covered Services

MCNA provides, at a minimum, all benefits and services deemed medically necessary services that are covered under the contract with the Agency in accordance with 42 C.F.R. § 438.210. MCNA will not avoid costs for services covered in the contract by referring members to publicly supported health care resources. We will ensure services are provided consistent

with the United States Supreme Court's Olmstead decision and shall promote the Agency's goal of serving individuals in community integrated settings.

F.6.16: Benefit Packages

MCNA ensures the provision of covered benefits in accordance with the member's eligibility group as described in the contract and in Special Contract Exhibit E.

F.6.17: Hawki Enrolled Members

MCNA provides benefits to members of the CHIP program (known as "Hawki") as described in Special Contract Exhibits D and E of this contract. Members not otherwise specified in Section F.6.16 or who are enrolled in the Hawki program who are enrolled with MCNA are eligible for all medically necessary covered benefits in Iowa's State Plan as amended and all waivers approved by CMS. MCNA will provide services to members for which they are eligible as described in this contract.

F.6.18: Iowa Dental Wellness Plan Benefits

MCNA will ensure that members eligible for the Iowa Dental Wellness Plan receive plan benefits. Iowa Dental Wellness Plan coverage is described in the State Plan and summarized in Special Contract Exhibit E.

F.6.22: Changes in Covered Services

We acknowledge that the Agency will provide MCNA with ninety (90) days of advanced written notice preceding any change in covered services under the contract unless such change is pursuant to a legislative or regulatory mandate, in which event, the Agency will use best efforts to provide reasonable notice to the contractor. In the event the Agency provides less than ninety (90) days of advanced written notice to MCNA, we will comply with the change in covered services within ninety (90) days from the date the notice is given.

F.6.23: Integrated Care

MCNA will develop, implement, and adhere to strategies to integrate the delivery of dental healthcare across the healthcare delivery system as part of delivering services under this contract.

F.6.24: QTL & NQTL

MCNA will provide all medically necessary services in a manner that is no more restrictive than the State Medicaid program, including quantitative and non-quantitative treatment limits (QTL and NQTL), as indicated in State statutes and regulations, the State Plan, and other State policies and procedures.

F.6.25: Early and Periodic Screening, Diagnostic Treatment (EPSDT) Services

MCNA is committed to the goals of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and will continue to ensure that children and adolescents receive appropriate dental services. Our team's proven record of success makes MCNA the right fit for Iowa. MCNA will provide EPSDT services to all of our members who are under age 21, including necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered during screening, whether or not such services are covered under the dental program. [redacted]

F.6.25.a: Partnering with Local Agencies for Screening

We 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.

F.6.25.b: Services

MCNA assures the 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. We make 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.

We acknowledge that MCNA 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.

MCNA covers 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 State determines that the needed services are more readily available in another 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). MCNA considers 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.

F.6.25.c: Transportation

MCNA will offer Iowa Care for Kids EPSDT-eligible members 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.

F.6.25.d: Reports and Records

MCNA understands that the Agency has the obligation of assuring the Federal government that EPSDT services are being provided as required. MCNA ensures that all requested records, including dental and peer review records, shall be available for inspection by State or Federal personnel or their representatives. We record dental screenings and

examination related activities and shall report those findings in an Agency approved format at the Agency established frequency.

F.6.25.e: Outreach

MCNA has a robust plan for outreach, monitoring, and evaluation strategies for EPSDT, including collaboration with local community stakeholders and public health agencies. Our provider and member education activities are designed to increase member awareness of and access to applicable EPSDT services.

F.6.26: Prior Authorization - EPSDT

Prior Authorization or PCP (if applicable) referral is not required for the provision of Iowa Care for Kids EPSDT screening services. While prior authorization limits may be placed on diagnostic and treatment services, EPSDT covered services are not limited to the services, amount, frequency, or duration of codes included in the State Plan, if found medically necessary during clinical review. MCNA is required to review service prior to denial for medical necessity on a case-by-case basis. We acknowledge that we are not required to provide payment for any service determined as not safe, not effective, or considered experimental in nature. We ensure that all services that require prior authorization for members under 21 years of age are reviewed according to EPSDT federal requirements for covering medically necessary services prior to denial.

F.6.28: Sufficiency of Services - F.6.30: Functional Capacity

MCNA provides all medically necessary services. We ensure that services address the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. Under the auspices of medically necessary services, we cover both services to enable a member to achieve age-appropriate growth and development and services related to the ability for a member to attain, maintain, or regain functional capacity.

F.6.33: In Lieu of Services

We recognize that MCNA may cover services or settings for members that are in lieu of those covered under the State Plan if:

a) The Agency determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the State Plan.
b) The Agency determines that the alternative service or setting is a cost-effective substitute for the covered service or setting under the State Plan.
c) The member is not required by MCNA to use the alternative service or setting.
d) The approved in lieu of services are authorized and identified in the contract.
e) The approved in lieu of services are offered to members at the option of MCNA.

F.7: Provider Preventable Conditions

F.7.01: General

MCNA does not pay for provider preventable conditions that meet the following criteria:

a) Is identified in the State Plan.

b) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
c) Has a negative consequence for the member.
d) Is auditable.
e) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Pursuant to 42 C.F.R. § 447.26(c), no reduction in payment for a provider preventable condition is imposed when the condition defined as a Provider preventable condition for a particular patient existed prior to the initiation of treatment for that patient by that provider. Reductions in provider reimbursement may be limited to the extent that the identified provider preventable conditions would otherwise result in an increase in payment; and MCNA can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.

F.7.02: Reporting by Providers – F.7.04: Future Additions to Preventable Conditions

MCNA requires all providers to report provider preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. We will report all identified provider preventable conditions in a form or frequency as specified by the Agency. MCNA will comply with any future additions to the list of non-reimbursable provider preventable conditions.

F.8: Cost Sharing

F.8.01: Restriction on Cost Sharing

MCNA limit any cost sharing imposed on members to the cost sharing permitted in Medicaid FFS regulations found at 42 C.F.R. § 447.50 through 42 C.F.R. § 447.82, all applicable State Plan obligations, and any approved State Plan waivers.

F.8.02: Cost Sharing

MCNA and all providers and subcontractors will not require any cost sharing responsibilities for covered services except to the extent that cost sharing responsibilities are required for those services in accordance with law and as described in Section F.8.

F.8.03: Public Notice

We share the following information with our providers and members:

- Groups of individuals subject to the cost sharing charges
- Consequences for non-payment
- Cumulative cost-sharing maximums
- Mechanisms for making payments for required charges

F.8.06: Copayments

MCNA only imposes Agency required copayments for Iowa Dental Wellness Plan participants in accordance with the State's 1115 waiver and Hawki Enrolled Members in accordance with the State's CHIP State Plan. Any copayment requirements will be at the discretion of the Agency.

F.8.07: Exempt Populations

MCNA ensures that the following populations are exempt from copayments:

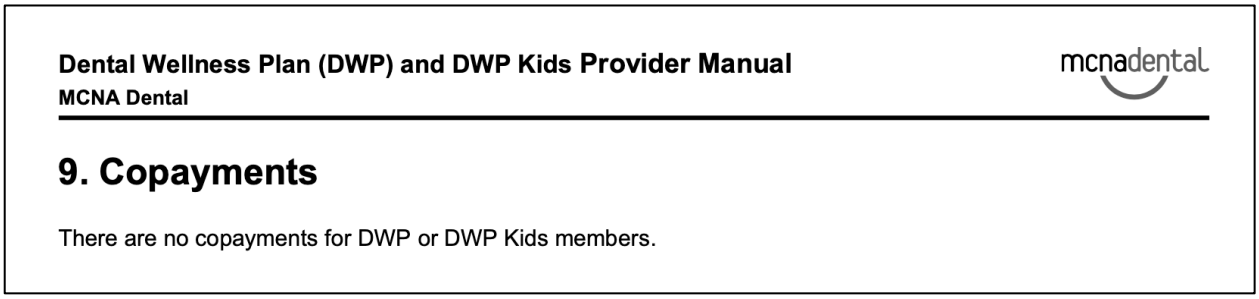
a) Individuals between ages one (1) and eighteen (18), eligible under 42 C.F.R. § 435.118;
b) Individuals under age one (1), eligible under 42 C.F.R. § 435.118;
c) Disabled or blind individuals under age eighteen (18) eligible under 42 C.F.R. § 435.120 or 42 C.F.R. § 435.130;
d) Children for whom child welfare services are made available under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving Benefits under Part E of that title, without regard to age;
e) Disabled children eligible for Medicaid under the Family Opportunity Act;
f) Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty (60) day period following termination of pregnancy ends;
g) Any individual whose medical assistance for services furnished in an institution or HCBS setting is reduced by amounts reflecting available income other than required for personal needs;
h) An individual receiving hospice care, as defined in Section 1905(o) of the Social Security Act;
i) An Indian (as defined in Special Contract Exhibit B) who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services; and
j) Individuals who are receiving Medicaid by virtue of their breast or cervical cancer diagnosis under 42 C.F.R. § 435.213.

F.8.08: Exempt Services

MCNA's management information system, DentalTrac™, ensures that copayments are not imposed for (i) preventive services provided to children under twenty-one (21) years of age covered under EPSDT; (ii) dental services provided during pregnancy, (ii) Provider preventable services as defined at 42 C.F.R. § 447.26(b); and (iii) Emergency Services.

F.8.10: Inability to Pay

Currently, there are no copayments for DWP-A or DWP-K members. However, should cost sharing be applied in the future, we understand that members can assert to providers that they are unable to pay the copayment. Providers may not deny care or services to any member because of their inability to pay the copayment. MCNA implements the following mechanisms to enforce this policy: (i) Provider education; (ii) documentation in the Provider policy manual; and (iii) assisting members who report they have been denied services for inability to pay. Please see below language from our current Agency-approved Provider Manual regarding copayments.



Dental Wellness Plan (DWP) and DWP Kids Provider Manual
MCNA Dental

9. Copayments

There are no copayments for DWP or DWP Kids members.

F.8.11: Claims Payment

MCNA reduces the payment made to a provider by the member's copayment obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 C.F.R. § 447.56(c).

F.8.13: Indian Premium Exemption

Any AI/AN member who is eligible to receive or has received an item or service furnished by an IHCP or through referral under contract health service is exempt from premiums.

F.8.14: Indian Cost Sharing Exemption

Any AI/AN member who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services is exempt from all cost sharing provisions pursuant to federal law and regulations..

F.15: Moral Objections

F.15.01: Generally

MCNA understands that we are not required to provide, reimburse for, or provide coverage of a counseling or referral service if we object to the service on moral or religious grounds. MCNA does not have any moral objections related to the provision of all covered services under this contract.

F.16: Enrolled Member Rights

F.16.01: Right to Receive Information

We maintain written policies guaranteeing each member's right to receive information on the managed care program and their plan. MCNA's Agency-approved Member Handbook contains easy-to-understand program information for our members. The Member Handbook is prominently displayed on our website and helps our members understand medically necessary covered dental services, value-added benefits and services, the role of the primary care dentist, and details about age restrictions and service limitations. Topics addressed in MCNA's Member Handbook include all required content identified in this contract, such as:

- How to Contact MCNA
- Member Rights and Responsibilities
- Eligibility, including Enrollment and Disenrollment
- The Role of the Primary Dental Provider (PDP), How to Select or Change PDPs, and Schedule an Appointment
- The Importance of Good Oral Hygiene
- Medically Necessary Covered Dental Services
- How to Access Value-Added Benefits and Services
- How to Obtain Pre-Authorization for Dental Services
- Obtaining a Replacement ID Card
- Reporting Suspected Fraud and Abuse
- Notice of Privacy Practices and Advance Directives
- Accessing Dental Care and What to Do in an Emergency Situation
- Benefit Exclusions and Limitations
- Filing a Complaint, Grievance, Appeal, or Requesting a State Fair Hearing
- Coordination of Care, Continuity of Care, and How to Access Out-of-Network Care

F.16.02: Right to be Treated with Respect

We have written policies guaranteeing each member's right to be treated with respect and with due consideration for the member's dignity and privacy. We do not in any way restrict the member's right to fully participate in the community and to work, live, and learn to the fullest extent possible.

F.16.03: Right to Participate in Community

We do not in any way restrict the member's right to fully participate in the community and to work, live, and learn to the fullest extent possible.

F.16.04: Right to Receive Information on Treatment Options

We guarantee each member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

F.16.05: Right to Participate in Decisions

Each member has a right to participate in decisions regarding their health care, including the right to refuse treatment.

F.16.06: Right to be Free from Restraint

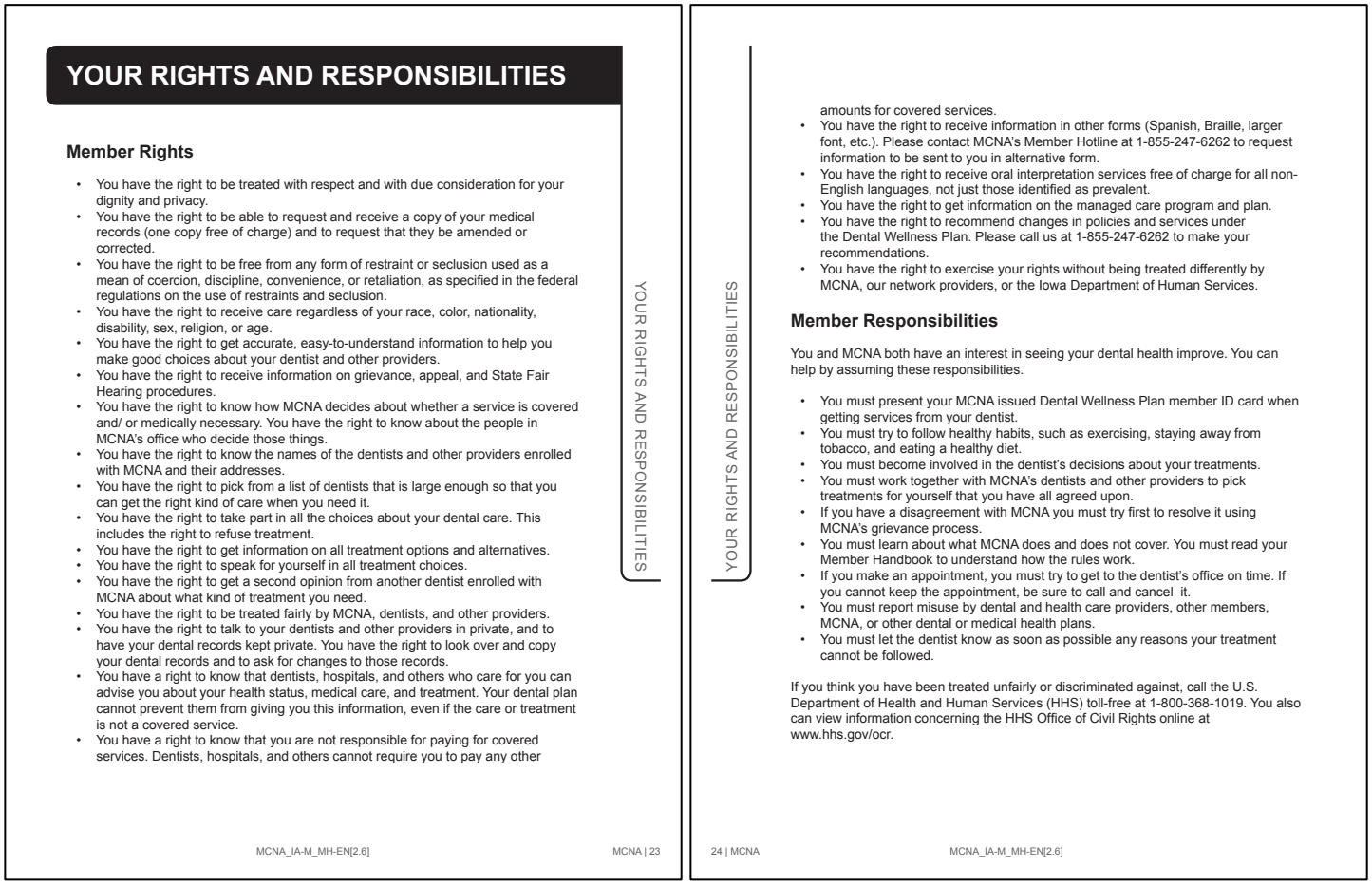
All members are to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

F.16.07: Right to Copy of Medical Records

A member may request and receive a copy of their medical/dental records at no cost, and they can request that the records be amended or corrected in accordance with state and federal law.

F.16.08: Free Exercise of Rights

Each member is free to exercise their rights without MCNA or our network providers treating the member adversely. Please see the following pages from our Agency-approved Iowa Member Handbook as an example of how we inform members of their rights and responsibilities.



YOUR RIGHTS AND RESPONSIBILITIES

Member Rights

- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to be able to request and receive a copy of your medical records (one copy free of charge) and to request that they be amended or corrected.
- You have the right to be free from any form of restraint or seclusion used as a mean of coercion, discipline, convenience, or retaliation, as specified in the federal regulations on the use of restraints and seclusion.
- You have the right to receive care regardless of your race, color, nationality, disability, sex, religion, or age.
- You have the right to get accurate, easy-to-understand information to help you make good choices about your dentist and other providers.
- You have the right to receive information on grievance, appeal, and State Fair Hearing procedures.
- You have the right to know how MCNA decides about whether a service is covered and/ or medically necessary. You have the right to know about the people in MCNA's office who decide those things.
- You have the right to know the names of the dentists and other providers enrolled with MCNA and their addresses.
- You have the right to pick from a list of dentists that is large enough so that you can get the right kind of care when you need it.
- You have the right to take part in all the choices about your dental care. This includes the right to refuse treatment.
- You have the right to get information on all treatment options and alternatives.
- You have the right to speak for yourself in all treatment choices.
- You have the right to get a second opinion from another dentist enrolled with MCNA about what kind of treatment you need.
- You have the right to be treated fairly by MCNA, dentists, and other providers.
- You have the right to talk to your dentists and other providers in private, and to have your dental records kept private. You have the right to look over and copy your dental records and to ask for changes to those records.
- You have a right to know that dentists, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your dental plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
- You have a right to know that you are not responsible for paying for covered services. Dentists, hospitals, and others cannot require you to pay any other

YOUR RIGHTS AND RESPONSIBILITIES

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YOUR RIGHTS AND RESPONSIBILITIES

amounts for covered services.
- You have the right to receive information in other forms (Spanish, Braille, larger font, etc.). Please contact MCNA's Member Hotline at 1-855-247-6262 to request information to be sent to you in alternative form.
- You have the right to receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- You have the right to get information on the managed care program and plan.
- You have the right to recommend changes in policies and services under the Dental Wellness Plan. Please call us at 1-855-247-6262 to make your recommendations.
- You have the right to exercise your rights without being treated differently by MCNA, our network providers, or the Iowa Department of Human Services.

Member Responsibilities

You and MCNA both have an interest in seeing your dental health improve. You can help by assuming these responsibilities.

- You must present your MCNA issued Dental Wellness Plan member ID card when getting services from your dentist.
- You must try to follow healthy habits, such as exercising, staying away from tobacco, and eating a healthy diet.
- You must become involved in the dentist's decisions about your treatments.
- You must work together with MCNA's dentists and other providers to pick treatments for yourself that you have all agreed upon.
- If you have a disagreement with MCNA you must try first to resolve it using MCNA's grievance process.
- You must learn about what MCNA does and does not cover. You must read your Member Handbook to understand how the rules work.
- If you make an appointment, you must try to get to the dentist's office on time. If you cannot keep the appointment, be sure to call and cancel it.
- You must report misuse by dental and health care providers, other members, MCNA, or other dental or medical health plans.
- You must let the dentist know as soon as possible any reasons your treatment cannot be followed.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

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Excerpt Pages from Current Agency-Approved Iowa Member Handbook Related to Member Rights and Responsibilities

F.16.09: Exceptions to Policy

Under the exception to policy process, a member can request an item or service not otherwise covered by the Agency or MCNA. Exceptions to policy may be granted to MCNA's policies, but they cannot be granted to federal or State law or regulations. We forward requests for exceptions to Agency policy to the Agency for consideration. We understand that an exception to policy is a last resort request and is not appealable to the extent the request is for services outside of State Plan or waiver benefits.

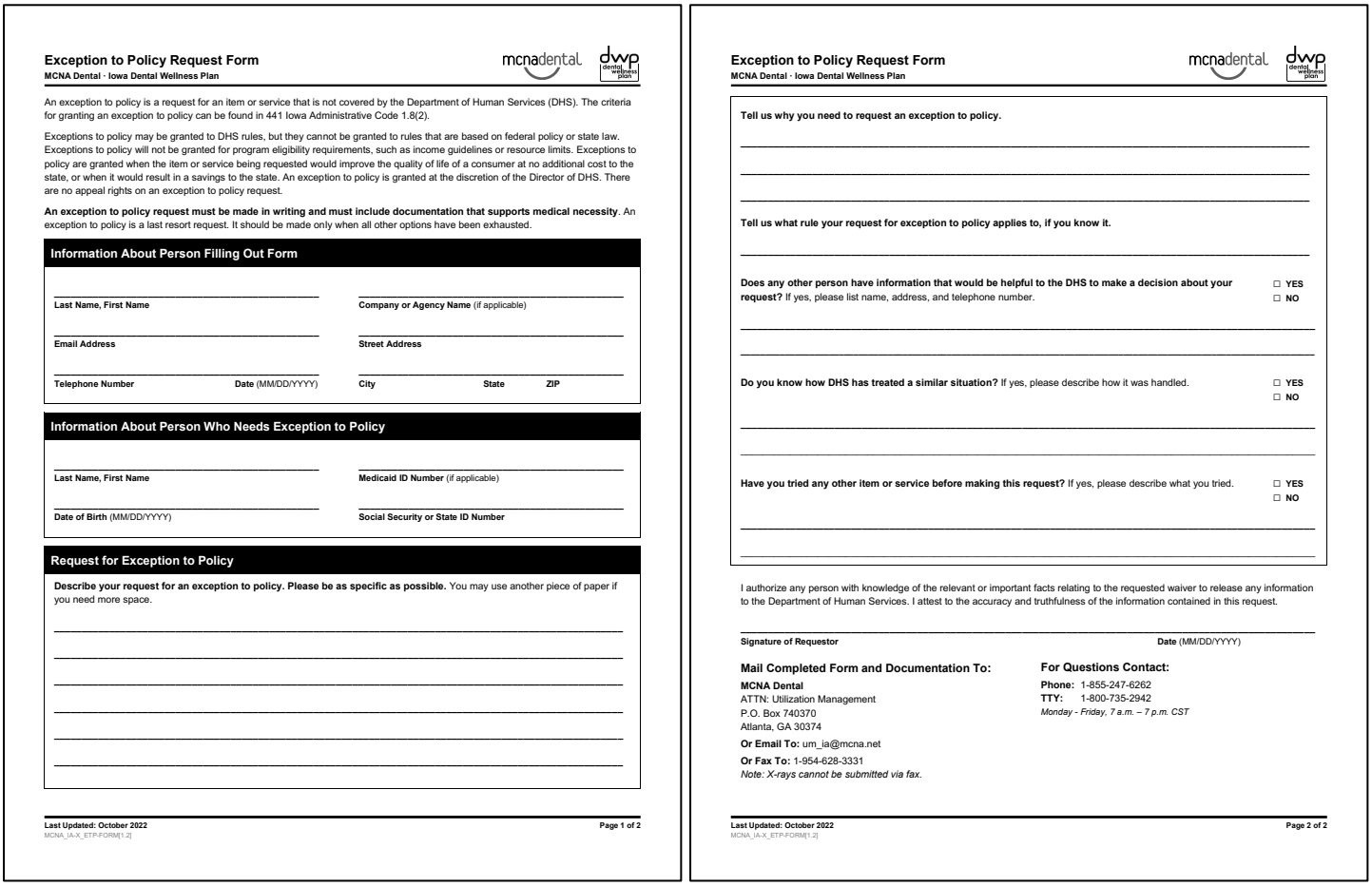
Waivers of administrative rules referred to as exceptions to policy may be granted in individual cases upon the DHHS Director's own initiative or upon request. Exceptions to Medicaid policy are only specifically granted by the DHHS Director with the recommendation of the Medicaid Director. The Department issues written decisions for all requests for an exception to policy.

MCNA is not responsible for decisions regarding exceptions to policy under state rule and should not present themselves as such and shall not use the terms "exception to policy" to describe their own internal medical necessity review decisions when communicating with a member.

MCNA, on our own and by our own determination, may make an exception to our policies, but we will not refer to these actions as an exception to policy as defined in administrative rule. Any scenario in which MCNA determines to provide coverage for items or services outside of their own policies must not be referred to as an exception to policy.

MCNA recognizes that we may determine that an exception to the administrative rules such as a request for an item or service not typically covered by Medicaid or a request to exceed service limits is appropriate to meet a member's assessed needs may initiate an administrative exception to policy request following the process outlined in 441 IAC 1.8.

Any scenarios in which MCNA determines to approve, deny, reduce, or terminate a member's services remains subject to all applicable Iowa Administrative Code (IAC), Iowa Code and the Code of Federal Regulations, including timely notification, content of the notification, and appeal rights.



Exception to Policy Request Form
MCNA Dental · Iowa Dental Wellness Plan

An exception to policy is a request for an item or service that is not covered by the Department of Human Services (DHS). The criteria for granting an exception to policy can be found in 441 Iowa Administrative Code 1.8(2).

Exceptions to policy may be granted to DHS rules, but they cannot be granted to rules that are based on federal policy or state law. Exceptions to policy will not be granted for program eligibility requirements, such as income guidelines or resource limits. Exceptions to policy are granted when the item or service being requested would improve the quality of life of a consumer at no additional cost to the state, or when it would result in a savings to the state. An exception to policy is granted at the discretion of the Director of DHS. There are no appeal rights on an exception to policy request.

An exception to policy request must be made in writing and must include documentation that supports medical necessity. An exception to policy is a last resort request. It should be made only when all other options have been exhausted.

Information About Person Filling Out Form

Last Name, First Name | Company or Agency Name (if applicable)
Email Address | Street Address
Telephone Number | Date (MM/DD/YYYY) | City | State | ZIP

Information About Person Who Needs Exception to Policy

Last Name, First Name | Medicaid ID Number (if applicable)
Date of Birth (MM/DD/YYYY) | Social Security or State ID Number

Request for Exception to Policy

Describe your request for an exception to policy. Please be as specific as possible. You may use another piece of paper if you need more space.

Last Updated: October 2022 Page 1 of 2
MCNA_IA-X_ETP-FORM[1.2]

Exception to Policy Request Form
MCNA Dental · Iowa Dental Wellness Plan

Tell us why you need to request an exception to policy.

Tell us what rule your request for exception to policy applies to, if you know it.

Does any other person have information that would be helpful to the DHS to make a decision about your request? If yes, please list name, address, and telephone number. ☐ YES ☐ NO

Do you know how DHS has treated a similar situation? If yes, please describe how it was handled. ☐ YES ☐ NO

Have you tried any other item or service before making this request? If yes, please describe what you tried. ☐ YES ☐ NO

I authorize any person with knowledge of the relevant or important facts relating to the requested waiver to release any information to the Department of Human Services. I attest to the accuracy and truthfulness of the information contained in this request.

Signature of Requestor | Date (MM/DD/YYYY)

Mail Completed Form and Documentation To:
MCNA Dental
ATTN: Utilization Management
P.O. Box 740370
Atlanta, GA 30374
Or Email To: um_ia@mcna.net
Or Fax To: 1-954-628-3331
Note: X-rays cannot be submitted via fax.

For Questions Contact:
Phone: 1-855-247-6262
TTY: 1-800-735-2942
Monday - Friday, 7 a.m. – 7 p.m. CST

Last Updated: October 2022 Page 2 of 2
MCNA_IA-X_ETP-FORM[1.2]

MCNA's Agency-Approved Exception to Policy Request Form

F.17: Telehealth

F.17.01: Telehealth

MCNA treats dental services provided through in-person consultations or through telehealth as equivalent to services rendered in an in-person setting for the purposes of reimbursement. There is no additional payment for telehealth components of service associated with the underlying service being rendered. An in-person contact between a dental health care professional and a member is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted dental health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under IAC 653-13.11 (147, 148, 272C).

Section G: Quality, Care Coordination, and Utilization Management

Serving over 5 million members across the nation since 1992, MCNA understands the complex needs of the populations we serve. Our Care Coordination Program is at the heart of our unique approach to care, supporting members to ensure that their needs are met across the continuum of care. Over decades of experience in multiple markets, MCNA has developed key partnerships with our medical health plan partners through which we collectively provide the best possible care at all levels, with full consideration of their medical, oral, behavioral, and social healthcare needs.

We are confident that our comprehensive Quality, Care Coordination, and Utilization Management (UM) programs and innovative strategies maximize the ability of our members to receive the level of attention and dental care they need throughout their healthcare journey.

We have read, understand, and will comply with Iowa Dental Wellness Plan and Hawki Dental PAHP RFP# MED-24-004. In our response below, we address key requirements from RFP Attachment G: Quality, Care Coordination, and Utilization Management.

G.1: External Quality Review (EQR)

G.1.01: Annual EQR

MCNA has extensive experience in addressing and reporting on quality performance measures. Our quality improvement strategies, policies, and procedures undergo rigorous oversight on an annual basis. As part of this oversight process, MCNA has flawlessly passed our yearly Performance Measure Validation (PMV) conducted by each state's External Quality Review Organization (EQRO). The PMV audits apply the same rigor as that of a HEDIS audit, covering in scope the annual dental visit (ADV), CMS 416 preventive dental care visits, Dental Quality Alliance performance measures, and any other contract specific measures.

Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review activity with each of the contracted managed care plans (MCPs) delivering services to members enrolled in the Iowa Health Link program. **In 2020 and 2022, MCNA's EQRO report resulted in 100% for Quality, 100% Calendar Year 2022, 100% for Clinical Practice Guidelines.**

The EQROs for each Medicaid and CHIP plan we serve regularly audit our Quality Management/Quality Improvement (QM/QI) QM/QI Program, work plan, and annual evaluation. Our most recent EQRO scores in Iowa and other markets, highlighted in the table below, demonstrate our ongoing commitment to quality improvement in both care and service delivery.

MCNA's EQRO Results			
Program	**EQRO**	**Year**	**Results**
Iowa	HSAG	2022	✔ **100%**
Utah	HSAG	2022	✔ **100%**
Arkansas	QSource	2022	✔ **100%**
Florida Healthy Kids	QSource	2022	✔ **100%**
Idaho	Telligen	2022	✔ **100%**
Nebraska	HSAG	2022	✔ **100%**
Louisiana	IPRO	2022	✔ **100%**

MCNA agrees to comply with all contract requirements related to External Quality Reviews (EQRs), including undergoing annual, external independent reviews of the Quality, timeliness, and Access to the services covered under each Contract, as stated in 42 C.F.R. § 438.350; 42 C.F.R. § 457.1250(a); 42 C.F.R. § 457.1240(f); 42 C.F.R. § 457.1201(n).

G.1.02: Process

MCNA's Management Information System (MIS) and Provider Portal have been recognized as "Best in Class Technology" by every EQRO we work with across every Medicaid and CHIP market we serve. The EQROs have recognized, verbalized, and documented the technological strengths of maintaining timely and consistent outreach and education at all member touch points. The administrative ease of use reduces administrative costs for both providers and MCNA and simplifies efforts for members to understand their oral health needs and access care.

[redacted]

MCNA will collaborate with HSAG to develop studies, surveys, and other analytic activities to assess the Quality of care and services provided to Enrolled Members and to identify opportunities for Contractor improvement. We will work collaboratively with the Agency and the EQRO to annually measure identified Performance Measures to assure Quality and accessibility of health care in the appropriate setting to Enrolled Members, including the Validation of PIPs and Performance Measures. MCNA agrees to respond to recommendations made by the EQRO within the timeframe established by the EQRO, the Agency, or its Designee.

G.2: Care Coordination

Attachment J, G.2.a-d: Care Coordination

G.2.a: Coordinating Care and Connecting Members to Resources

[redacted]

[redacted]

G.2.b: Our Community Partners Support Members' SDOH Needs

[redacted]

[redacted] Our team currently assists members with accessing stable housing, childcare services, food insecurity, and safety.

G.2.c: Identifying Members Who Are Not Accessing Their Benefits

[redacted] Our MSRs educate the member about the importance of oral health and assist them in scheduling an appointment. [redacted]

Additionally, providers play a key role in MCNA's multifaceted strategy to address care gaps and keep members engaged in their care. [redacted]

G.2.d: Tracking and Monitoring Our Care Coordination Program

[redacted]

[redacted]

G.2.01.a-b: General

Ensuring Each Enrolled Member Has an Ongoing Source of Care Appropriate to their Needs

MCNA takes pride in the quality of care and attention we give to members who receive assistance through our comprehensive Care Coordination program. Our nearly 30 years of experience serving members across the country who need additional support to obtain dental care has led to the development of our proven Care Coordination program. Our Care Coordination services ensure each member has an ongoing source of care appropriate to their individual needs.

[redacted]

G.2.02: Information Requirements

[redacted]

G.2.06: Coordination with Other Contractors

[redacted] We routinely coordinate a wide variety of carved-out services, including Medicaid services that are provided by the member's MCO.

[redacted] MCNA will continue to collaborate and coordinate with organizations throughout Iowa, including the MCOs, free and low-cost dental clinics, Iowa dental providers, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs), among others. [redacted]

G.2.07: Coordination with FFS Medicaid

MCNA will implement procedures to coordinate all services, including services the member receives in FFS Medicaid.

G.2.08: Coordination with Community Supports

MCNA will implement procedures to coordinate the services the member receives from community and social support Providers.

G.2.09: Timeliness

Conducting an Initial Screening of Each Enrolled Member's Needs

MCNA will make a best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members.

[redacted] MCNA outreaches to all new members to conduct an Initial Oral Health Risk Screening within 90 days of the effective date of enrollment for all new members. [redacted]

MCNA will comply will all state standards and timelines related to conducting member Initial Oral Health Risk Screening.

Making Subsequent Attempts with Hard-to-Reach Members

MCNA makes subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful. [redacted]

[redacted]

[redacted]

G.2.10: Initial Oral Health Risk Screening

During the Initial Oral Health Risk Screening process, members are offered assistance in arranging an initial visit with a dentist (as applicable) for a baseline oral health assessment and other preventive services, including an assessment or screening of the member's potential risk, if any, for specific diseases or conditions. We will continue to implement and adhere to the Agency-approved plan. We will coordinate with the Agency for prior approval, and we will seek approval prior to making changes to the plan.

MCNA will continue to obtain Agency approval for a plan to conduct Initial Oral Health Risk Screenings for:

1. Newly enrolled members ages 21 years and over, within 90 days of enrollment for the purpose of assessing need for any special dental health care or Care Coordination services; and
2. Enrolled members who have not been enrolled in the prior 12 months.

MCNA will assist in coordinating care for new members under 21 years of age, following the assessment and Care Coordination services provided under the Maternal Child and Adolescent Health programs. We will utilize the Oral Health Equity Self-Assessment tool to complete Initial Oral Health Risk Screenings.

G.2.11: Oral Health Equity Self-Assessment Tool

MCNA will obtain Agency approval of an oral health equity self-assessment tool. At minimum, the information collected will assess the member's oral status and needs. The tool will help determine the need for Care Coordination or any other health or community services. The tool will comply with National Committee for Quality Assurance (NCQA) standard for oral health risk screenings and contain standardized questions that tie to social determinants of health.

In addition, the Initial Oral Health Risk Screening will include the social determinants of health questions as determined by the Agency. We agree to follow the Agency's approved tool as well as file exchange format and requirement specification documents to support uniformity across contractors.

G.2.12: Screening Method

As described above, MCNA will conduct the Initial Oral Health Risk Screening:

1. By mail;
2. Electronically through our secure website/member portal;
3. By phone or text; or
4. In person visits from our member advocates for those with special needs.

MCNA will continue to develop methods to maximize contacts with members in order to successfully complete the Initial Oral Health Risk Screening.

G.2.13: Completion of Initial Oral Health Risk Screening

MCNA agrees to complete an Initial Oral Health Risk Screening no later than ninety 90 days after member enrollment. Each quarter, at least 70% of newly enrolled members, who have been assigned to MCNA for a continuous period of at least 90 days, will complete an Initial Oral Health Risk Screening within 90 days. For any member who does not obtain an Initial Oral Health Risk Screening, MCNA will document at least three attempts to conduct the screening, as described in G.2.09.

G.2.16: Assessments – Special Conditions

MCNA recognizes and appreciates that every member is unique and so are their overall healthcare needs. As such, the level of required contact varies based on the member's condition and anticipated dental needs. MCNA has implemented mechanisms to comprehensively assess each member identified as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.

Members may be referred for evaluation for case management or care coordination by their provider, or through other internal referrals from MCNA team members, such as our Utilization Management Department. Members referred to case management, receive outreach from one of our Case Managers or Care Coordination team members to comprehensively assess their dental health and needs.

G.2.17: Referral Following Initial Oral Health Screening

The Initial Oral Health Screening described in Section G.2.10 includes a referral to a provider within the member's service area and Network Adequacy requirements described in Special Contract Exhibit C, and referrals to the appropriate community resources identified during the Oral Health Equity Self-Assessment.

G.2.20: Member Identification

[redacted]

MCNA proactively identifies and risk stratifies members who are likely to need care coordination based on member-specific factors identified during our automated risk assessment process, which includes, but is not limited to a review of health and social needs indicators, other barriers to care, and Initial Oral Health Risk Screening data. [redacted]

[redacted]

G.2.21: Care Coordination Program

MCNA leverages over 30 years of designing and operating Care Coordination programs to meet the contractual requirements of this RFP. MCNA takes pride in the quality of care and attention we give to members who receive assistance through our comprehensive Care Coordination and Case Management services, which support improved dental health outcomes and coordination of care. Our years of experience serving members in Iowa and in other states who need additional support to obtain dental care has led to the development of our proven, evidence-based program.

[redacted]

MCNA's Care Coordination team takes pride in the quality of care and attention that we give to members who receive assistance through our comprehensive Care Coordination program. [redacted]

[redacted]

G.2.23: Involved Parties

When developing and operating MCNA's Care Coordination program, in addition to working with qualified oral health care professionals, we collaborate with transportation companies, Iowa Health Link MCOs and their case managers, other dental Program Contractors, community stakeholders, and local I-Smile agencies.

MCNA will provide an integrated care plan which avoids duplication and/or fragmentation of services, removing barriers for the member in accessing specialty providers, and assisting the member with health literacy and scheduling of appointments when needed including ongoing dental treatment.

G.2.25: Tracking and Reporting

[redacted]

[redacted]

G.2.27: Monitoring

As described above, MCNA utilizes our MIS, DentalTrac™, for tracking all care coordination/case management activities and monitoring the effectiveness of its Care Coordination program and processes. MCNA promptly remediates all case specific findings identified through the monitoring process and tracks/trends findings to identify systemic issues of poor performance or non-compliance. We will continue to implement strategies to improve the Care Coordination program and processes and resolve areas of non-compliance.

G.2.29: Information Sharing Obligation

MCNA will continue to share with the State or other MCOs, PIHPs, and PAHPs serving the enrolled members the results of any identification and assessment of that member's needs to prevent duplication of those activities.

G.2.30: Health Record Sharing Obligation

MCNA will continue to ensure that each provider furnishing services to members maintains and shares a member health record in accordance with Professional Standards.

G.2.31: Medical Record

MCNA develops, implements, and adheres to policies, procedures and contractual requirements for Participating Provider Medical Records content and documentation in compliance with the provisions of Iowa Admin. Code r. 441-79.3.

We agree to document all policies and procedures in its PPM. After Agency approval, MCNA will communicate those policies and procedures to Network Providers and assure that its records and those of its Participating Providers document all medical services that the Enrolled Member receives in accordance with law and consistent with utilization control requirements in 42 C.F.R. Part 456.

MCNA will continue to maintain member’s Medical Records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical Records shall be legible, signed, dated, and maintained as required by law.

G.2.32: Maintenance and Retention

MCNA maintains a Medical Records system that:

- Identifies each medical record by State identification number;
- Identifies the location of every medical record;
- Places Medical Records in a given order and location;
- Maintains the confidentiality of Medical Records information and releases the information only in accordance with applicable law;
- Maintains inactive Medical Records in a specific place;
- Permits effective professional review in medical audit processes; and
- Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.

G.2.33: HIPAA Compliance

[redacted]

MCNA will continue to use and disclose individually identifiable health information, such as Medical Records and any other health or Enrollment information that identifies a particular Enrolled Member, in accordance with the confidentiality requirements in 45 C.F.R. § parts 160 and 164.

G.2.34: Transition of Care Policy

MCNA has developed a transition of care policy that is consistent with federal requirements and meets the State defined transition of care policy. All transition of care activities for the Iowa DWP and Hawki program will be carried out to prevent a lapse in service per 42 C.F.R. § 438.62(b)(1) - (2); 42 C.F.R. § 457.1216.

G.2.35: Continuity of Care Policy

MCNA has a proven track record of continuing dental services for members transitioning into our programs, taking all necessary steps to ensure continuity of care when a member transfers to MCNA from another dental benefit manager or program. Successful continuity of care is dependent on the ability of a treating dentist to complete the treatment plan throughout the transition.

As the dental benefits program manager for the Iowa DWP program, we transitioned approximately 146,000 additional child members into the program when Iowa transitioned the Medicaid child population from fee-for-service to dental managed care in 2021. These transitions were seamless for our members and providers due to our proven approach of involving the entire MCNA team in ensuring continuity of care.

MCNA will implement mechanisms to ensure the continuity of care of members transitioning in and out of enrollment pursuant and complies with requirements in 45 CFR to ensure continuity of care during transitions.

Ensuring Members Have Access to Services

[redacted]

Our Iowa DWP and Hawki program members will continue to have access to services consistent with the access they previously had and will be permitted to retain their current provider for 90 days if that provider is enrolled in Iowa Medicaid.

MCNA takes special care to provide continuity of care for members who have oral health needs and are under the care of existing treatment providers whose health could be placed in jeopardy, or who could be placed at risk of hospitalization if covered services are disrupted or interrupted. [redacted]

Referring Members to Appropriate Providers of Services

All transition of care activities for the Iowa DWP and Hawki program are carried out to prevent a lapse in service per 42 C.F.R §438.62(b)(1) and per MCNA's transition of care policy. [redacted]

MCNA assists members with selecting a PDP. We inform members of their right to choose their own PDP. Whenever possible, MCNA encourages the continuation of any existing member-dentist relationship with current PDPs participating in our network. In a situation where multiple members live in one household; we make every effort to ensure that members understand the advantages of selecting the same PDP for all family members.

Our written policies and procedures document the processes for member selection of a PDP and auto-assignment. As part of our overall welcome process, MCNA conducts telephonic outreach to new members upon receipt of the enrollment file in order to welcome them to the plan and encourage them to select a PDP.

If a member's PDP leaves MCNA's network, we send the member a letter notifying them of the change and providing them with information about selecting a new PDP.

[redacted] Upon auto-assignment of a PDP, we send a letter and member ID card to the member informing them of their assigned PDP's contact information within five business days. The letter also describes the members' ability to change their PDP at any time.

Complying with Requests for Historical Utilization Data

MCNA will continue to ensure the entity (Contractor or Agency) previously serving the enrolled member, fully and timely complies with requests for historical utilization data in compliance with Federal and State law.

Obtaining Copies of the Enrolled Member's Medical Records

We will continue to proactively contact the previous dental benefit manager to obtain utilization data and dental provider information and supply all required information about members switching to a new dental benefit manager.

Ensuring Continued Access to Services to Prevent Serious Detriment to the Enrolled Member's Health or Reduce the Risk of Hospitalization or Institutionalization

MCNA ensures continued access to any other necessary procedures, as specified by the Centers for Medicare & Medicaid Services (CMS), to prevent serious detriment to the enrolled member's health or reduce the risk of hospitalization or institutionalization.

G.2.36: Prior Authorization

During the first two years of the contract, MCNA will continue to honor all existing authorizations for covered benefits for a minimum of 90 days, without regard to whether such services are being provided by contract or non-contract providers, when an enrolled member transitions from another source of coverage.

MCNA honors existing exceptions to policy granted by the Director for the scope and duration designated. At all other times, MCNA will honor all existing authorizations for a minimum of 30 days when an enrolled member transitions to MCNA from another source of coverage, without regard to whether services are being provided by contract or non-contract Providers.

We will obtain Agency approval for policies and procedures to identify existing Prior Authorizations at the time of enrollment. MCNA will implement and adhere to the Agency's approved policies and procedures. Additionally, when an enrolled member transitions to another Program Contractor, we provide the receiving entity with information on any current Service Authorizations, utilization data and other applicable clinical information such as disease management or Care Coordination notes.

All previous prior authorizations on file for the member that MCNA receives from the State or the previous dental benefit manager are fully documented in the member's unique record within DentalTrac™ and will be available for ensuring continuity of care, ongoing utilization management activities, and claims processing. Any prior authorizations received from the State or the previous dental benefit manager for ongoing dental services will show as authorized in DentalTrac™. MCNA will ensure all prior authorizations for ongoing dental services include all required information by following up with the previous dental benefit manager and the dentist as needed.

G.2.37: Transition Period-Out of Network Care

MCNA is committed to members choice, and as appropriate, will establish a single Case Agreement (SCA) and/or authorize Out-of-Network services to provide continuity of care for enrolled members receiving out-of-network services.

During the first 90 days following Contractor's entry into the Iowa Dental Wellness Plan and Hawki Dental program, MCNA allows an enrolled member who is receiving covered Benefits from a non-Network Provider at the time of enrollment to continue accessing that Provider, even if the network has been closed due to meeting the network Access requirements.

In these situations, MCNA will establish a SCA with Providers enrolled with Iowa Medicaid, or otherwise authorize non-network care, past the initial 90 days of the Contract.

MCNA will make commercially reasonable attempts to contract with Providers from whom an enrolled member is receiving ongoing care. Out-of-Network Providers will be reimbursed a percentage of the network rate unless otherwise agreed upon through a Single Case Agreement.

G.2.41: Special Needs Treatment Plans

MCNA takes pride in the quality of care and attention we give to members through our comprehensive Care Coordination/Case Management services. Our years of experience serving members in Iowa, Florida, Texas, Louisiana, Idaho, Nebraska, Arkansas, and Utah who need additional support to obtain dental care has led to the development of our evidence-based, person-centered program. Members with special health care needs, including behavioral and medical

conditions, and members with other challenges that impact their ability to obtain services receive high-touch assistance with all aspects of their dental service experience.

[redacted]

MCNA educates providers and members on the importance of routine dental care and assess for additional frequency of preventive services as included in the Medicaid State Plan, for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring.

MCNA's Care Coordination team continually evaluates member files for potential appropriateness of special health care needs and services related to dental care and care coordination. We routinely analyze data from a variety of resources to identify any members who may need additional assistance through care coordination services.

G.2.43: Special Health Care Needs Plan Obligations

MCNA's prevention and treatment services have been developed (and will be maintained) in accordance with any applicable State Quality assurance and Utilization Review standards.

G.2.44: Specialist Direct Access

MCNA has mechanisms in place to allow members with special health or dental care needs to directly access a Specialist as appropriate to address to member's condition and identified needs.

G.3: Authorization and Utilization Management

We have read, understand, and will comply with Iowa Dental Wellness Plan and Hawki Dental PAHP RFP# MED-24-004. In our response below, we address key requirements from RFP Attachment G.3: Authorization and Utilization Management.

MCNA is the largest insurer of state-sponsored CHIP and Medicaid members in the nation. With over 30 years of experience, MCNA has emerged as an industry leader in the management of state CHIP and Medicaid dental programs, serving over 5 million children and adults across the nation. Since 2016, MCNA has provided this high level of utilization and care management service to hundreds of thousands of Iowans and the various stakeholders supporting the Medicaid dental program.

[redacted]

[redacted]

G.3.01: Utilization Management Program

MCNA's UM Clinical and UM Administrative functions are primarily located in Iowa, Texas, and Florida. In accordance with 42 C.F.R.§438.210(a), MCNA accepts all assigned members into our program and makes all medically necessary covered dental services available to our members in no less than the amount, duration, and scope as defined in this RFP. [redacted]

Our UM Program is documented in a written policies and procedures and reviewed and updated annually. [redacted] s part of our UM Program, we review all types of care for dental necessity, appropriate services, level of care, and quality of care as well as benefit and coverage determinations. [redacted] Our UM Program, it's policies and procedures ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope because of diagnosis, type of illness, or condition.

[redacted] CNA will always consider the appropriateness of a specific dental treatment for which Prior Authorization (PA) is sought on its own merit based on the radiographs, narratives, and other supporting documentation submitted with the request. Our Clinical Reviewers have no history of disciplinary action or sanctions, including loss of staff privileges or participating restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by MCNA's licensed Clinical Reviewers. Our Dental Director and all Clinical Reviewers are required to attest that no adverse determinations will be made regarding any dental procedure or service outside of the scope of their expertise. All authorization determinations for the Iowa program will be conveyed to our Iowa providers in accordance with state requirements and in alignment with standards for timeliness and format of the notification. As stated above, MCNA does not arbitrarily deny or reduce required services.

[redacted]

On an annual basis, our UM Criteria and Guidelines are reviewed to ensure they are current with industry best practice standards and comply with our contractual agreements. [redacted] We assure that our UM strategies, including identification of criteria, are approved by the Agency prior to implementation or change and that we notify our providers at least 30 days before implementation or change.

G.3.02: UM Policies and Procedures

MCNA's UM program policies and procedures meet all standards of MCNA's accrediting entity and have criteria that (i) are objective and based on clinical, peer-reviewed evidence; (ii) are applied based on individual needs; (iii) include an assessment of the local delivery system; (iv) involve appropriate practitioners in developing, adopting, and reviewing them; and (v) are annually reviewed and updated as appropriate.

In full compliance with Contract and SOW A.19, our UM policies and procedures are part of a global Policy and Procedures Manual (PPM) and have been submitted to and approved by the Agency. MCNA creates and maintains written corporate policies and procedures that govern the operations of the company and establish accountability for providing quality services to our clients and consumers. Our UM policies, procedures, and standards of conduct guide the manner in which we conduct our business and articulate MCNA's commitment to comply with all applicable state and federal regulations, and URAC (formerly Utilization Review Accreditation Commission) and NCQA standards. MCNA was the first plan in the country to be awarded full URAC Dental Plan Accreditation.

G.3.03: Program Elements

MCNA's UM Program core elements include data collection and sharing; CPG review, updating, and sharing; UM staff training; and program evaluation to ensure appropriateness of care and continuous improvement over time.

[redacted]

[redacted]

Each service requiring prior authorization has defined UM criteria based on the nationally accepted clinical guidelines and the medical necessity definition required by our state partners. The clinical guidelines address the provision of acute and chronic dental services. Our Criteria and Guidelines are based upon considerations including:

[redacted]

[redacted]

As MCNA conducts its annual update of the Utilization Review Criteria and Guidelines to ensure they are current with industry best practices and the unique needs of Iowa DWP, the UM clinical staff consults with participating general dentists and specialists and provides updates to all affected providers via our provider newsletter and email and fax blasts should changes to the guidelines be incorporated. All clinical criteria is available to providers upon request and is included in our Provider Manual. Should a service not meet medical necessity, the reason is explained in the PA notice.

[redacted]

[redacted] MCNA will always consider the appropriateness of a specific dental treatment for which prior authorization is sought on its own merit based on the radiographs, narratives, and other supporting documentation submitted with the request. Our Clinical Reviewers have no history of taken or pending disciplinary action or sanctions, including loss of staff privileges or participation restrictions, by any hospital, governmental agency or unit, or regulatory body. MCNA requires Clinical Reviewers to attest that they will make no adverse determination regarding any dental procedure or service outside of the scope of their individual expertise.

[redacted]

[redacted]

[redacted]

[redacted]

MCNA educates our Clinical Reviewers on both the terminology and qualifying criteria defining the amount, duration, and scope of treatment specified in the Iowa DWP and Hawki programs. [redacted]

G.3.04: UM Care Coordination

[redacted]

On an annual basis, our UM Criteria and Guidelines are reviewed to ensure they are current with industry best practice standards and comply with our contractual agreements. [redacted]

MCNA's Utilization Review Criteria and Guidelines are based on the needs of our members and plan requirements, and we provide our UM Criteria and Guidelines to members, potential members, and network providers upon request.

[redacted]

[redacted]

G.3.05: UM Committee

MCNA's UM Committee is responsible for the review of our utilization management procedures and for ensuring that our Clinical Reviewers and support staff adhere to our qualitative clinical review standards. [redacted]

The activities and functions of the UM Committee are conducted in compliance with HIPAA privacy regulations and in a manner that protects the confidentiality of all committee proceedings and member information used in committee deliberations.

[redacted]

The UM Committee is responsible for the development, adoption, and annual update of MCNA's Utilization Review Criteria and Guidelines and all other UM activities described in the RFP Attachment F: Contract and SOW. MCNA's UM Committee reports to our QIC as part of our overall Quality Assessment and Performance Improvement structure. The UM Committee meets quarterly and reports up through the QIC to the Board of Directors.

[redacted]

G.3.06. Coverage and Authorization of Services

MCNA will continue to ensure that services for Iowa members are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope as specified by the State. We currently review all PA requests for children ages 0-20 in our DWP program for medical necessity in accordance with EPSDT requirements. Procedures requested for children are not denied for benefit limitations. By continuing to tailor our UM Program to meet the needs of our members, MCNA ensures that the provision of dental care services is high quality, cost-effective, and provided in the most appropriate setting consistent with 42 CFR Chapter 456.

[redacted]

[redacted]

G.3.07: Medical Necessity Determinations

MCNA's Care Coordination team takes pride in the quality of care and attention that we give to members who receive assistance through our comprehensive Case Management program, which supports Iowa's goal of better dental health outcomes and improved coordination of care. Our years of experience serving members who need additional support to obtain dental care in Iowa and in other states has led to the development of our proven program.

[redacted]

Our Clinical Reviewers use clinical evidence such as x-rays, models, narratives, and chart notes to determine the medical necessity of procedures. [redacted]

[redacted]

MCNA attests that medical necessity determinations shall not be more restrictive than the Medicaid State Plan, State, and Federal Law.

G.3.09: Prior Authorization Requests

MCNA's UM Program includes service authorization policies and procedures consistent with all state and federal laws and regulations and the requirements of this RFP. The goal our UM Program is to monitor the appropriateness, quality, and necessity of dental services provided to our members. Our monitoring methodologies include prospective, concurrent, and retrospective review and evaluation. In support of the state's mission to ease the administrative burden on providers, we will incorporate the state's PA standards into our UM policies and procedures.

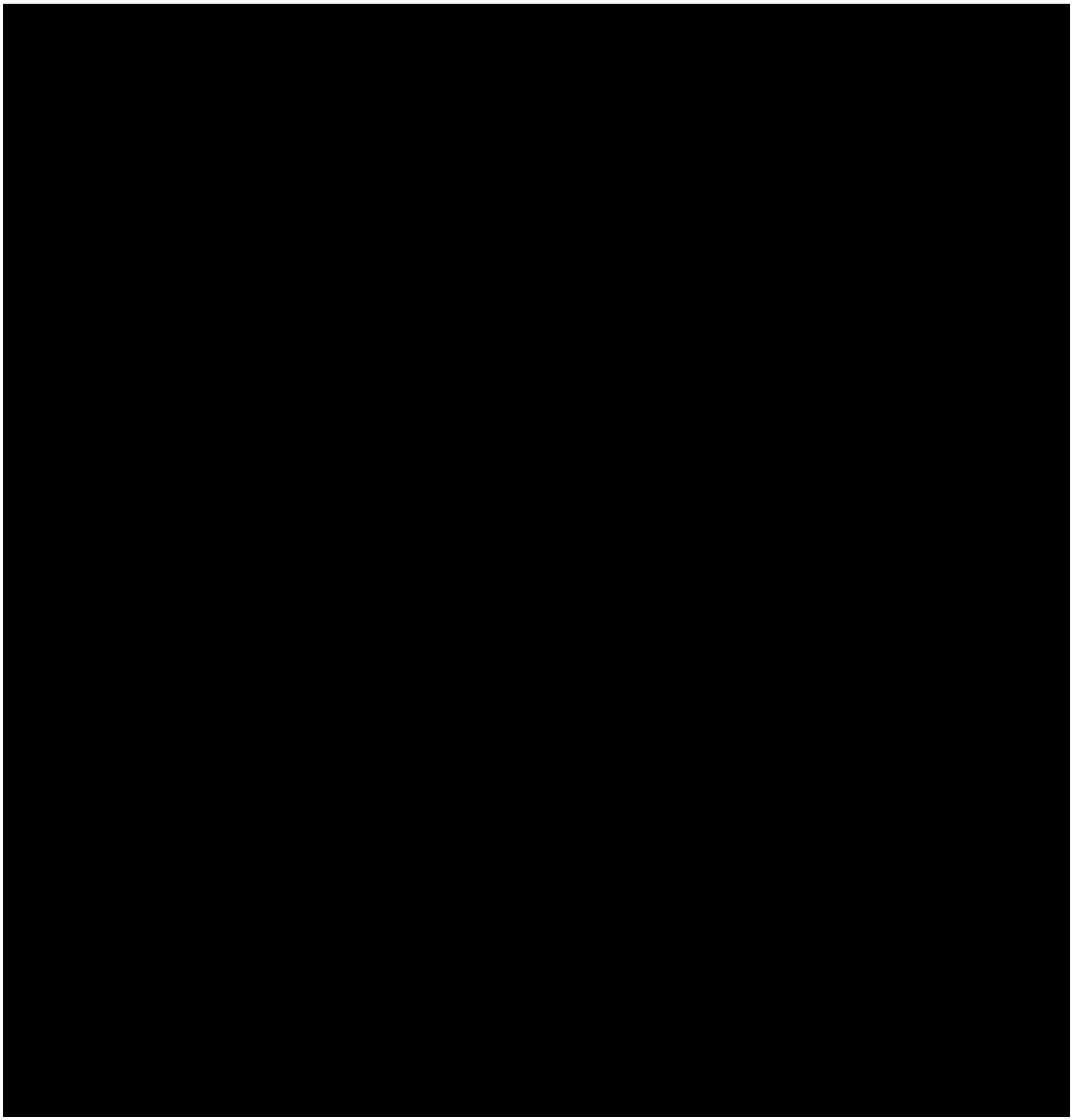
G.3.09.a: Processing

MCNA PA requests shall be processed in accordance with 42 C.F.R. § 438.210 and related rules and regulations, which include but are not limited to provisions regarding decisions, Notices, medical contraindications, and the failure of a Contractor to act timely upon a request. Details of PA request processing can be found below.

MCNA accepts PA requests submitted by providers via our free, easy-to-use online Provider Portal, clearing house, toll-free fax line, or on paper. [redacted] Providers are instructed to maintain original sets of all documents submitted for PA in the event backup documentation is needed and to ensure they retain original copies for personal records and reference.

[redacted] Requests for services are reviewed to determine that the service is a medically necessary covered benefit and that the service is being delivered consistent with established criteria and guidelines.

We provide members and providers with timely notifications of all authorization decisions in accordance with contractual requirements, including notices of adverse benefit determination to members. MCNA will adjudicate standard PA requests within 14 calendar days, and urgent requests within 72 hours of receipt, or as expeditiously as the member's health requires. MCNA acknowledges that an extension of up to 14 days to complete a PA request may be granted in accordance with a process to be defined by the state. If an extension is granted that is not requested by a member, MCNA will provide the member with a written explanation and information on how to file an appeal in response to the extension. The following figure shows a flowchart of our workflow for processing PA requests from initial requests to final disposition, including the process for expedited authorizations.



Prior Authorization Process Flowchart

G.3.09.b: Emergency and Post-Stabilization Care Services

MCNA shall provide Emergency Services without requiring PA or PCP referral, regardless of whether these services are provided by a contract or non-contract Provider. MCNA shall provide Post-Stabilization Care Services in accordance with 42 C.F.R. § 438.114. While MCNA aims to reduce potentially preventable emergency department visits through the provision of timely and high-quality preventive care, we understand that emergencies may occur. We ensure that our members have access to emergency care without the need to obtain prior authorization and can receive services through any emergency facility or provider, regardless of whether the facility is in or out-of-network.

G.3.09.c: EPSDT

MCNA shall not require PA or PCP (if applicable) referral for the provision of EPSDT screening services. MCNA will provide EPSDT services to all our members who are under age 21, including necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physician and mental illnesses and conditions discovered during screening, whether or not such services are covered under the Iowa Medicaid Program. MCNA captures dental screening information to quickly facilitate preventive and restorative care for our members. We improve oral health outcomes through early identification of decay, inflammation, infection, periodontal disease, and malocclusions.

G.3.09.d: Transitioning of New Members

Pursuant to the requirements in Section G.2 regarding transition of newly Members, MCNA shall provide for the continuation of medically necessary covered services regardless of Prior Authorization or referral requirements. [redacted] MCNA will ensure all prior authorizations for ongoing dental services include all required information by following up with the previous DBM and the dentist as needed.

G.3.10: Tracking and Reporting

G.3.10.a: PA Tracking Requirements

[redacted]

G.3.10.b: PA Denials

[redacted]

G.3.11: Policies and Procedures

MCNA and its Subcontractors have in place and follow comprehensive written policies and procedures for processing requests for initial and continuing authorization of services. Through years of direct experience in Iowa, these policies have already been intentionally adapted to meet the needs of the Iowa DWP and its members.

G.3.12: Consistent Application

MCNA has in effect mechanisms to ensure consistent application of review criteria described in other sections for authorization decisions. See: 42 C.F.R. § 438.210(b)(2)(i); 42 C.F.R. § 457.1230(d). {From CMSC G.3.02}.

G.3.13: Required Provider Consult

MCNA will consult with the requesting Provider for medical services when appropriate. See: 42 C.F.R. § 438.210(b)(2)(ii); 42 C.F.R. § 457.1230(d). {From CMSC G.3.03}.

G.3.15: Appropriate Expertise

MCNA's UM staff has decades of expertise to address Member medical, behavioral, or long-term services and supports health needs. Decisions to deny a Service Authorization request, or to authorize a service in an amount, duration or scope that is less than requested, is only made by individuals with appropriate expertise consistent with 42 C.F.R. § 438.210(b)(3); 42 C.F.R. § 457.1230(d). {From CMSC G.3.05}. [redacted]

G.3.17: Notice – Timeframe

MCNA meets the Contract standard of 14 days, typically providing members with timely notification of all authorization decisions in accordance with contractual requirements within the anticipated timeframe, and within 72 hours of receipt or as expeditiously as the member's health requires for urgent requests. MCNA shall continue to provide notice as expeditiously as the member's condition requires and within State-established timeframes that may not exceed fourteen (14) days after receipt of request for service, with a possible extension of fourteen (14) days if the Member or Provider requests an extension or MCNA justifies the need for additional information and how the extension is in the Member's interest.

G.3.18: Exceptions to Notice Timeframe

MCNA agrees that when a provider indicates, or when the State determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, MCNA shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

G.3.19: PA Performance Metric

[redacted] MCNA affirms that our approach to UM and Care Coordination will continue these trends in coming years. Additional information regarding timeliness commitments and authorization processes can be found in section G.3.09.a.

G.3.21: Prohibition on Incentives

MCNA attests that compensation to individuals or entities that conduct UM activities is not and shall not be structured so as to provide incentives for denying, limiting, or discontinuing Medically Necessary Services to any member.

G.4: Practice Guidelines

G.4.01: Evidence-Based Practice Guidelines

MCNA's UM Program uses evidence-based guidelines to ensure services are medically necessary and provided in the amount, duration, and scope required for each patient. [redacted] Each service requiring prior authorization has defined UM criteria based on the nationally accepted clinical guidelines referenced above and the medical necessity definition required by our partners in Iowa.

[redacted]

Our UM Program is designed to monitor the appropriateness, quality, and necessity of dental services consistent with Iowa state requirements and generally accepted dental standards of care. All types of care are reviewed for dental necessity, appropriateness of services, level of care, location of care, and quality of care, as well as benefit and coverage determinations. [redacted]

[redacted] MCNA will submit our QAPI Program to the State for written approve and to ensure the QAPI Program is fully integrated into all appropriate operations.

G.4.02: Considering Needs of Members

Through 7 years of experience serving Iowans, and through key partnerships with local Iowan providers, MCNA has tailored our approach to caring for children, adults, and individuals with special health care needs who live throughout the state. MCNA takes the time to get to know the unique needs of our members and the providers who care for them. Our UM Program incorporates Utilization Review Criteria and Guidelines based on the needs of Iowa members and plan requirements, including:

- Age
- Co-morbidities
- Complications
- Progress in treatment
- Psychosocial situations
- Other social determinants of health

[redacted]

G.4.03: Obligation to Consult

MCNA has no guidelines for its Iowa members that do not include input from Iowa-licensed and practicing provider partners. Our UM Committee maintains responsibility for the development, adoption, and annual update of MCNA's Utilization Review Criteria and Guidelines. This includes membership seats from Iowa-based and participating general dentists to ensure appropriate clinical expertise. Other participating specialist providers will be called upon as needed to compliment the Committee.

G.4.04: Periodic Review

As described above, MCNA reaffirms that our UM Committee conducts an annual update of our Utilization Review Criteria and Guidelines. Furthermore, our UM Committee leverages service utilization and other operational data collected by the UM Department to inform discussions and updates to remain consistent with local member needs and nationally accepted clinical guidelines.

G.4.05: Following Practice Guidelines

[redacted]

MCNA's UM Program incorporates Utilization Review Criteria and Guidelines based on the needs of our members and plan requirements. [redacted]

G.4.06: Dissemination of Practice Guidelines

MCNA disseminates practice guidelines to all affected Providers. See: 42 C.F.R. § 438.236(c); 42 C.F.R. § 457.1233(c).

[redacted]

G.5: Quality

MCNA is committed to the ongoing monitoring and evaluation of the quality and appropriateness of care and service delivery for members and providers. [redacted]

G.5.01: Program Objectives

MCNA is deeply committed to improving the quality of care and dental outcomes for all members, including the country's most vulnerable populations. Throughout the states we serve, including Iowa, MCNA has gathered extensive experience and lessons learned in improving the oral health of millions, including child beneficiaries of CHIP and Medicaid. MCNA builds upon this experience to bring to Iowa our national best practices and industry-leading quality improvement strategy for ensuring the highest quality of care for our Iowa Dental Wellness Plan (DWP) and Healthy and Well Kids Iowa (Hawki) members.

[redacted]

[redacted]

G.5.02: QM/QI Program Requirements

[redacted] MCNA will comply with all requests from the Agency and its EQRO to demonstrate our compliance with all federal and state regulations.

Our QM/QI Program Descriptions, Work Plan, and Program Evaluation are exclusive to Iowa Medicaid and include all elements specified in section G.5.02 of the RFP. MCNA will submit our QM/QI Program Description to the Agency for approval within 60 days after contract execution; and annually thereafter for written approval. MCNA will also submit our QM/QI Work Plan and annual QM/QI Evaluation to the Agency for written approval on an annual basis. We will inform providers and members of our QM/QI Program through training, education, and communications through avenues such as our website, Member Handbook, and Provider Manual.

G.5.03: Member Incentive Program: General

[redacted] Prior to deployment of any new member incentive programs or changes to existing programs, MCNA will obtain Agency approval and identify opportunities for alignment with state or local program goals or efforts. Below we highlight some ongoing initiatives already approved and in use within Iowa.

[redacted]

[redacted]

G.5.04: Member Incentive Program Payment Restrictions

Regarding member incentive programs, MCNA will continue to comply with all marketing provisions set forth in 42 C.F.R. § 438.104, as well as federal and state regulations regarding inducements. We will continue to take all measures necessary to confirm the legality and impact on any member's eligibility of any value-added services, including but not limited to the permissibility of any such service under the Anti-Kickback Statute and the Stark law. 42 U.S.C. § 1320a-7b (Anti-Kickback Statute); 42 U.S.C. § 1395nn (Stark law). Measures taken include, but are not limited to, obtaining an advisory opinion under the federal statutory schemes where necessary, ensuring Agency approval of all incentives, and requiring annual employee trainings to ensure compliance.

G.5.05: QM/QI Committee

MCNA has established a robust local QM/QI committee structure to support analysis and evaluation, policymaking efforts, provider participation, and overall engagement in QM/QI efforts across the plan and member population.

[redacted]

[redacted]

G.5.05.a: QM/QI Committee Minutes

Each committee and subcommittee meeting sets their agenda prior to the meeting and circulates the agenda and all relevant materials to members for review. Dated written meeting minutes are signed and maintained for each meeting and are made available for review by the Agency or its Designee. Minutes of the previous meeting are reviewed at each QIC and QIC subcommittee meeting and members of the committee are given an opportunity to amend any discrepancies or errors. All minutes and associated materials are maintained in a locked file and compliant with Agency requirements and policies. Attendance is taken at each meeting and attendance is considered to be mandatory for all members unless prior approval for an excused absence is obtained from the CDO.

G.5.05.b: QM/QI Committee Notice of Meetings

MCNA will notify the Agency of regularly scheduled QIC meetings at least ten days in advance and understands that the Agency may attend meetings at its option. MCNA's QIC meetings are not publicly available and are not publicly announced. Relevant committee and subcommittee information is made available to members and providers through relevant external sources and communications materials. Committee members are given early and advance notice of all meetings, as well as all relevant documentation for productive engagement.

G.5.06: QAPI Program

[redacted]

[redacted]

G.5.07: Performance Improvement Projects - Clinical and Non-Clinical Areas

[redacted]

Our PIPs are designed in accordance with all relevant Agency and CMS requirements, including clear study questions, defined and measurable goals and objectives, specific population descriptions, objective measurement methodology, clear evaluation criteria, targeted interventions and effective evaluation processes, documented data collection methodology, and planned activities to increase and sustain improvement.

[redacted]

[redacted]

G.5.08: Performance Measurement Data

[redacted] In addition to state-specific reporting, MCNA monitors and reports on all CMS-required measures, including the CMS-416 metrics, CMS Core Set measures, DQA metrics, and the HEDIS Annual Dental Visit (ADV) metrics. [redacted]

MCNA will submit a report on any performance measures used for purposes of evaluating the impact of care delivery on quality, including key measures used within CMS programs. [redacted]

[redacted]

G.5.09: Under- and Over-Utilization Detection

[redacted] Our Utilization Management Program uses evidence-based guidelines to ensure services are medically necessary and provided in the amount, duration, and scope required for each patient. [redacted]

Our Utilization Management (UM) Program is designed to monitor the appropriateness, quality, and necessity of dental services consistent with state requirements and generally accepted dental standards of care. [redacted]

MCNA manages the full spectrum of dental care for our Medicaid and CHIP members, including diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, orthodontic, oral and maxillofacial surgery, and adjunctive general services.

[redacted]

G.5.10: Special Health Care Needs Obligations

At MCNA we pride ourselves on the quality of care and attention we give to members with special needs. We ensure there are mechanisms in place in our QAPI Program to assess the quality and appropriateness of care furnished to Iowa members with special health care needs, as defined in the Iowa State Quality Strategy (§ 438.340).

[redacted]

[redacted]

G.5.18: Annual Measurement

MCNA measures and reports on standard quality measures required by the state annually. We closely track and monitor performance on the five performance standards required by the Agency, as described in Section N and Exhibit A of the RFP. Further, MCNA will comply, as it currently does, with all reporting requirements, including the timely and accurate submission of all data to the Agency.

Our robust information system submits data to the state, as specified, for the measurement of standardized quality measures and indicators. All data is collected in accordance with standardized measurement specifications and data elements, as detailed by the Agency and set forth in both state rule and in the Iowa Quality Strategy.

[redacted]

[redacted]

G.5.19: Improving Health Outcomes

MCNA's QM/QI efforts and PIPs are focused on improving the oral health of Medicaid beneficiaries. [redacted]

In designing our PIPs, we work closely with our Iowa EQRO, HSAG, to develop a comprehensive quality strategy, as required by the most current managed care rules to ensure that our QAPI Program is focused on meeting Agency quality goals and ensuring positive oral health outcomes and satisfaction for our members.

[redacted] For additional information, please see our results in section G.5.27.

[redacted]

G.5.20: Objective Quality Indicators

MCNA's PIPs include objective measurement of performance using validated quality indicators and measures. [redacted]

- **HEDIS Annual Dental Visit (ADV)**
- **CMS-416**
- **CMS Child Core Set Measures**
  - Oral Evaluation, Dental Services (NQF 2517)
  - Topical Fluoride for Children (NQF 2528/3700/3701)
  - Sealant Receipt on Permanent First Molars
- **DQA Adult Measures**
  - Periodontal Evaluation in Adults with Periodontitis
  - Non-Surgical Ongoing Periodontal Care for Adults with Periodontitis
  - Topical Fluoride for Adults at Elevated Caries Risk
  - Adults with Diabetes - Oral Evaluation
  - Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults
  - Follow-up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults
- **DQA Pediatric Measures**
  - Utilization of Services
  - Preventive Services for Children
  - Treatment Services
  - Caries Risk Documentation
  - Oral Evaluation
  - Topical Fluoride for Children
  - Sealant Receipt on Permanent 1st Molar
  - Sealant Receipt on Permanent 2nd Molar
  - Care Continuity
  - Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children
  - Follow-up After Emergency Department Visits for Dental Caries in Children

G.5.21: Interventions to Improve Quality and Access

MCNA designs all PIPs to include interventions aimed at achieving improvement to access and quality of care for members. Over the years MCNA has been serving enrolled members in Iowa, a number of successful interventions have been put in place to promote improvements to dental care access, care coordination, and quality. These interventions are detailed below.

[redacted]

[redacted]

G.5.22: Evaluation of Effectiveness

MCNA regularly monitors standardized performance metrics to evaluate the effectiveness and quality of care received by our members.

[redacted]

G.5.23: Increasing and Sustaining Improvement

Following the systematic evaluation of all PIPs, our QIC reviews all data and makes recommendations on which interventions and programs should be continued or modified to sustain or increase improvements to quality of care for members. The QIC will make the final determination as to when a corrective action plan or PIP may be closed for compliance to the identified performance measure that was not meeting MCNA's or contract standard(s). Once the designated goal and level of acceptable performance has been met, the study indicator will periodically be re-measured to determine that the level of performance has sustained improvement.

G.5.24: Reporting

MCNA reports the status and results of each PIP to the Agency, as outlined in 42 C.F.R. § 438.330(d)(1) and (3) and 42 C.F.R. § 457.1240(b). MCNA makes additional data available to the Agency, upon request. All findings, results, resolutions, actions taken, and re-assessments are reported to the QIC and MCNA Board of Directors on a quarterly basis. As required by Contract, the status and results of each PIP is reported to the Agency as requested, but not less than once per year. MCNA submits all PIP deliverables to HSAG via SFTP annually.

G.5.25: Medicare Advantage Organization Option

MCNA understands that the state may permit any plan exclusively serving Dual Eligibles to substitute a Medicare Advantage Organization Quality Improvement project for one or more of the PIPs otherwise required.

G.5.26: Evaluation

MCNA is committed to meeting all evaluation requirements in the RFP with our QM/QI evaluation, ensuring compliance with 42 C.F.R. § 438.330(e)(2); 42 C.F.R. § 438.310(c)(2); 42 C.F.R. § 457.1240(b); 42 C.F.R. § 457.1240(f); 42 C.F.R. § 457.1201(n). [redacted]

[redacted]

[redacted]

Additionally, our PIPs are designed in accordance with all relevant state and CMS requirements, such as clear study questions, defined and measurable goals and objectives, specific population descriptions, objective measurement methodology, clear evaluation criteria, targeted interventions and effective evaluation processes, documented data collection methodology, and planned activities to increase and sustain improvement. Annually, MCNA will report the status and results of each PIP developed to the Agency for both the DWP and the Hawki Dental Programs.

G.5.27: Value-Based Purchasing Programs

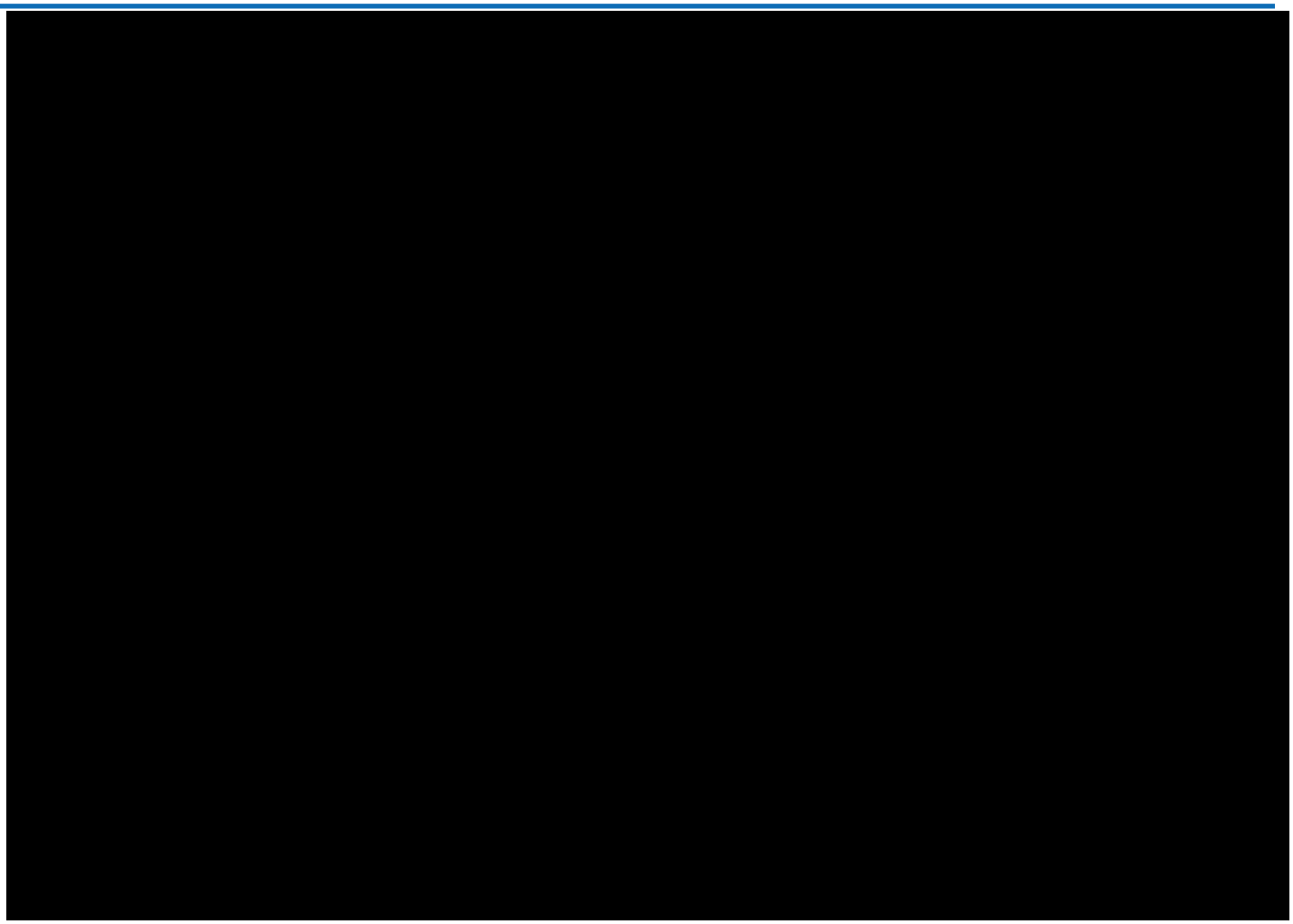
MCNA recognizes that Alternative Payment Models (APMs) are a means of incentivizing providers to innovate their practices and achieve higher quality outcomes and cost effectiveness. [redacted]

[redacted]

[redacted]

G.5.28: Dental Quality Strategy

[redacted]



We are committed to supporting the State's Dental Quality Strategy through strategic alignment with the state goals of improving network adequacy and availability of services, increasing recall and prevention services, improving oral health equity, and improving coordination and continuity of care to enhance medical/dental integration.

G.5.29: Value-Based Purchasing - PDPs

MCNA recognizes that VBP arrangements are an important means of incentivizing providers to innovate their practices and achieve higher quality outcomes and cost effectiveness.

In implementing incentive programs and VBPs, we will consider State goals and seek and receive State approval prior to implementation.

G.6: Cultural Competence

G.6.01: Cultural Competence Obligation

[redacted]

Our statewide provider networks are comprised of diverse dental practitioners who value people of all races, ethnicities, and socioeconomic backgrounds, including individuals with disabilities. All network providers are required to comply with MCNA's Cultural Competency Plan and the Americans with Disabilities Act (ADA).

[redacted]

[redacted]

G.6.02: Promoting Cultural Competence

MCNA will continue to promote the delivery of services in a culturally competent manner to all members, including those with LEP and diverse cultural and ethnic backgrounds. Our culturally appropriate care model is designed to help identify and address the special health needs of members who are poor, homeless and/or members of a minority population group.

[redacted]

G.6.03: Culturally Appropriate Care

MCNA is committed to providing culturally competent care to all of our members. MCNA's Cultural Competency Plan complies with all Culturally and Linguistically Appropriate Standards (CLAS) and aims to promote access to and delivery of services in a culturally competent manner to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities, and regardless of gender, sexual orientation, or gender identity.

[redacted]

G.7: Accreditation

G.7.01: Notice of Obligation

MCNA will ensure full compliance with Contract and SOW G.7.01 by promptly informing the State regarding accreditation status from a private independent accrediting agency. We maintain information about all accreditations on our public website, including the name of our accrediting entities, accreditation programs, and accreditation levels. This information is updated with each reaccreditation and no less than annually. MCNA will authorize URAC and NCQA, our current independent accrediting entities, to provide The Agency with our most recent accreditation review documentation to ensure that The Agency has access to full details regarding our accreditation status, recommended actions, summaries of findings, and accreditation expiration dates.

G.7.02: Provision of Information

Should MCNA receive accreditation by a private independent accrediting entity, we commit to authorizing the accrediting entity to provide the Agency with a comprehensive report of our most recent accreditation review. The report will include MCNA's accreditation status, survey type and level, recommended actions or improvement, Corrective Action Plans, summaries of findings, and the expiration date of the accreditation. MCNA is fully committed to transparency and compliance with all necessary reporting obligations.

G.7.03: NCQA Accreditation Obligation

MCNA has been accredited by the NCQA for credentialing and recredentialing since 2011. Additionally, we achieved the distinction of becoming the first dental plan in the country to be awarded full URAC Dental Plan Accreditation in 2014. This achievement is part of our ongoing effort to ensure exceptional services that meet all industry standards of care. We have successfully completed multiple reaccreditation cycles with URAC. Most recently, in 2020, MCNA was once again awarded full Dental Plan Accreditation effective through December 2023.

[redacted]

Section H: Grievances and Appeals

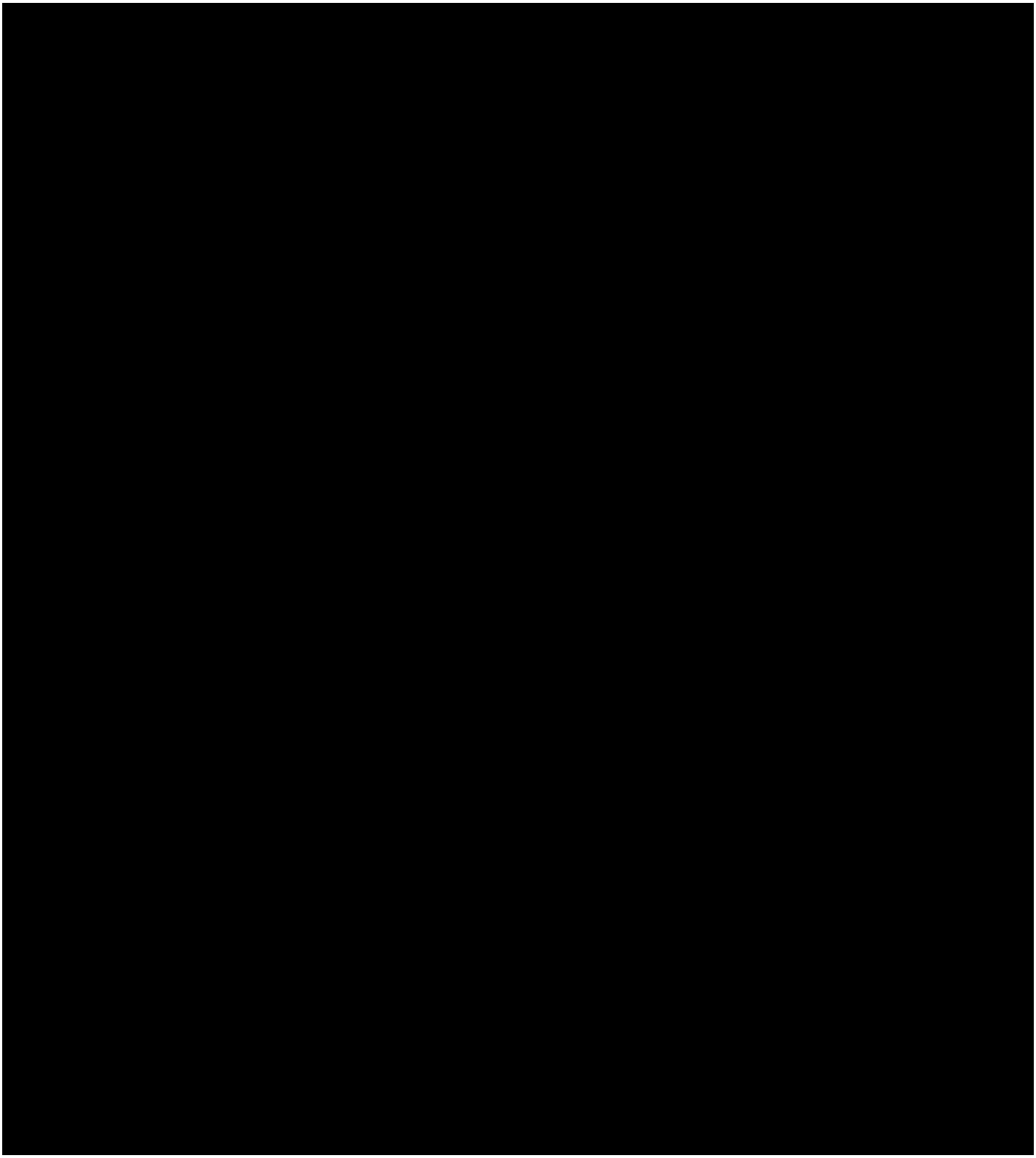
Since 2016, our Grievances and Appeals (G&A) Department has provided a fair, thorough, timely investigation and resolution of all grievances and appeals lodged by or on behalf of our Iowa Dental Wellness Plan (DWP) members, and for the over 5 million Medicaid and CHIP members we serve across the country.

[redacted]

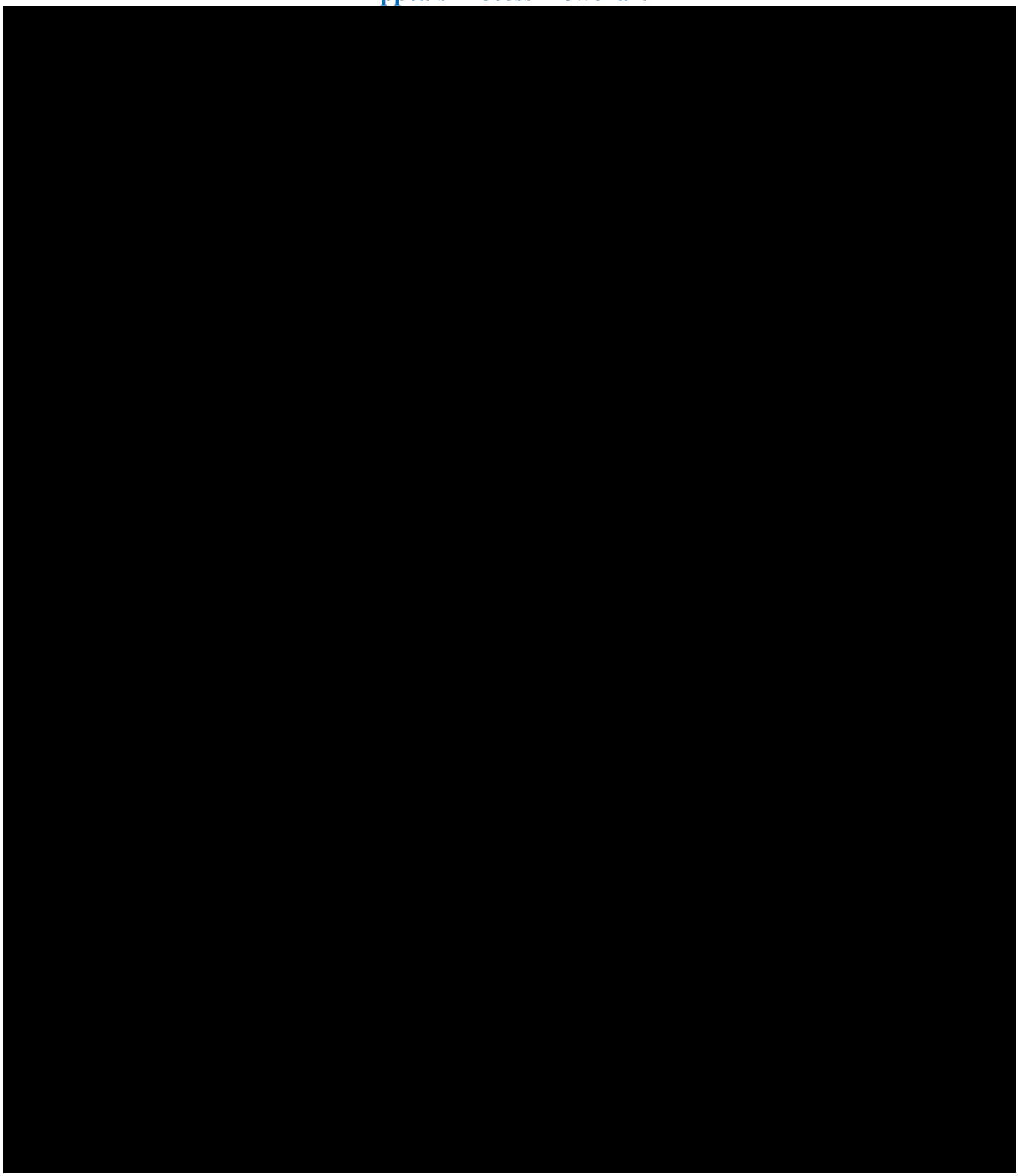
We have read, understand, and will comply with Iowa Dental Wellness Plan and Hawki Dental PAHP RFP# MED-24-004. In our response below, we address key requirements from RFP Attachment F: Contract and Scope of Work Section H. Grievances and Appeals H.1-H.11.

Please see the following flowcharts illustrating MCNA's grievance and appeals processes.

Grievance Process Flowchart



Appeals Process Flowchart



H.1: Grievance and Appeals System

H.1.01: Grievance and Appeal Systems

MCNA's G&A system includes our grievance process, appeal process, and access to the State Fair Hearing process, is fully compliant with all State and Centers for Medicare & Medicaid Services (CMS) requirements, and promotes ease of access for members, including those with disabilities and non-English speakers. Administration of our G&A system includes comprehensive maintenance of all information related to grievances or appeals filed by members. Such records meet the conditions outlined in 42 CFR §438.416(b) and are made available to CMS and the State, or their authorized designee upon request. [redacted]

H.1.02: Authority to File

Any member, or their authorized representative, can file a grievance or appeal. Members can also request a State Fair Hearing after receipt of notification from MCNA that their adverse benefit determination was upheld.

H.1.03: Eligibility, Effective Date of Coverage, Premiums, Copayments, and Exceptions to Policy

MCNA will process grievances and appeals internally in a timely manner. However, if the grievance or appeal is related to eligibility determinations, effective dates of coverage, premium and copayment responsibilities, or exceptions to policy regarding services outside of State Plan Benefits, we will refer these requests directly to the Agency.

H.1.04: Single Level of Contractor Appeals

We educate and inform members about how to access the grievance, appeal, and State Fair Hearing process through our Member Handbook, Member Hotline, and website. MCNA only has a single level of appeal available to members.

H.1.05: Assistance

[redacted]

We make every effort to inform and assist our members and their authorized representatives in accessing the grievances and appeals process.

H.1.06: Acknowledging Appeals

Regardless of whether the grievance or appeal is made orally or in writing, MCNA will provide written acknowledgement within three business days.

H.1.07: Separation of Duties

Clinical decision makers are held to the highest standards of impartiality and expertise to assure fair and consistent outcomes for our members. We confirm that G&A decision makers have not been involved in any previous review nor are they subordinate to any previous reviewer or decision maker.

H.1.08: Appropriate Knowledge of Decision Makers

MCNA members and providers have the right to a clinical decision made by an individual with appropriate clinical expertise in treating the enrolled member's condition or disease, particularly when the decision involves clinical issues, an assessment of medical necessity, or a grievance regarding denial of an expedited appeal. [redacted]

H.1.09: Factors that Must Be Considered

Our impartial, clinically appropriate decision makers conduct a comprehensive review before coming to resolution on any grievance or appeal of an adverse benefit determination. That review can include comments, documents, and records. It may also include additional information submitted by or on behalf of the member, even if that information available or relied upon during the initial adverse benefit determination.

H.1.10: Grievance Regarding Disenrollment

MCNA will evaluate and resolve any grievance regarding disenrollment in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the member requests disenrollment or we refer the request to the State.

H.1.11: Contractor Grievance Support

MCNA works to ensure members have robust access to a fair G&A system, while also acting as a strong steward to responsibly administer the Dental Wellness Plan. Throughout the G&A process, we provide support, such as factual and expert testimony, to back our position on the member’s claim. That support also includes any assistance needed by the Attorney General’s Office in relation to a judicial review related to the State Fair Hearing process. MCNA understands we are responsible for any award of attorneys’ fees and costs provided at any stage of State Fair Hearing or judicial review of our decisions.

H.2: Notice of Adverse Benefit Determination Requirements

H.2.01: Notice Obligations

MCNA notifies our members in writing with a notice of adverse benefit determination of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested within the timeframes outlined by the State. Member notices are written at or below a 6th grade reading level to ensure ease of understanding and are in compliance with state and federal requirements. All notices are mailed in accordance with the requirements outlined under Section H.2.

H.2.02: Minimum Contents of Notice

Each notice of adverse benefit determination informs our members of their right to be provided, free of charge, all documentation relevant to the adverse benefit determination. MCNA fully complies with all language requirements including translation of member notifications.

Member notifications explain, at a minimum the:

- Action MCNA has taken or intends to take
- Reasons for the action
- Medical necessity criteria
- Methodology for setting coverage limits

H.2.03: Obligation to Explain Rights

MCNA's notice of adverse benefit determination will also clearly explain the member's right to an appeal, detailing MCNA's single level of appeal. It will also explain the member's right to request a State Fair Hearing after MCNA's appeal process has been exhausted, after they receive notice that the adverse benefit determination has been upheld.

H.2.04: Obligation to Explain Procedures

The notice of adverse benefit determination will also detail the procedures for exercising the member's appeal rights.

H.2.05: Obligation to Explain Right to Expedited Appeal

The notice of adverse benefit determination will also detail the circumstances under which expedited resolution is available and how to request it. MCNA understands how critical it is for members to receive quick resolution when delay may seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The notice also explains circumstances under which expedited resolution is available and how to request it, as well as the member's right to request that benefits continue pending the resolution of the appeal.

H.2.06: Obligation to Explain Continuation of Benefits

The notice of adverse benefit determination will also detail the member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services.

H.2.07: Notices Regarding Denied Payment

Denying payment for service is considered an adverse benefit determination, but not if the sole issue is that the claim does not meet the definition of a "clean claim". Only if there is another reason for the denial of payment will a notice be sent out.

H.3: Notice of Adverse Benefit Determination Timing

H.3.01: Timely Notice of Adverse Benefit Determination

Timely notification of any adverse action or resolution, provides our members with the information and guidance they need to best move forward to protest or adapt to their services. When the action is termination, suspension, or reduction of previously authorized services or a denial of payment, MCNA mails the notice of adverse benefit determination at least 10 days before the date of action.

H.3.02: Timely Mailing of Notice

If the Agency has facts, preferably verified through a secondary source, that the member has committed probable fraud, the notice of adverse benefit determination is mailed at least five days prior to the date of action.

H.3.03: Mailing Obligations

MCNA mails the notice of adverse benefit determination by the date of the action when any of the following occurs:

- Member has died
- Member submits a signed written statement asking for service termination
- Member submits a signed written statement that includes information that requires service termination or reduction and indicates that they understand that service termination or reduction will result
- Member has been admitted to an institution that is ineligible under their plan for further services
- Member's address is unknown based on unreturned mail with no forwarding address
- Member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth
- Member's physician prescribes a change in the level of medical care
- The notice involves an adverse determination regarding preadmission screening requirements of section 191(e)(7) of the Social Security Act
- The transfer or discharge from a facility will occur in an expedited fashion

H.3.04: Notice Timing when Payment Denied

When MCNA denies payment, we provide members with the notice of adverse benefit determination on the date the determination decision is made.

H.3.05: Fourteen Day Notice Deadline

MCNA's decisions to authorize, modify, or deny a dental treatment are made within the Agency-established timeframes and no later than 14 calendar days after receipt of the request for authorization of services for all standard requests. In cases of standard authorization decisions that may deny or limit services, MCNA gives notice of an adverse benefit determination as expeditiously as the member's condition requires. Notice will not exceed the 14 days following receipt of the request for service.

H.3.06: Extensions of Fourteen (14) Day Deadline

If a member, their authorized representative, or their provider requests an extension, MCNA may extend the timeline for a standard authorization decision up to an additional 14 days.

H.3.07: Extensions of Standard Authorizations

MCNA may only extend the timeline for a standard authorization decision up to an additional 14 days if we can show a need for more information, and that the need and extended timeline is in the member's best interest. We will provide the necessary justification to the Agency, upon request.

H.3.08: Written Notice Obligations

In circumstances where MCNA moves forward with extending the decision timeline for standard authorization that deny or limit services, we will issue and carry out its determination as expeditiously as the member's health condition requires and no later than the expiration date. In addition, we will give the member written notice of the reason for the extension and inform the member of their right to file a grievance if they disagree with the decision to extend.

H.3.09: Duty to Make the Determination Expeditiously

MCNA takes seriously our duty to make authorization decisions expeditiously. MCNA is committed to ensuring our members have access to an easy-to-use, timely, and efficient G&A system. We will issue and carry out determinations as expeditiously as the member's health condition requires and no later than the date of expiration of the extension.

H.3.10: Expedited Service Authorization Decisions

Expedited determinations are completed as expeditiously as the member's health or dental condition requires, but no later than 72 hours after receipt of the request. We acknowledge that service authorization decisions not reached within required timeframes constitute a denial and are, therefore, an adverse benefit determination. MCNA will make an expedited service authorization decision if following the standard authorization time frame could seriously jeopardize the enrolled member's life; health; or ability to attain, maintain, or regain maximum function. For such cases, a notice will be provided as expeditiously as the enrolled member's health condition requires and no later than 72 hours after receiving the request for service.

H.3.11: Extensions of Timeline – Expedited Service Authorizations

Should the enrolled member request an extension or if MCNA justifies a need for additional information, we understand that we may extend the 72-hour expedited service authorization decision period by up to 14 days.

H.3.12: Notice Obligations

We have a proven track record of resolving member grievances and appeals well in advance of contractually required time limits. However, should MCNA not reach a service authorization decision within the standard or expedited timeframe, we will provide notice on the resolution deadline.

H.3.13: Untimely Service Authorizations

MCNA understands that untimely service authorization decisions constitute a denial and are thereby subject to all the notice and resolution requirements as an adverse benefit determination.

H.4: Who May File Appeals and Grievances

H.4.01: Enrolled Member Rights

Our G&A Department provides a fair, thorough, timely investigation and resolution of all grievances and appeals lodged by or on behalf of our members. Any member, or their authorized representative, can file a grievance or appeal. Members can also request a State Fair Hearing after being notified that their adverse benefit determination was upheld.

H.4.02: External Medical Review

MCNA will comply with any external medical review and external medical review processes that the Agency, at its discretion, chooses to offer.

H.4.03: Authorized Representatives

MCNA allows all enrolled members who receive an adverse benefit determination notice to file appeals, grievances, and State Fair Hearing requests themselves, or via an authorized representative or their provider. A member's authorized representative must have written consent from the member to submit appeals or grievances on their behalf. A provider must also have written consent from the member.

H.4.04: Prohibition on Appeals Regarding Provider Payment

One exception to note, a provider may not file an appeal on behalf of a member if the appeal suggests that the contracted provider is entitled to a State Fair Hearing when the sole issue of the appeal is a payment dispute.

H.5: Timeframes for Filing Appeals

H.5.01: Deemed Exhaustion – Notice & Timing Requirements

We ensure that members are informed of their right to request a State Fair Hearing after exhausting MCNA internal G&A processes. However if we fail to meet any of the notice or timing requirements in this contract, we understand and acknowledge that the member is deemed to have exhausted our appeals process and may initiate a State Fair Hearing.

H.5.02: Deemed Exhaustion – Thirty (30) Day Timeline

We attest that if MCNA does not resolve and provide notice to the affected parties within 30 days from the date we received the appeal, the member will be deemed to have exhausted our appeal process and can request a State Fair Hearing.

H.5.03: Contractor Sixty (60) Day Appeal Timeline

Members may file an appeal within 60 days from the date on the adverse benefit determination notice.

H.5.04: Contractor Sixty (60) Day Appeal Timeline – Authorized Representatives

As State law permits, MCNA allows the provider or authorized representative acting on behalf of the member to file an appeal within 60 days from the date on the adverse benefit determination notice.

H.6: Process for Filing an Appeal or Expedited Appeal Request

H.6.01: Right to File Orally or in Writing

We provide members with a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The member or their authorized representative may examine the case file, including dental records and any other material to be considered during the process. MCNA's approach provides members multiple avenues to express dissatisfaction or concerns. Members may file complaints, grievances, or appeals orally or in writing through our Member Hotline; via mail, fax, or email; via our secure member portal; or through referrals from other departments.

H.6.02: Authorized Representative Authority

We affirm that an authorized representative or provider acting on behalf of a member, with the member's written consent, may also file an appeal either orally or in writing on the member's behalf.

H.6.04: Acceptance of Oral Appeals

We treat oral inquires for an appeal of an adverse benefit determination that is made by the member, their provider, or their authorized representative as an appeal within the MCNA G&A system.

H.6.05: Due Process Obligations

MCNA understands the due process we owe our members at all stages of the G&A process. We provide members with a reasonable opportunity, both in person and in writing to:

- Present evidence
- Present testimony
- Make legal and factual arguments

H.6.06: Obligation to Provide Case File

As part of our continued support for our members through the G&A process, we provide a full case file containing medical records and other documentation, including any new or additional evidence considered, relied upon, or generated by MCNA in connection with the appeal.

H.6.07: Obligations Related to Case File

MCNA documents the nature of an appeal in the G&A module of DentalTrac™ and prepares a case file including all pertinent information and supporting documentation (i.e., x-rays, narratives, dental records, member benefits, claims, and other relevant materials). The case file is provided to the member and their authorized representative in a timely manner prior to resolution of their appeal at no cost. For standard resolution, no longer than 30 days and for expedited resolution no longer than 72 hours, from when we receive the appeal.

H.6.08: Recognition of Parties in Interest

MCNA recognizes that parties of interest to an appeal may include the member, their representative, or the legal representative of their estate, if the member is deceased.

H.6.09: Expedited Procedures

When MCNA or the member's provider determines that the timeframe for a standard resolution could seriously jeopardize the life, physical or mental health of member, or impact their ability to attain, maintain, or regain maximum function, we will route the appeal through our expedited review process.

H.6.10: Notice of Time Availability

MCNA will notify members whose appeals are processed according to expedited timelines and explain how those expedited timelines limit the member's window to present evidence and testimony. This notification is made as soon as possible to ensure sufficient opportunity for the member to make legal and factual arguments.

H.6.11: Denials of Expedited Requests

If MCNA's determination is that a member's health condition does not require an expedited timeline, the appeal will be process under the standard resolution timeline of no longer than 30 days, with a possible 14-day extension.

MCNA sends an acknowledgement letter to the member within three business days of receipt of the appeal of adverse benefit determination.

[redacted] If the request for an expedited appeal is denied, the appeal will be handled according to the standard appeals process and timeframes. If the member requests an extension, the request will be treated as a denial for expedited appeal and handled according to standard appeal processes as expeditiously as possible.

H.7: Timeframes for Resolving Appeals and Expedited Appeals

H.7.01: Resolution Deadline

MCNA makes every effort to promptly resolve all appeals as expeditiously as the member's health status requires and within the required timeframe of 30 calendar days. Once MCNA receives a request for appeal, we gather and route the case file for investigation and review by a Clinical Reviewer who is a dentist with the appropriate clinical expertise. We complete the review and make a determination no later than 30 calendar days after our receipt of the appeal. Our resolution notices are sent to all parties within that same timeline.

H.7.02: Resolution Extensions

If a member requests an extension, the timeline for appeal resolution may be extended up to an additional 14 days. MCNA may only extend the timeline for a standard appeal resolution up to an additional 14 days if we can show a need for more information, and that the need and extended timeline is in the member's best interest. We will provide the necessary justification to the Agency, upon request.

H.7.03: Extension Obligations

When the member has not requested an extension for appeal resolution, but MCNA determines it is in the member's best interest to do so, we make reasonable efforts to provide verbal notice as promptly as possible and provide written notice within two days. The written notice includes the justification for the extended timeline and the member's right to file a grievance if they disagree with the extended timeline.

H.7.04: Expedited Appeal Deadline

If the case meets expedited appeal criteria, MCNA will notify the provider and member, orally and in writing, of the determination to approve or deny the appeal as expeditiously as the member's health condition requires and in no event longer than 72 hours, unless the timeframe is extended in accordance with the State requirements.

H.7.05: Extensions – Expedited Appeals

If a member requests an extension, the timeline for expedited appeal resolution may be extended up to an additional 14 days. MCNA may only extend the timeline for an expedited appeal resolution up to an additional 14 days if we can show a need for more information, and that the need and extended timeline is in the member's best interest. We will provide the necessary justification to the Agency, upon request.

H.7.06: Extension Obligations

When the member has not requested an extension for expedited appeal resolution, but MCNA determines it is in the member's best interest to do so, we make reasonable efforts to provide verbal notice as promptly as possible and provide written notice within two days. The written notice includes the justification for the extended timeline and the member's right to file a grievance if they disagree with the extended timeline. The expedited appeal will be resolved no later than the date the extension expires.

[redacted]

H.8: Notice of Resolution for Appeals

[redacted] Our notices inform the member of their right to a State Fair Hearing and the process for requesting a hearing.

H.8.01: Notice Obligations Regarding Resolution of Appeals

In the case of a regular or expedited appeal, MCNA notifies the member, their authorized representative, and provider (as applicable) of the resolution. MCNA provides written notice of the appeal in Agency-approved format and language.

Upon completing the appeal review process, we send a notification of appeal resolution that includes:

- Date and results of the appeal resolution
- The right to request a state fair hearing

We include the following information for members whose appeals were not decided in their favor:

- How to request a state fair hearing
- The right to request and receive benefits pending a hearing
- How to request continuation of benefits
- Notice that the enrolled member may, consistent with State policy, be liable for the cost of any continued benefits if MCNA's adverse benefit determination is upheld in the hearing

H.8.02: Notice Obligations – Expedited Appeals

Our G&A team members provide written notice and make a reasonable effort to provide an oral notice by telephone of the resolution of an expedited appeal.

H.9: Continuation of Benefits

H.9.01: Inapplicability

MCNA's continuation of benefits policy is compliant with Section H.9. MCNA ensures that DWP members' benefits are continued during the appeal according to the conditions outlined Section H.9 and understands that those continuation of benefits requirements do not apply to Hawki members.

H.9.02: Continuation of Benefits

We understand that members, except for those receiving Hawki program services, have the right to request the continuation of benefits while appeals are pending under the following conditions:

- The member or their authorized representative files an appeal with MCNA on or before the latest of the following time frames: within 60 days from the date of the adverse benefit determination, within 10 business days after we mail the notice of the adverse action, or within 10 business days after the intended effective date of the action.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- An authorized provider ordered the services.
- The period covered by the original authorization has not expired.

For members who request a continuation of benefits on or before the 10 days we have sent a notice of adverse benefit determination or the intended effective date of the proposed adverse benefit determination, and if the conditions listed above are met, we will continue the benefits while the appeal is in process.

H.9.03: Continuation of Benefits During Appeal

If the request for continuation of benefits meets these conditions, MCNA continues to provide benefits to the member in accordance with Contract requirements and State and Federal laws and regulations. Benefits will continue until one of the following scenarios occurs:

- The member withdraws the appeal or state fair hearing request.
- The member misses the 10-day deadline to request a state fair hearing and continuation of benefits following the notice of adverse appeal resolution.

- The State Fair Hearing process issues an adverse decision.

H.9.04: Recovery from Enrolled Member

MCNA understands its right to recover the cost of continued services during a pending appeal or State Fair Hearing if the final resolution upholds our original decision.

H.9.05: Continuation of Benefits

If MCNA's original determination to deny, limit, or delay services is reversed, we will provide the disputed services no later than 72 hours from the date we receive the reversal notice, if not provided previously.

H.9.06: Continuation of Benefits Payment Obligations

We understand our obligation to pay for disputed services while the appeal is pending or upon receiving a reversal notice.

H.9.07: Notice Obligations

We provide notice to the provider and written notice to the member regarding any service authorization denial or service authorization that was less than the amount, duration, or scope requested.

H.10: Grievances

H.10.01: When Grievances Must be Accepted

MCNA's approach to grievances and appeals provides members multiple avenues to express dissatisfaction by filing at any time.

H.10.02: Written and Oral Grievances

Grievances may be filed orally or in writing through our Member Hotline; via mail, fax, or email; via our secure member portal; or through referrals from other departments.

H.10.03: Grievance Filings with Contractor

MCNA understands we are the only contractually authorized recipient for all member grievances. When a grievance is received by our G&A Department, we enter the grievance into the customized G&A module of DentalTrac™ and assesses the nature and urgency of the case to determine the appropriate resolution path. Our Administrator immediately researches the issue and coordinates with dental offices, involved parties, and other MCNA departments such as Provider Relations and Quality Improvement. The role of the Administrator is to resolve the grievance and provide notice of the determination to the member or authorized representative as quickly as possible and within State-required timeframes. Upon receipt of all supporting documentation and findings, the Administrator analyzes the information, documents the findings in the G&A module, and creates a disposition letter that addresses the member's concern.

H.10.04: Timeline for Resolutions

We address each grievance and provide notice, as expeditiously as the member's health condition requires, within the timeframes required in Section H of the Contract. We offer a determination and resolution within 30 days after MCNA's receipt of the grievance. Our resolution notices are sent to all parties.

H.10.05: Extension of Timeline

MCNA notifies members of the disposition of the grievance within 30 calendar days unless the member has requested an extension. If a member requests an extension, the timeline for grievance resolution may be extended up to an additional 14 days. MCNA may only extend the timeline for grievance resolution up to an additional 14 days if we can show a need for more information, and that the need and extended timeline is in the member's best interest. We will provide the necessary justification to the Agency, upon request. [redacted]

H.10.06: Extension Notice Obligation

If the timeframe is extended other than at the member's request, MCNA will provide prompt oral notice of the delay and written notice of the reason for the delay within two days. The written notice will also inform the member of their right to file a grievance if they disagree with the decision to extend the grievance resolution timeline.

H.10.07: Notice Requirement

MCNA notifies members in writing of the resolution of all grievances within 30 days. That notice is in a format and language that is compliant with all Agency notification standards.

H.11: Grievance and Appeal Recordkeeping Requirements

[redacted]

[redacted]

H.11.01: Obligation to Maintain Records

All communicated grievances and appeals are captured in DentalTrac™, MCNA's proprietary management information system. DentalTrac™ time stamps each grievance and appeal, enabling the creation of a complete audit trail to ensure all complaints, grievances, and appeals are appropriately recorded and can be resolved in a timely manner.

H.11.02: Contents of Records

The records for each grievance and appeal within DentalTrac™ is extensive, but contains at a minimum:

- General description of reason for grievance or appeal
- Receipt date
- Date of each review and review meeting
- Resolution information at each level of grievance or appeal review
- Date of each resolution
- Name of the member for whom the appeal or grievance was filed

H.11.03: Records Accessibility

All documentation exchanged and the activities involved in researching and resolving the case are logged in DentalTrac™ for easy reference and superior tracking. MCNA maintains all data for a period of no less than 10 years. Our G&A records are accessible to the State and available to CMS, upon request.

H.11.04: Grievance Resolution Performance Metric

[redacted]

H.11.05: Hearings and Appeals Performance Metric

We will acknowledge receipt of each appeal within three business days and decide on standard, non-expedited appeals within 30 business days of receipt of the appeal, and within 72 hours for expedited appeals.

Section I: Program Integrity

We have read, understand, and will comply with Iowa Dental Wellness Plan and Hawki Dental DWP RFP# MED-24-004. In our response below, we address key requirements from RFP Attachment F: Contract and Scope of Work Section I; Program Integrity I.1.01-I.13.

I.1: Exclusions

MCNA's Agency-approved Program Integrity Compliance Plan provides written policies and procedures demonstrating MCNA's commitment to effectively combat FWA through interdepartmental collaboration. We comply with all State and federal requirements and use established protocols to monitor and identify debarred individuals or excluded providers. The Credentialing and Human Resources departments are responsible for ensuring that MCNA does not hire or enter into contracts with individuals or entities that are listed as debarred, suspended, excluded or otherwise ineligible for participation in state and federal health care programs.

I.1.01: Excluded Providers

MCNA does not and will not employ or contract with providers or others excluded from participation in federal health care programs. We check all required state and federal Medicaid sanction lists to ensure we do not engage in any contracts with excluded or prohibited individuals or entities. MCNA conducts regular monitoring and auditing activities to ensure we are not employing or contracting with providers or others excluded from participation in federal health care programs.

I.1.02: Exclusion Checks

To ensure all staff members, providers, and subcontractors are not excluded from participation in Medicare, Medicaid, and/or any federal healthcare programs, we search the following websites:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
- GSA System of Aware Management (SAM; formerly known as the GSA Excluded Parties List System (EPLS))
- Social Security Administration Death Master File (SSDMF)
- National Plan and Provider Enumeration System (NPPES)
- Medicaid Exclusion Lists, including the Iowa Medicaid Exclusion List

MCNA searches these websites monthly to capture exclusions and reinstatements that have occurred since a previous search. Any and all exclusion information discovered is immediately reported to the applicable state agency. Any individual or entity that employs or contracts with an excluded provider or individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This

prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against any person including an organization, agency, or other entity who employs or enters into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries in accordance with Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003. Our Program Integrity Unit conducts a series of monitoring and auditing activities on a monthly, quarterly, or annual basis to ensure that MCNA is meeting all state, federal, and accrediting organization requirements.

I.1.03: Actions Against Network Providers

To ensure delivery of high quality, safe, and effective member care, MCNA has established systems, policies, and procedures to monitor providers for sanctions and quality issues. We will continue to notify the Agency within 24 hours of any action we take to limit the ability of an individual or entity to participate in our provider network. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the network to avoid a formal sanction. The notification includes the reason for the proposed action. MCNA will also submit an assurance that services to members will not be impacted if there has been a significant change in our operations.

I.1.04: Sanctioned Individual Prohibition

MCNA is not and will not be controlled by a sanctioned individual under section 1128(b)(8) of the Act.

I.1.05: Contracting Prohibition – Conviction of Crimes

MCNA does not and will not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in section 1128(b)(8)(B) of the Social Security Act. These requirements are built into our policies and procedures.

I.1.06: Contracting Prohibition – Debarment/Suspension

MCNA does not and will not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. MCNA complies with all exclusion check requirements, which we have built into our standard contracting and credentialing processes.

I.1.07: Contracting Prohibition – Excluded Individuals or Entities

MCNA does not and will not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act. MCNA complies with all exclusion check requirements, which we have built into our standard contracting and credentialing processes. A detailed description of our credentialing policies and procedures can be found in our response to Attachment F: Contract and Scope of Work, Section E.3.03 (SOW).

I.1.10: Contracting Prohibition – Debarment/Suspension, Additional Requirements

MCNA does not and will not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. MCNA complies with all exclusion check requirements, which we have built into our standard contracting and credentialing processes.

I.1.11: Contracting Prohibition – Excluded Individuals or Entities, Additional Requirements

MCNA does not and will not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act. MCNA complies with all exclusion check requirements, which we have built into our standard contracting and credentialing processes. A detailed description of our credentialing policies and procedures can be found in our response to SOW, Section E.3.03.

MCNA does not pay claims to or execute contracts with individuals or groups of providers who have been excluded from participation in federal health care programs under either Section 1128, Section 1128A, or Section 1156 of the Social Security Act or state funded health care programs. We will also terminate contracts with providers who have been excluded from participation or who are otherwise barred from participation in the Medicaid and/or Medicare program. As required in the SOW, MCNA is not controlled by a sanctioned individual under section 128(b)(8) of the Social Security Act.

I.2: Submission of Data & Documents Requirements, Procedures, and Reporting

[redacted] We understand that the Agency will complete readiness reviews of MCNA prior to the Contract start date in accordance with 42 CFR §438.66(c)-(d). Our implementation plan contains explicit controls for assessing the completion of activities required for readiness review.

I.2.01: Encounter Data Submission Obligation - I.2.02: Encounter Data HIPAA Compliance

[redacted] MCNA privacy, security, and confidentiality controls and policies and procedures are regularly audited. MCNA does not use any information obtained in any manner except as necessary for the proper discharge of our obligations under the Contract.

[redacted]

The data format for submission of encounter data is HIPAA 837D-compliant and will be extended by specific mapping requirements from the Agency's 837D specification guidelines as well as those defined by the Uniform Managed Care Manual. Encounter data includes all new claims and claim adjustments performed during the reporting period, along with value-added services without any associated costs. [redacted]

We will collect and maintain sufficient dental health plan member encounter data in compliance with the SOW, 42 C.F.R. §438.242(c), and all applicable state and federal laws, as well as in accordance with 42 C.F.R. §438.818(a)(1). [redacted] he encounter data will include fully adjudicated claims from the previous seven days as well as any corrections from previous encounter submissions. [redacted]

[redacted]

[redacted]

If the Agency notifies MCNA of a system issue or defect, we respond to the inquiry within five business days with either an explanation of the issue (not a defect) or our root cause analysis of the issue and plans for corrective action. MCNA will correct minor issues within 15 business days or if the issue is more complex, we will develop and publish a requirements analysis and proposed corrective action specifications document for Agency review and approval. This document will contain the proposed implementation date for the correction for Agency consideration and approval. Any changes implemented to our system are date stamped and recorded as an update to our core system.

[redacted]

I.2.03: Data Supporting Actuarial Soundness

Our actuarial, finance and accounting teams employ sophisticated validation processes to supply data to the Agency to certify the actuarial soundness of capitation rates, as specified in 42 CFR §§ 438.604(a)(2); 438.606; 438.3; and 438.5(c). We evaluate critical data points as shown below to ensure we supply accurate data to the Agency to certify actuarial soundness.

I.2.04: Data Supporting Compliance

MCNA maintains financial records and reports revenues and expenses using Generally Accepted Accounting Principles (GAAP), which are auditable. We generate financial reports quarterly and annually. These include particulars concerning cash flow, balance sheets, changes in capital, and income statements. MCNA submits data in compliance with the MLR requirement described in 42 CFR § 438.8, and certification requirements described in 42 CFR § 438.606, and CMS guidance.

I.2.05: Data Supporting Insolvency Protections

MCNA will submit data to the Agency to provide satisfactory assurances showing that our controls against the risk of insolvency are adequate in accordance with 42 CFR § 438.116 and CMS guidance. MCNA's experience providing efficient and effective contract performance has put us on a solid financial footing. We understand that our sustained financial health positions will allow us to continue to provide high-caliber services and fulfill our obligations to the DWP program, as well as the Hawki program in the future, and to our members. **We are in full compliance with our financial solvency requirements as a longstanding partner to the Agency, and we will continue to comply with all financial requirements described in the SOW.**

MCNA has consistently met all quarterly and annual regulatory reporting requirements of the DWP program as well as those specifically required by departments of insurance and state agencies overseeing our other program contracts. To demonstrate our financial solvency, MCNA is providing our audited financial statements with this RFP response. MCNA's parent company is committed to maintaining MCNA's financial viability throughout the life of any Contract that may result from the RFP.

External auditors review our processes, data integrity, enrollment, and claims accuracy, as well as the financial accuracy of our systems, reports, and processes, at least once per year. These audits include our SOC 2 Type 2 audits as well as review of other internal processes, accuracy, HIPAA-related, and financial audits.

I.2.06: Data Supporting Accessibility, Availability, & Adequacy of Network

[redacted]

MCNA will continue to submit documentation to the Agency, in a format specified by the Agency, to demonstrate that we comply with the federal requirements of offering an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of members for the service area, and that we maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the dental needs of the anticipated number of members in our service area.

I.2.07: 455.104 Submission Obligations

MCNA will submit the following information to the Agency in accordance with federal regulations:

- The name and address of any person (individual or corporation) with an ownership or control interest in MCNA and its subcontractors, the address for corporate entities including as applicable primary business address, every business address, every business location, and P.O. Box address
- The date of birth and social security number (SSN) of any individual with an ownership or control interest in MCNA and our subcontractors
- Other tax identification number of any corporation with an ownership or control interest in MCNA and any subcontractor in which we have a five percent or more interest
- Information on whether an individual or corporation with an ownership or control interest in MCNA is related to another person with ownership or control interest in MCNA as a spouse, parent, child, or sibling
- Information on whether a person or corporation with an ownership or control interest in any subcontractor in which MCNA has a five percent or more interest is related to another person with ownership or control interest in MCNA as a spouse, parent, child, or sibling
- The name of any Other disclosing entity in which an owner of MCNA has an ownership or control interest
- The name, address, date of birth, and SSN of any managing employee of MCNA

I.2.08: Making Information Available

MCNA will submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the Agency or Secretary of the U.S. Department of Health and Human Services (Secretary), including without limitation, the submission of data including provider type, name, address, date of birth, and SSN.

I.2.09: Claims Reports and Performance Targets

[redacted]

We understand that during the implementation of this program and throughout the lifespan of the contract, the Agency may need to review specific information and analytical reports in order to make decisions about the course of the program, and MCNA will work closely with Agency staff to ensure access to all necessary reports.

[redacted]

[redacted]

We will submit claims processing and adjudication data to the Agency, identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing, and meet the performance targets described in Section D.6.

I.2.10: Impermissible Cost Avoidance

MCNA will not refer members to publicly supported health care resources to avoid costs for services covered as a benefit under the Contract.

I.2.11: Certification

MCNA will certify any data, documentation, or information specified under Sections I .2.01-I.2.09, and will ensure that the certification required by Section I.2.11(a) is done by our Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification. We will also continue to ensure that the designated individual who submits data to the Agency shall provide a certification, which attests, under penalty of perjury, based on best information, knowledge, and belief that the data, documentation, and information are accurate, complete, and truthful. We will submit certification concurrently with the submission of data, documentation, or information.

I.2.12: Prohibitions

In accordance with 42 CFR 438.610, MCNA will not knowingly have a relationship with an individual or entity (or an affiliate of such individual or entity) that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

I.2.13: Prohibited Affiliations

In accordance with 42 CFR 438.610, we acknowledge that if the Agency learns that we have a prohibited relationship with an individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act, the Agency may continue an existing agreement with MCNA unless the Secretary directs otherwise.

We also acknowledge that the Agency may not renew or extend the existing agreement with MCNA unless the Secretary provides to the Agency and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation. This includes any prohibited relationship with an individual or

entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if MCNA has a relationship with an individual who is an affiliate of such an individual.

I.2.14: Disclosures

MCNA will provide written disclosures of

- A director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549
- A subcontractor of MCNA who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549
- A person with ownership of five percent (5%) or more of MCNA's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549
- A network provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549
- An employment, consulting, or other agreement for the provision of Contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549
- An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

I.2.15: Continuation of Agreement in Certain Circumstances

MCNA acknowledges that if the Agency learns that MCNA has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if MCNA has a relationship with an individual who is an affiliate of such an individual, the Agency may continue an existing agreement with MCNA unless the Secretary directs otherwise.

I.2.16: Excluded Providers

In accordance with MCNA's organizational policies, MCNA does not and will not subcontract with providers who have been excluded by the Agency from participating in the Iowa Medicaid program for FWA. MCNA checks and will continue to check lists of providers currently excluded by the Agency and the federal government every 30 days. In addition, MCNA checks the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System, the System for Award Management, the Medicare Exclusion Database, and any such other databases as the Secretary of the U.S. Department of Health and Human Services may prescribe. Upon request by the

Agency, MCNA will terminate its relationship with any provider identified in continued violation of law by the Agency. Any and all exclusion information discovered is immediately reported to the applicable state agency.

I.2.17: Medicaid Provider Enrollment Obligation

As part of our credentialing and recredentialing process, we will continue to compare network providers against the state of Iowa Medicaid provider file to ensure they are enrolled in Medicaid. We do not include non-Medicaid enrolled providers in our network.

I.2.18: Excess Payment Reporting

MCNA's extensive investigation process is designed to identify and prevent unnecessary cost to the DWP and Hawki programs. We report all tips, confirmed or suspected FWA and neglect information to the Agency, MFCU, and other appropriate agencies immediately upon discovery, and submit required reports on activities to the Agency monthly, quarterly, and annually. We report any notice that action is being taken against MCNA or any staff member, provider, or subcontractor having been excluded, suspended, or debarred from any state or federal health care benefit program. When making a referral of suspected fraud, we use a Fraud Reporting Form deemed satisfactory by the Agency. Our reporting policies and procedures include a protocol for prompt reporting to the Agency of all identified and recovered overpayments, specifying those due to potential fraud, as well as overpayments made by the Agency to MCNA within 60 calendar days from the date the overpayment was identified. MCNA will and will ensure that its subcontractors report any capitation payments or other payments in excess of amounts specified in the contract to the Agency within 60 days of identification.

I.2.19: Audited Financial Statements

MCNA Insurance Company, the Bidder, has provided its audited financial statements and those of its parent organization with this RFP response. We have consistently demonstrated financial stability through our disciplined approach and careful stewardship of the State's dollars. Our strong financial footing, steadily built over many years, enables us to assist the Agency with its cash flow needs, if required. MCNA will submit audited financial reports specific to the Contract on an annual basis. The audit will be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

I.2.20: Annual Independent Audit

We are pleased to provide the Agency with assurances of our financial solvency and strong fiscal track record. MCNA has the financial capacity needed to complete the requirements in the SOW for this RFP. MCNA will submit to the Agency a copy of the annual audited financial report required by the Iowa Insurance Division. This report will specify MCNA's activities under the Contract six months following the end of each calendar year. The report, prepared using Statutory Accounting Principles as designated by the NAIC, will be prepared by an independent Certified Public Accountant on a calendar year basis. The auditor will be on the Iowa Insurance Division's list of approved auditors, and MCNA will bear the cost of the audit. MCNA's audit format and contents will include at a minimum: (i) TPL payments made by other third-party payers; (ii) receipts received from other insurers; (iii) a breakdown of the costs of service provision, administrative support functions, plan management, and profit; (iv) assessment of MCNA's compliance with financial requirements of the Contract including compliance with requirements for insolvency protection, surplus funds, working capital, and any additional requirements established in Administrative Rules for organizations licensed as HMOs; and (v) a separate letter from the independent Certified Public Accountant addressing non-material findings, if any.

I.2.21: Quarterly Financing Report

In addition to the annual audit, MCNA is also pleased to submit copies of its quarterly NAIC financial reports. A final reconciliation shall be completed by the independent auditing firm that conducted the annual audit. The final

reconciliation will make any required post-filing adjustments to estimates included in the audit completed within six months of the end of the Contract year. The final reconciliation will be completed no sooner than 12 months following the end of the Contract year.

I.3: Disclosure

MCNA will continue to disclose to the Agency all information as required in the SOW, Section I.3.

I.3.01: Ownership or Control Disclosures

MCNA and our subcontractors will continue to disclose to the Agency any persons or corporations with an ownership or control interest in MCNA that:

- Have direct, indirect, or combined direct/indirect ownership interest of five percent or more of MCNA's equity
- Own five percent or more of any mortgage, deed of trust, note, or other obligation secured by MCNA if that interest equals at least five percent of the value of MCNA's assets
- Is an officer or director of an MCO organized as a corporation
- Is a partner in an MCO organized as a partnership

I.3.02: OCD Timing

MCNA will and will ensure that our subcontractors disclose information on individuals or corporations with an ownership or control interest in MCNA to the Agency at the following times:

- When MCNA submits a proposal in accordance with the Agency's procurement process
- When MCNA executes a Contract with the Agency
- When the Agency renews or extends MCNA's Contract
- Within 35 days after any change in ownership of MCNA

I.3.03: OCD Review

We acknowledge and welcome the Agency's review of the ownership and control disclosures submitted by MCNA and any of MCNA's subcontractors.

I.3.04: United States Only

MCNA is located within the United States and acknowledges that the Agency will confirm that we are not located outside the United States in accordance with federal regulation.

I.5: Compliance Program and Reporting

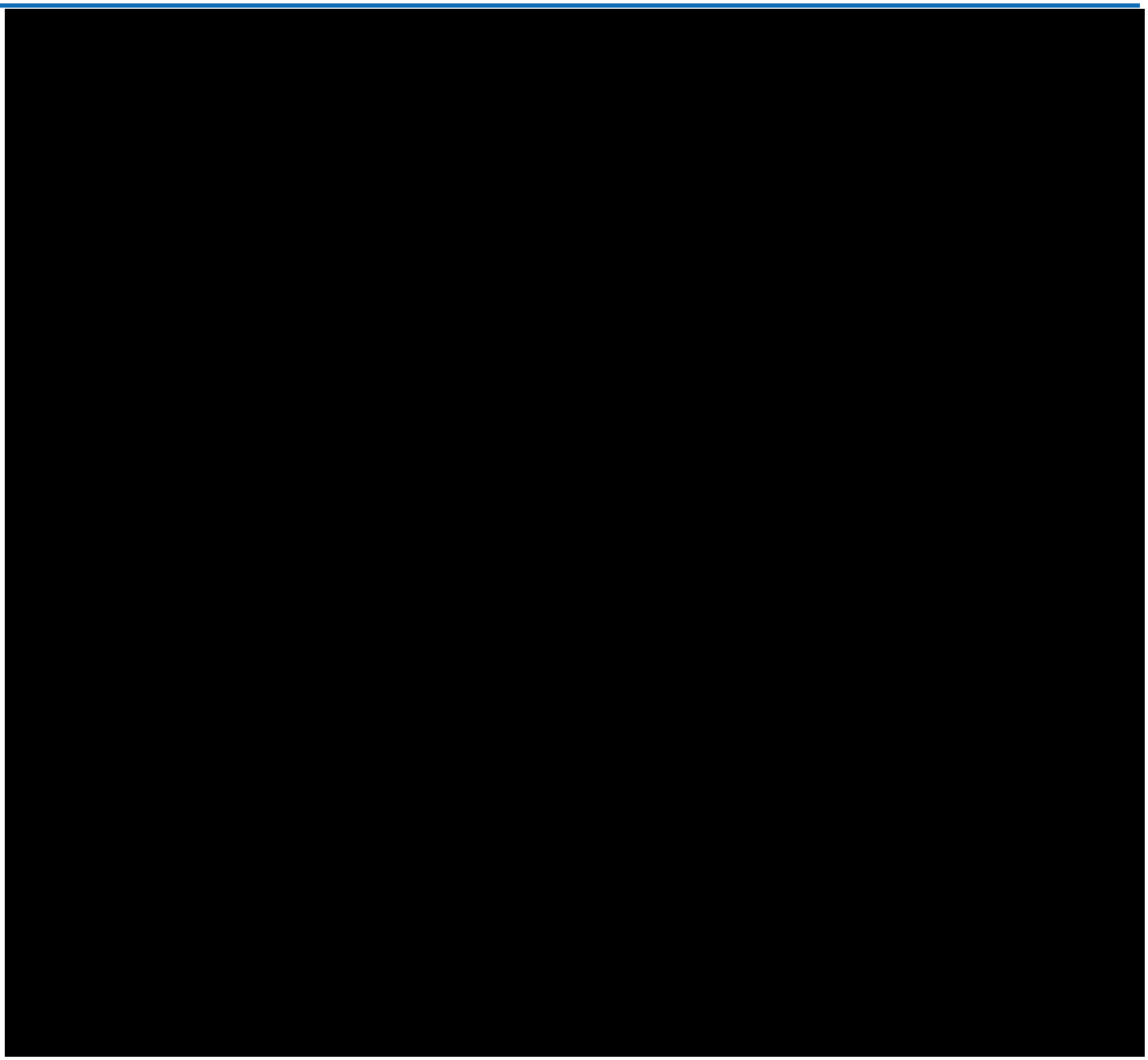
MCNA is committed to maintaining the highest levels of professional and ethical standards in the conduct of its business. We place great importance upon our reputation for honesty, integrity, and high ethical standards. To solidify our position as a leader in the delivery of quality, compassionate healthcare to our members and providers, we have developed the MCNA Program Integrity Compliance Plan as part of our Compliance Program. The Compliance Program represents a solemn commitment to our members, providers, community, government regulatory agencies, and to ourselves that we will provide quality healthcare services in an ethical and compliant manner.

MCNA operates in a healthcare environment that is highly regulated and increasingly complex. The Compliance Program, together with our Code of Ethical Conduct, guides and directs the daily activities of our organization. It also provides staff and clients with information about our expectations for ethical and legal conduct in the workplace.

We recognize that these standards can only be achieved and sustained through the actions and conduct of all our personnel. The goal of the Compliance Program is to promote compliance throughout our organization. It will provide for the ongoing prevention, detection, and resolution of conduct that does not conform to applicable state or federal laws or organizational standards of business ethics. The Compliance Program applies to MCNA, its staff, Board of Directors (Board) and business partners. MCNA's Chief Executive Officer is committed to promoting and endorsing the values that are essential to the Compliance Program.

I.5.01: Subcontractor Compliance Programs

MCNA and its subcontractors, to the extent we delegate responsibility to our subcontractors for coverage of services and payment of Claims under the contract between the Agency and MCNA, will continue to maintain arrangements that are designed to detect FWA. MCNA requires its subcontractors to have a compliance program consistent with MCNA's Compliance Program and in accordance with law, regulation, and Agency and CMS guidance. MCNA's Program Integrity Compliance Plan and our Compliance Program incorporate the following components.



[redacted]

[redacted]

MCNA will prepare an annual Compliance Plan on the date identified by the Agency, including the information requested and identified in the most current "Program Integrity Compliance Plan" template. MCNA's current Agency-approved Program Integrity Compliance Plan is included at the end of our response to Section I.

[redacted] **MCNA will prepare an Annual Compliance Work Plan on the date identified by the Agency, including the information requested and identified in the most current "Program Integrity Annual Work Plan" template.**

I.5.02: Reporting

[redacted]

Our SIU pursues all permissible recoveries and tracks all dollars received in accordance with state and federal requirements, including the recovery of improper payments, overpayments, and payments to excluded providers.

In accordance with the Affordable Care Act and the Agency policy and procedures, MCNA reports overpayments made to MCNA as well as overpayments made by MCNA to a provider and/or subcontractor. Providers must notify MCNA if an overpayment is received and return the overpayment to MCNA within 60 calendar days of the date on which the overpayment was identified, along with a written explanation for the overpayment.

[redacted]

[redacted] CNA provides an annual report to the Agency listing all overpayments to providers, including those related to FWA.

We will certify all reports in accordance with the requirements of Section I.2.11.

I.5.03: Annual Reports

MCNA will provide an annual report to the Agency, on the date identified by the Agency, listing all overpayments to providers, including those related to FWA.

I.5.04: Quarterly Reports

MCNA will submit quarterly reports on cost avoidance, program integrity activity, algorithms, and single case agreements, as described below, on the date identified by the Agency and on the identified reporting templates, including all information required by that template.

- **The Cost Avoidance Report**. As part of our due diligence in the proper management and administration of Medicaid programs, MCNA has policies and procedures in place to meet all obligations regarding third party liability (TPL) cost avoidance and recovery. [redacted]
- **Program Integrity Activity.** [redacted]
- **Algorithms.** [redacted]
- **Single Case Agreement Template.** [redacted]

[redacted]

I.5.05: Monthly Reports

MCNA will submit monthly, on the date identified by the Agency, the following reports on the identified reporting templates, including all of the information required by that template:

- Investigative activities
- FWA provider notices
- Recovery
- Credible allegation of fraud
- Independent medical examination provider action
- MCO provider action
- Requests for program integrity information
- Total non-program integrity recoveries

I.5.06: Certification

MCNA will certify all reports and plans required under this section I.5 and shall comply with all of the certification requirements identified in Section I.2.11.

I.6: Program Integrity Manager and Special Investigations Unit Staffing

MCNA devotes qualified resources to overseeing our robust program integrity infrastructure. Our program integrity focus is preventing and detecting FWA, including potential related overpayments and fraudulent or abusive member conduct. Our Program Integrity leadership team supports and will cooperate with state and federal agencies including the Agency, its Program Integrity Division, Iowa Medicaid Fraud Control Unit (MFCU), Medicaid recovery audit contractor(s), the CMS and/or Payment Error Rate Management, and the CMS Audit Medicaid Integrity Contractors to combat FWA.

I.6.01: Staffing Compliance

[redacted]

[redacted]

MCNA will comply with the Special Investigations Manager and Staffing requirements in Section A of the SOW.

I.7: Circumstances Where the Contractor May Not Recoup or Withhold Improperly Paid Funds

I.7.01: Prohibition on Certain Recoveries

MCNA will not take any action to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services, or claim upon which the withhold or recoupment are based meet one or more of the following:

- The improperly paid funds have already been recovered by the Agency or the federal government directly or through resolution of a State or federal investigation or lawsuit, including but not limited to False Claims Act investigations and cases; or
- The funds have already been recovered by the Medicare Recovery Audit Contractor (RAC); or
- The issues, services, or claims are the subject of a pending federal or State litigation investigation or are being audited by the Iowa RAC.

I.7.02: Required PI Unit Communication

MCNA will check with the Iowa Medicaid Program Integrity Unit before initiating any recoupment or withhold of any Program Integrity related funds to ensure that the recoupment and withhold are permissible. If MCNA obtains funds prohibited under this Section I, MCNA will return the funds to the provider.

I.8: Treatment of Recoveries

[redacted] MCNA's Compliance Program incorporates all program integrity requirements and combines prevention, vigilant monitoring, investigation, enforcement, training, and communication to foster a culture of ethics and compliance in our provider networks.

I.8.01: Compliance with Retention Policies

MCNA requires providers to adhere to all data elements and record keeping requirements described throughout the SOW, which are maintained in our dental record-keeping requirements. DentalTrac™ maintains all claims data received from providers, including all information needed for quality and Utilization Management review. MCNA and our providers will comply with the requirement to maintain records for at least 10 years after the last service is provided and will release records at no cost as required by the Agency or other state or federal government agencies. All subcontractors must agree that the Agency, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under MCNA's contract with the Agency. All such information shall be provided in accordance with the specified timeframe. We acknowledge that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

I.8.02: Recovery of Improper Payments

Except as otherwise provided in this Section and Sections I.7 and I.9, MCNA will recover improper payments and overpayments attributable to claims paid by MCNA, whether identified by MCNA or the Agency, for up to five years following the date the claim was paid.

I.8.03: Retention of Recouped Overpayments

We acknowledge that MCNA may recoup and retain overpayments attributable to claims paid by MCNA, except as otherwise provided in this Section and Sections I.7 and I.9.

I.I.8.04: Recoveries Not Made by Contractor

Where a provider overpayment owed to MCNA is recovered by the RAC, the Agency, or the federal government, by any means, including but not limited to False Claims Act lawsuits and investigations or any other State or federal action or investigation, MCNA acknowledges that it is not entitled to recoup, retain, or be reimbursed for any such overpayment, and that the Agency shall determine, in its sole discretion, if any portion of the recovered payment over which the Agency has authority will be returned to MCNA.

I.8.05: Payment of Recoveries

MCNA will continue to comply with the process, timeframes, and documentation the Agency requires for payment of recoveries of overpayments to the Agency in situations where MCNA is not permitted to retain some or all of the recoveries of overpayments. Our staff is committed to maintaining an adequate number of Program Integrity personnel to meet and exceed all contractual requirements.

I.9: Overpayment Audits by the Agency or Designee

I.9.01: Recovery of Overpayments from Contractor

MCNA acknowledges that the Agency or its designee may audit MCNA's provider claims and recover from MCNA identified provider overpayments by following the procedures in this Section.

I.9.02: Notice

MCNA acknowledges that if the Agency identifies a provider overpayment owed to MCNA, the Agency will send a notice to us identifying the overpayment.

I.9.03: Payment

MCNA acknowledges that we have 30 days following the notice of overpayment from the Agency to either pay the Agency the amount identified as a provider overpayment or submit a written letter of dispute. Should we dispute the overpayment, the Program Integrity Director or other Agency representative will consider our dispute and notify us of its final decision.

I.9.04: Payment Disputes

MCNA acknowledges that if MCNA disputes an overpayment, the Program Integrity Director or other Agency representative will consider MCNA's dispute and MCNA of its final decision on or before the 60th day following the date

the written dispute is received. The Agency has the sole discretion to uphold, overturn, or amend an identified overpayment. If MCNA disputes the overpayment and the Agency's final decision identifies an overpayment, MCNA will pay the Agency the identified overpayment on or before the tenth (10th) business day following the final decision.

I.9.05: Extensions

MCNA acknowledges that if it makes a written request for an extension on or before the due date for the payment of an overpayment, the Agency, through its Program Integrity Director or other Agency representative may, in its sole discretion, grant an extension of time within which MCNA must pay the Overpayment.

I.9.06: Contractor Recovery from Providers

MCNA acknowledges that where the Agency has identified an overpayment and MCNA has been required to pay the amount of the overpayment to the Agency, MCNA will recover the overpayment from the provider and may retain the overpayment recovered. MCNA provides the option to repay the overpayment all at once or through a payment plan. Overpayments can be paid by check, EFT/wire transfer, or through recoupments against future payments.

I.9.07: Offsets

MCNA acknowledges that if it fails to repay an overpayment identified under these procedures, the Agency may offset the amount of the overpayment owed by MCNA against any payments owing to MCNA under the Contract.

I.9.08: Contact Before Proceeding

MCNA acknowledges that if the Agency identifies an overpayment within two years of the date the claim was paid, the Agency will contact MCNA before proceeding with the procedures outlined above.

I.10: Provider Self-Reporting Procedures

I.10.01: Mechanisms for Reporting

MCNA has, and will require the use of, a mechanism for a network provider to report to MCNA when the provider has received an overpayment, to return the overpayment to MCNA 60 days after the date on which the overpayment was identified, and to notify MCNA in writing of the reason for the overpayment. Providers may report in writing to MCNA that an overpayment has been received and the reason why the overpayment was received. MCNA requires that the provider return the overpayment within 60 calendar days from the date on which the overpayment was identified. MCNA will provide an annual report to the Agency listing all overpayments to providers, including those related to FWA.

I.11: Notification of Enrolled Member and Provider Changes

I.11.01: Screening & Enrollment of Providers

MCNA understands that in accordance with 42 CFR § 438.602(b), MCNA and its subcontractors are not to enter into a network provider Agreement with a provider to deliver services to Medicaid beneficiaries when the provider is not otherwise appropriately screened by and enrolled with the Agency through the Iowa Medicaid Enterprise Provider Enrollment Unit. Such enrollment includes providers that order, refer, or furnish services under the State Plan and waivers, and it does not obligate providers to participate in the Fee-for-Service (FFS) healthcare delivery system.

Once providers are screened and enrolled with the Agency, they must also be credentialed by MCNA before they can participate in MCNA's provider network through a provider network agreement.

MCNA will not pay claims to or execute contracts with individuals or groups of providers who have been excluded from participation in federal health care programs under either Section 1128, Section 1128A, or Section 1156 of the Social Security Act or state funded health care programs. We will also terminate contracts with providers who have been excluded from participation or who are otherwise barred from participation in the Medicaid and/or Medicare program.

We will not remit payment for services provided under the Contract to providers whose practice location or pay-to location is located outside of the United States. We understand that the term "United States" means the 50 states, the District of Columbia, and any U.S. territories.

I.11.02: Agreements Pending Outcome of Screening

MCNA understands it may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days. MCNA also understands that it must terminate a network provider immediately upon notification from the Agency that the network provider cannot be enrolled, or the expiration of a 120-day period without enrollment of the provider, and that MCNA must notify affected enrolled members.

I.11.03: Notification of Enrolled Member Changes

MCNA will implement and maintain arrangements or procedures for prompt notification to the Agency when it receives information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence or the death of the member. We also ensure this for any subcontractor that may be delegated responsibility for coverage of services and payment of claims under the Contract between the Agency and MCNA,

[redacted]

I.11.04: Notification of Provider Network Changes

[redacted] MCNA submits to the Agency reports of quality deficiencies which result in the suspension or termination of a network provider. We have processes and procedure in place to ensure that the Agency it notified in a timely manner of a change in a provider's circumstances that may affect the provider's eligibility to participate in DWP and Hawki, including termination of the provider agreement with MCNA.

I.11.05: Notification of Provider Disenrollment

MCNA will notify the Agency and the Office of the Inspector General of provider de-credentialing for Program Integrity reasons and in compliance with 42 C.F.R. Part 1001.

I.11.06: Adverse Actions Taken on Provider Applications for Program Integrity Reasons

MCNA implements in its provider enrollment processes the obligation of providers to disclose the identity of any person described in 42 C.F.R. § 1001.1001(a)(1) as well as other permissible exclusions that would impact the integrity of the provider enrollment. MCNA forwards such disclosures to the Agency. MCNA abides by any direction provided by the Agency on whether to permit the applicant to be a provider in MCNA's provider network. Specifically, MCNA does not permit the provider to become a network provider if the Agency or MCNA determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services program, or if the Agency or MCNA determines that the provider did not fully and accurately make any disclosure pursuant to 42 C.F.R. § 1001.1001(a)(1).

I.11.07: Termination of Providers

MCNA will comply with all requirements for provider disenrollment and termination as required by 42 C.F.R. § 455.416.

I.12: Required Fraud, Waste, and Abuse Activities

[redacted]

I.12.01: Verifying Receipt of Services

MCNA's verification procedures include a method to verify services that are represented to have been delivered by network providers were in fact received by members. This verification process is conducted on a regular basis. [redacted]

I.12.02: Reviews & Audits

[redacted]

[redacted]

I.12.03: Internal Control

[redacted]

[redacted] We welcome the opportunity to have regularly scheduled system conference calls with the Agency and we will provide a liaison the Agency can contact at any time to resolve information processing issues.

Education and Training

MCNA provides education and training to staff, providers, and members about identifying and reporting FWA through newsletters, pamphlets, bulletins, and provider manuals.

[redacted]

[redacted]

I.12.04: FCA Policies & Procedures

MCNA implements and maintains written policies for all of its staff members, contractors, or agents that provide detailed information about the False Claims Act (FCA) and other Federal and State laws, including information about the rights of staff to be protected as whistleblowers. MCNA staff training includes the following topics:

- Code of Conduct
- Privacy and security
- Definitions of FWA
- Reporting FWA
- How to identify FWA with examples of provider and member FWA
- Federal False Claims Act and Whistleblower Protections
- Policies and procedures for exchange of information and collaboration with the Agency
- Program Integrity and FWA Program with organizational chart
- SIU overview and organizational chart
- Prevention and detection efforts
- Laws governing FWA
- Examples of civil and criminal penalties
- Enforcement

I.12.05: Responding to Claims of Fraud & Abuse

MCNA ensures sufficient organizational resources are available to effectively respond to complaints of FWA, and MCNA effectively and efficiently responds to complaints of FWA.

[redacted] MCNA complies with Section 1902(a)(68) of the Act to provide federal whistleblowers protections following the SOW. [redacted]

[redacted]

Throughout this process, MCNA will work closely with Iowa State Surveillance Utilization Review Services (SURS) and will refer potential instances of FWA promptly. MCNA will refer all credible allegations of fraud directly to the Iowa Attorney General's MFCU and will copy the same to Iowa SURS. If we determine there is a credible allegation of fraud, MCNA will email MFCU, with the Iowa SURS copied, as soon as possible and no later than two business days from determination of a credible allegation of fraud and no later than 10 business days for a non-credible allegation of fraud.

[redacted]

[redacted]

At MCNA we work hard every day to be an excellent partner to the states we serve. We are committed to upholding our responsibilities with the Agency and other Iowa state agencies, including those of systematic reporting and rights of review. MCNA promptly reports information we obtain indicating fraud or potential fraud by a provider, subcontractor, applicant, or member. We report all confirmed or suspected fraud to the Agency immediately upon discovery and submit required reports on activities to the Agency monthly with details and in the format as specified by the Agency. MCNA provides the Agency with a quarterly FWA report detailing prevention activities, potential offenses being investigated, and any confirmed instances of fraud or abuse. We may report information on violations of law by subcontractors, providers, members, or other relevant individuals to the Agency and/or to CMS, as appropriate, and acknowledge that we may only report such information regarding members when the information pertains to enrollment in the plan or covered services. MCNA will cooperate in any investigation by the Agency or any other state or federal entities and any subsequent legal action that may result from such an investigation.

I.12.06: Data Mining

[redacted]

[redacted]

[redacted] MCNA has been NCQA accredited for credentialing and recredentialing since 2011, and URAC accredited since 2014. [redacted]

[redacted]

I.12.07: FWA Referrals – Compliance

MCNA will and will ensure that its Subcontractor will, to the extent that the Subcontractor is delegated responsibility by MCNA for coverage of services and payment of claims under the Contract between the Agency and MCNA, comply with Agency procedures and requirements for implementation and maintenance of FWA arrangements. This includes but is not limited to compliance with the Agency procedures and requirements for the prompt referral of any potential FWA that MCNA identifies to the Agency's Program Integrity Unit or any potential fraud directly to the State MFCU.

[redacted]

I.12.08: Enforcement of Iowa Medicaid Program Rules

MCNA looks forward to collaborating with the Agency for development of a process for referral of providers to the Agency for sanction under 441 Iowa Administrative Code § 79.2. MCNA will vigorously pursue FWA in the Medicaid Program and notify the State Medicaid PI of any provider activity which would incur a sanction under 441 Iowa Administrative Code § 79.2(249A).

I.13: Credible Allegation of Fraud Temporary Suspensions

MCNA is committed to ensuring that no Medicaid dollars are received by any provider whose payments have been suspended or that has been terminated by the Agency. Upon notification from the Agency and other state or federal agencies to suspend payments because of a credible allegation(s) of fraud (CAF), MCNA immediately suspends further payments to the identified provider.

I.13.01: Suspending Payments

MCNA will and will ensure all applicable subcontractors, will comply with 42 C.F.R. § 455.23 and § 438.608(a)(8) by suspending all payments to a provider after the Agency determines that there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the Agency or law enforcement (including but not limited to MFCU) has identified in writing good cause for not suspending payments or to suspend payments only in part.

I.13.02: Notices

MCNA will and will ensure all applicable subcontractors will issue a notice of payment suspension that comports with 42 C.F.R. § 455.23 and retain the suspension for the time designated in that provision. In addition, the notice of payment suspension will state that payments are being withheld in accordance with 42 C.F.R. § 455.23. MCNA will not suspend payments without consulting first with the MFCU and second with the Agency. MCNA will maintain all materials related to payments suspension for five years as required by 42 C.F.R. § 455.23(g), and will provide a grievance process for providers whose payments have been suspended under this provision. See: 42 C.F.R. § 438.608(a)(8); 42 C.F.R. § 455.23. {From CMSC I.5.15}.

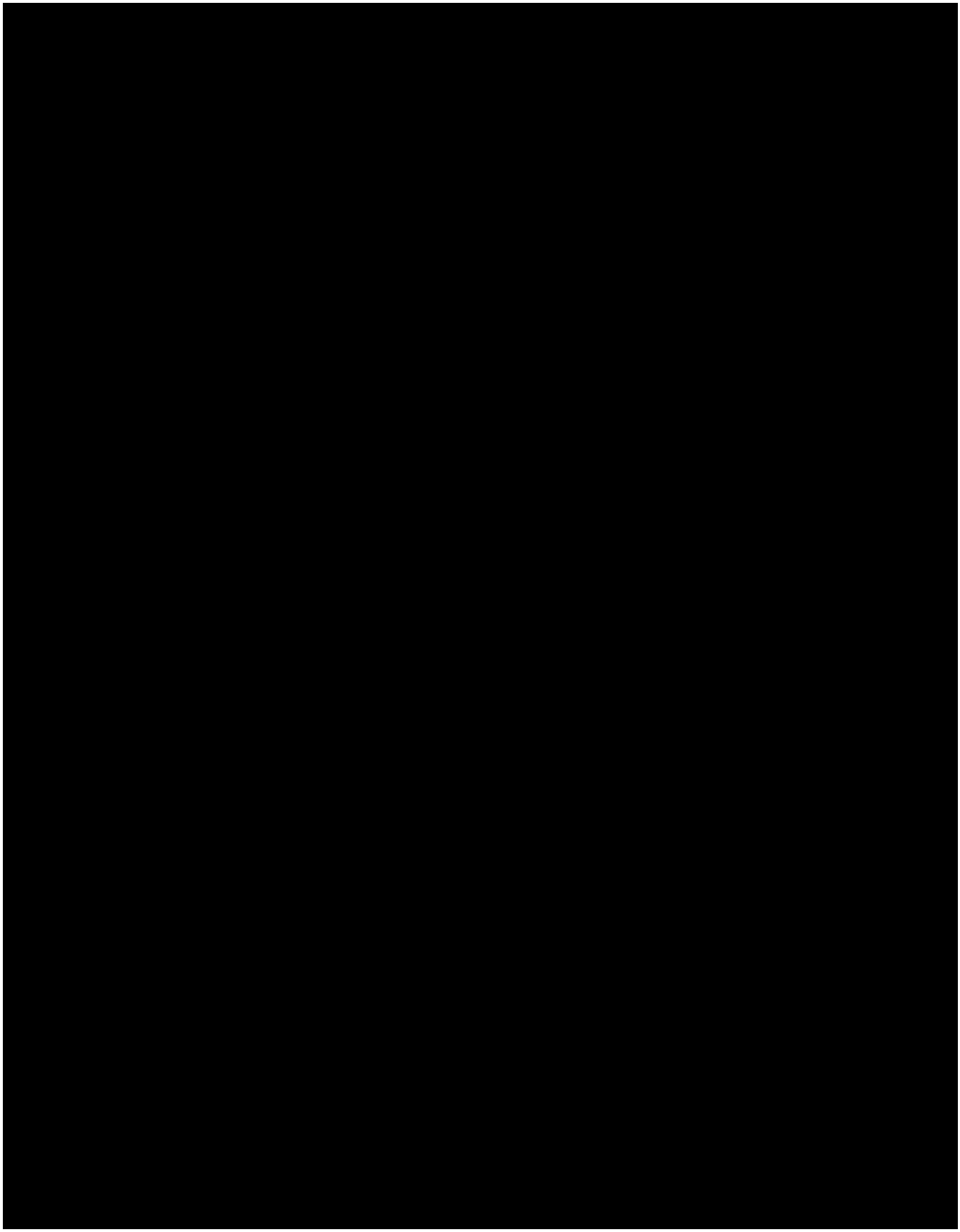
I.13.03: Lifting Suspensions

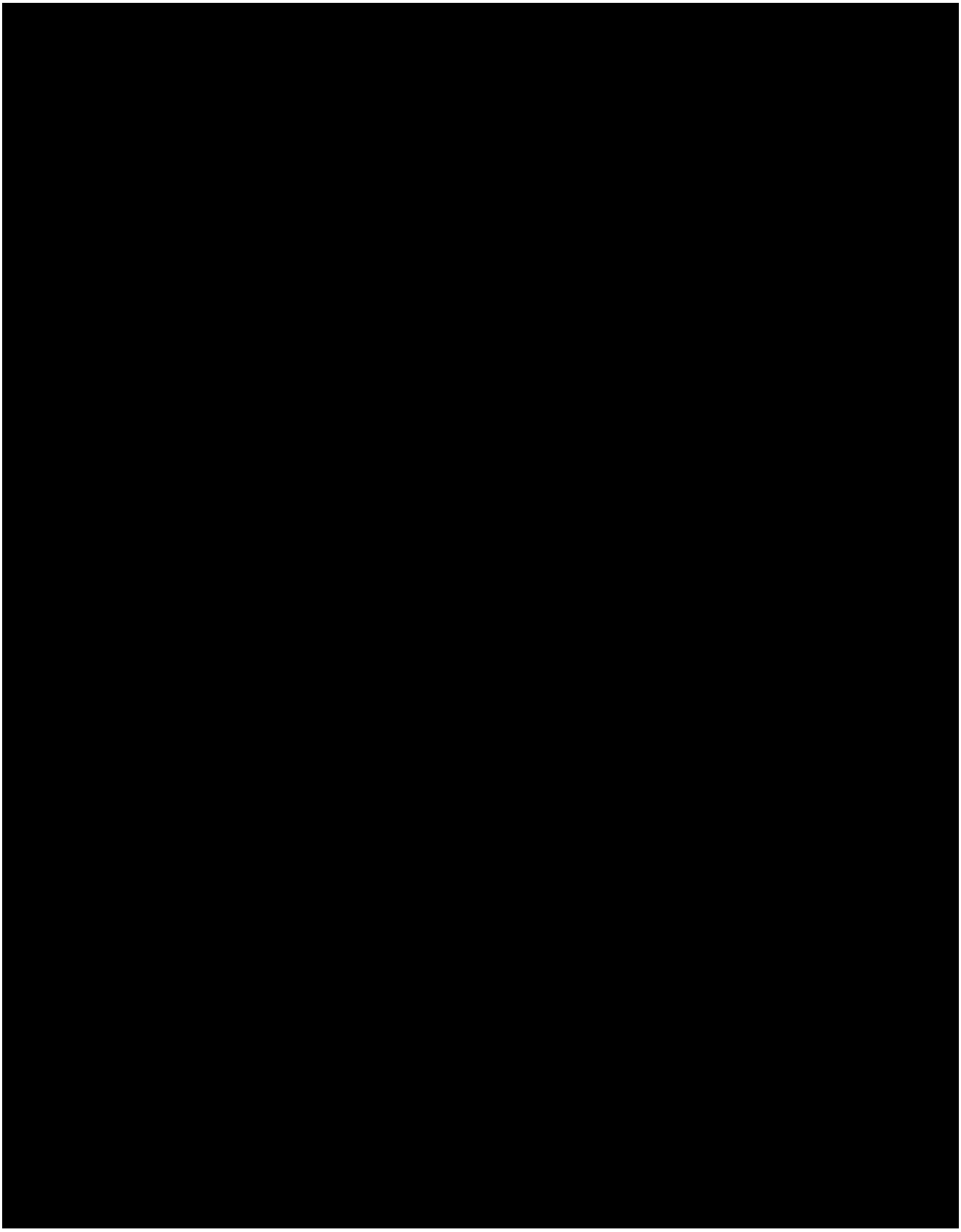
When notified that an Agency suspension has been lifted, MCNA will and will ensure all applicable subcontractors lift the suspension of payments and return the suspended payments to the provider unless MCNA has other authority to continue to withhold those payments. See: 42 C.F.R. § 438.608(a)(8); 42 C.F.R. § 455.23. {From CMSC I.5.15}.

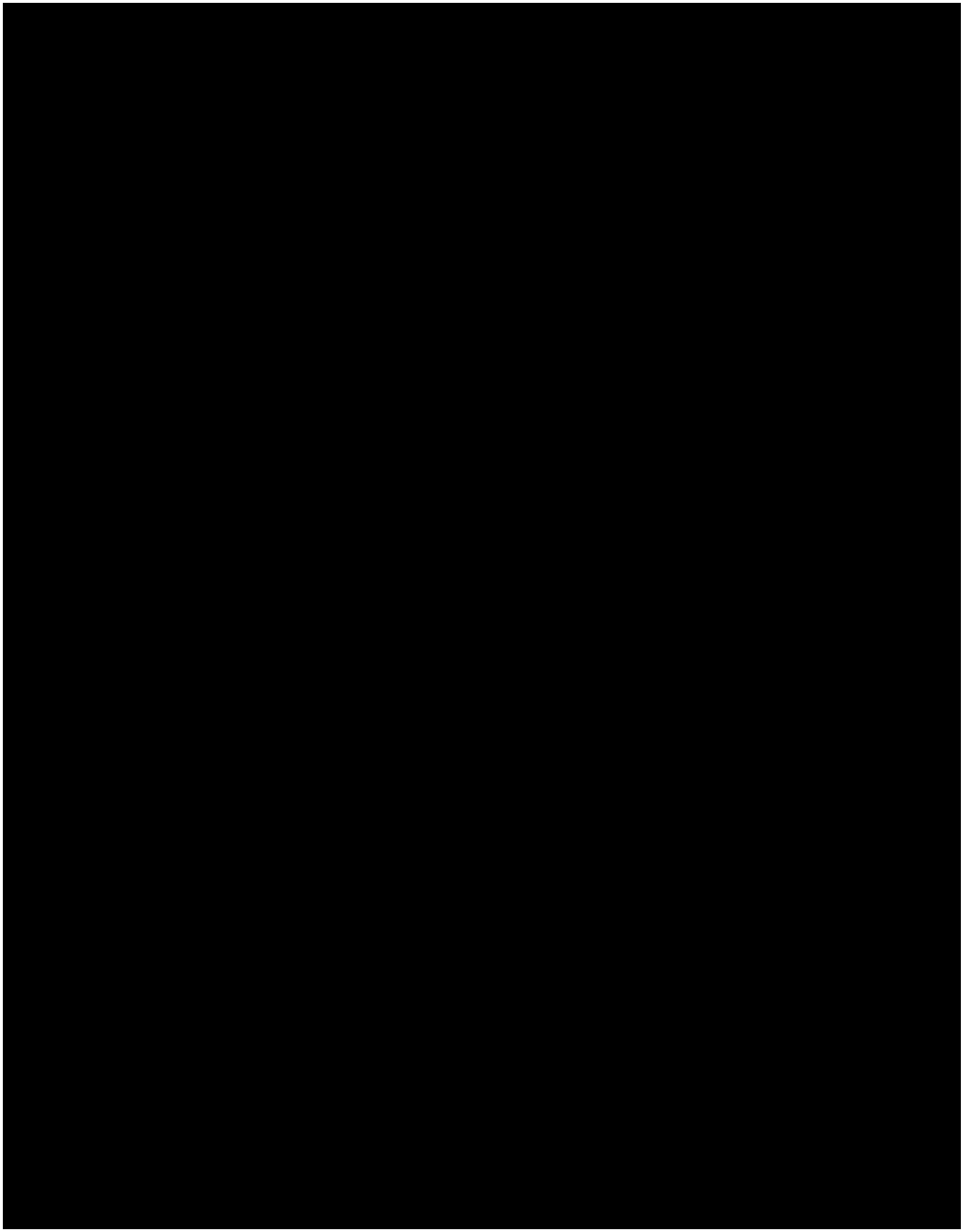
I.13.04: Evaluation of SIU Activities

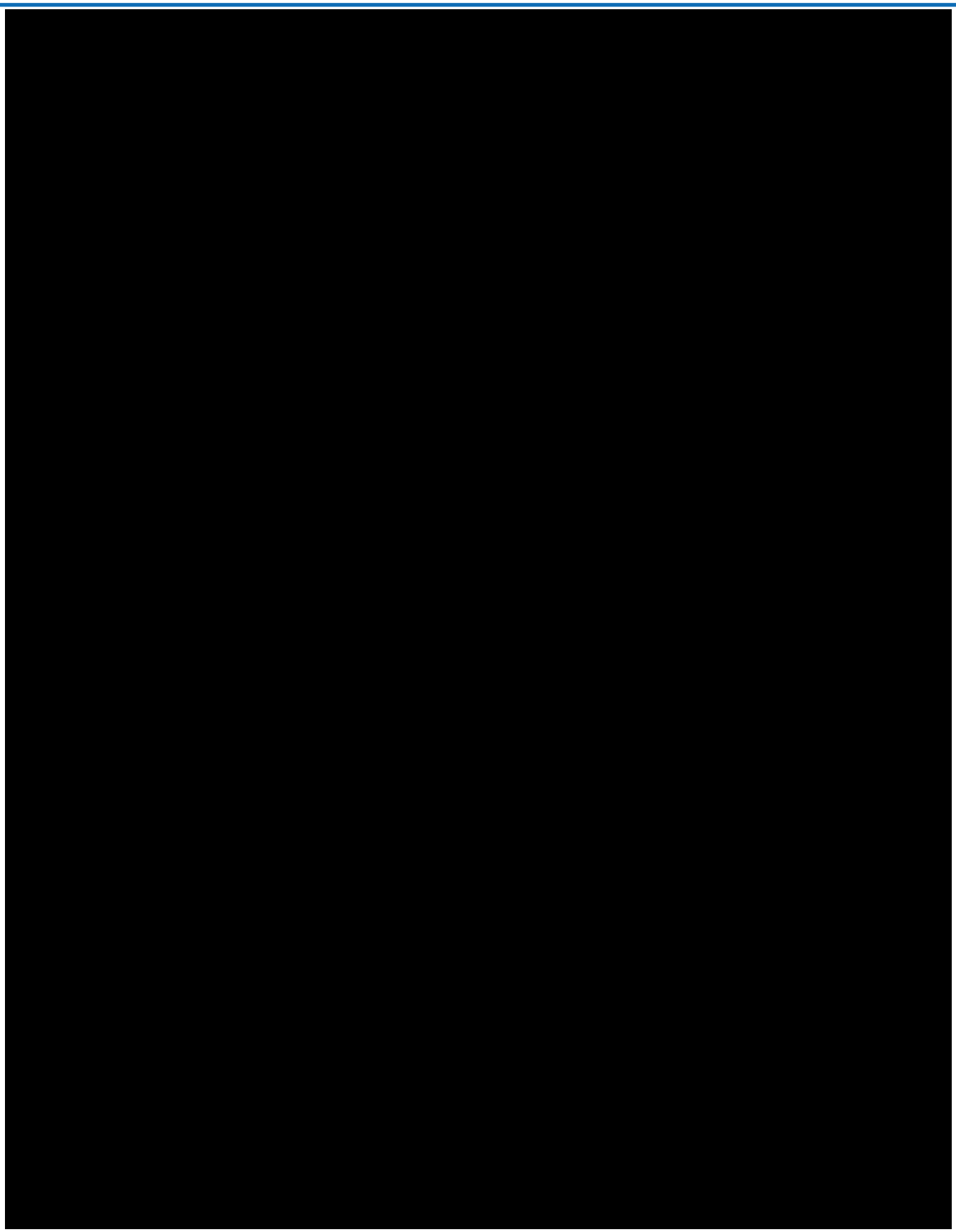
MCNA acknowledges that the Agency will evaluate the DWP and Hawki program integrity performance based on a set of standards developed by the Agency. We look forward to working collaboratively with the Agency to assist with its evaluation of the program.

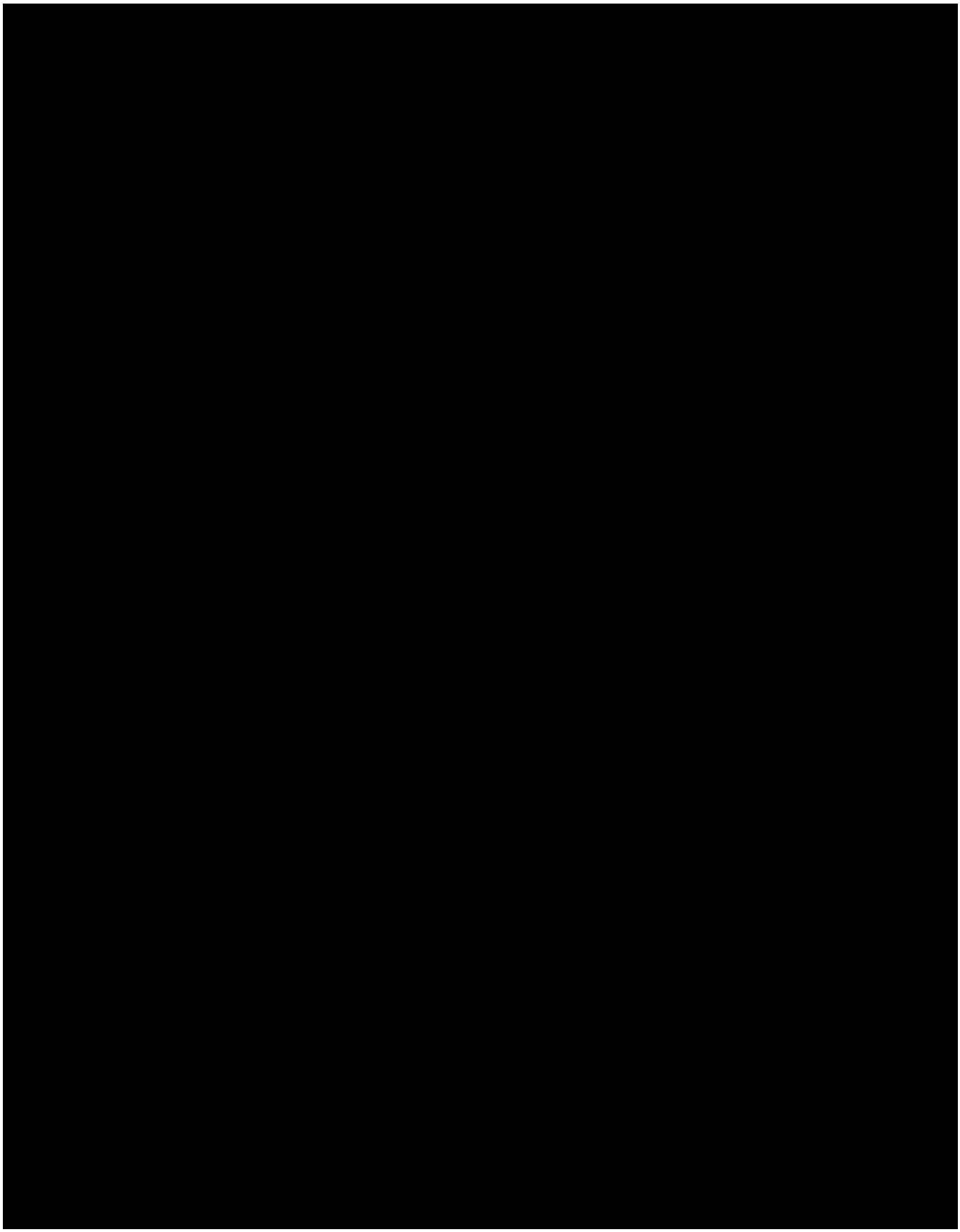
Program Integrity Compliance Plan

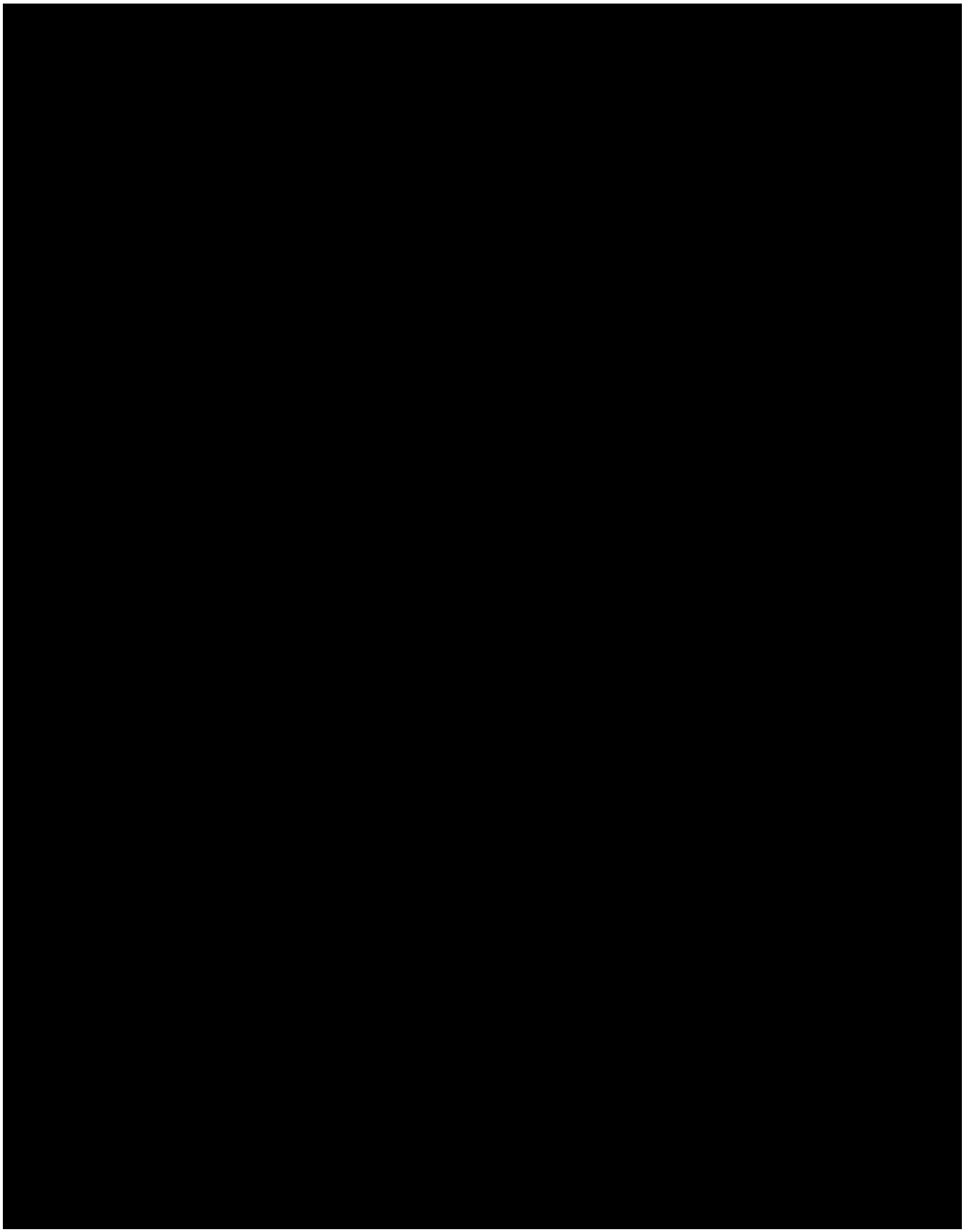


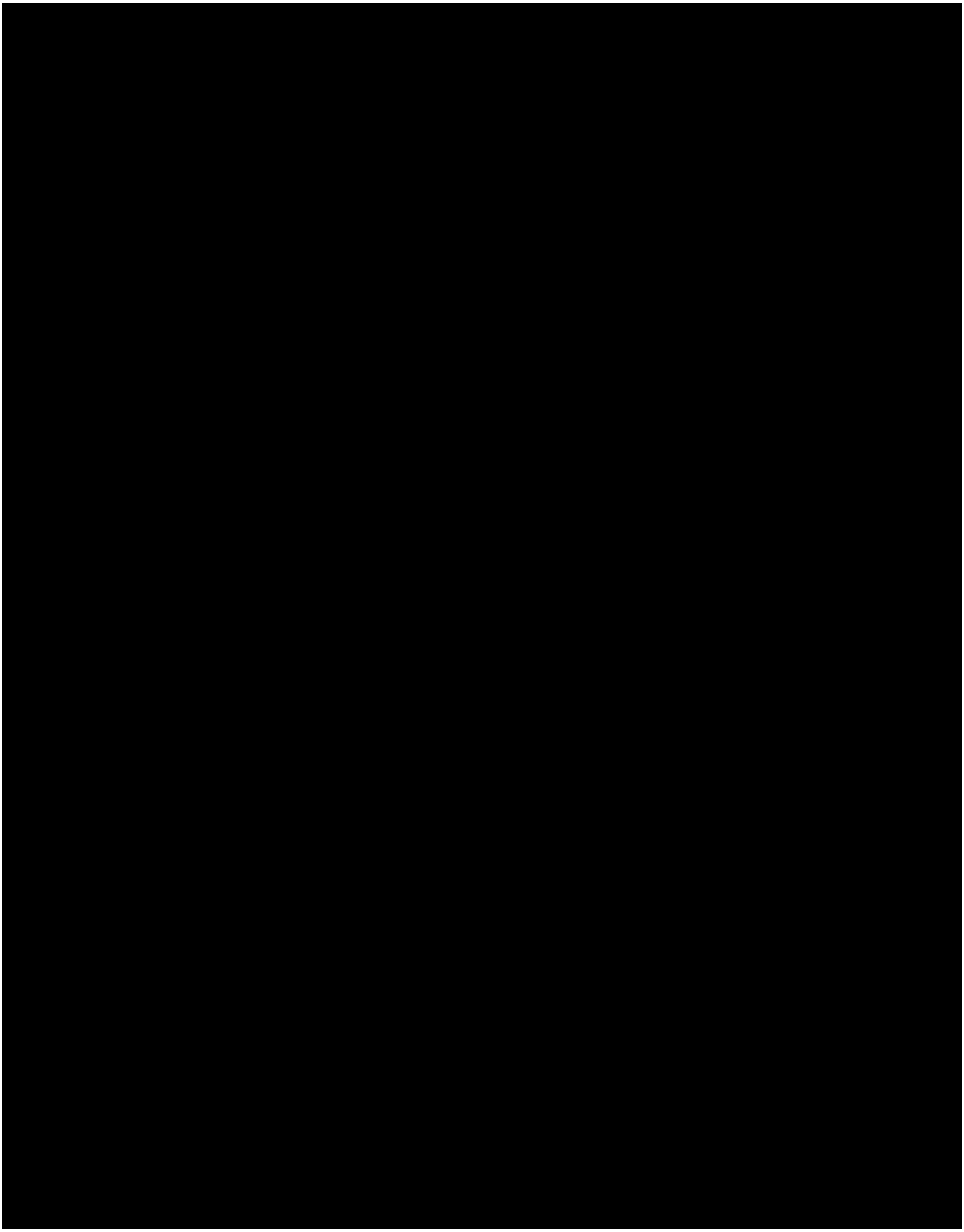


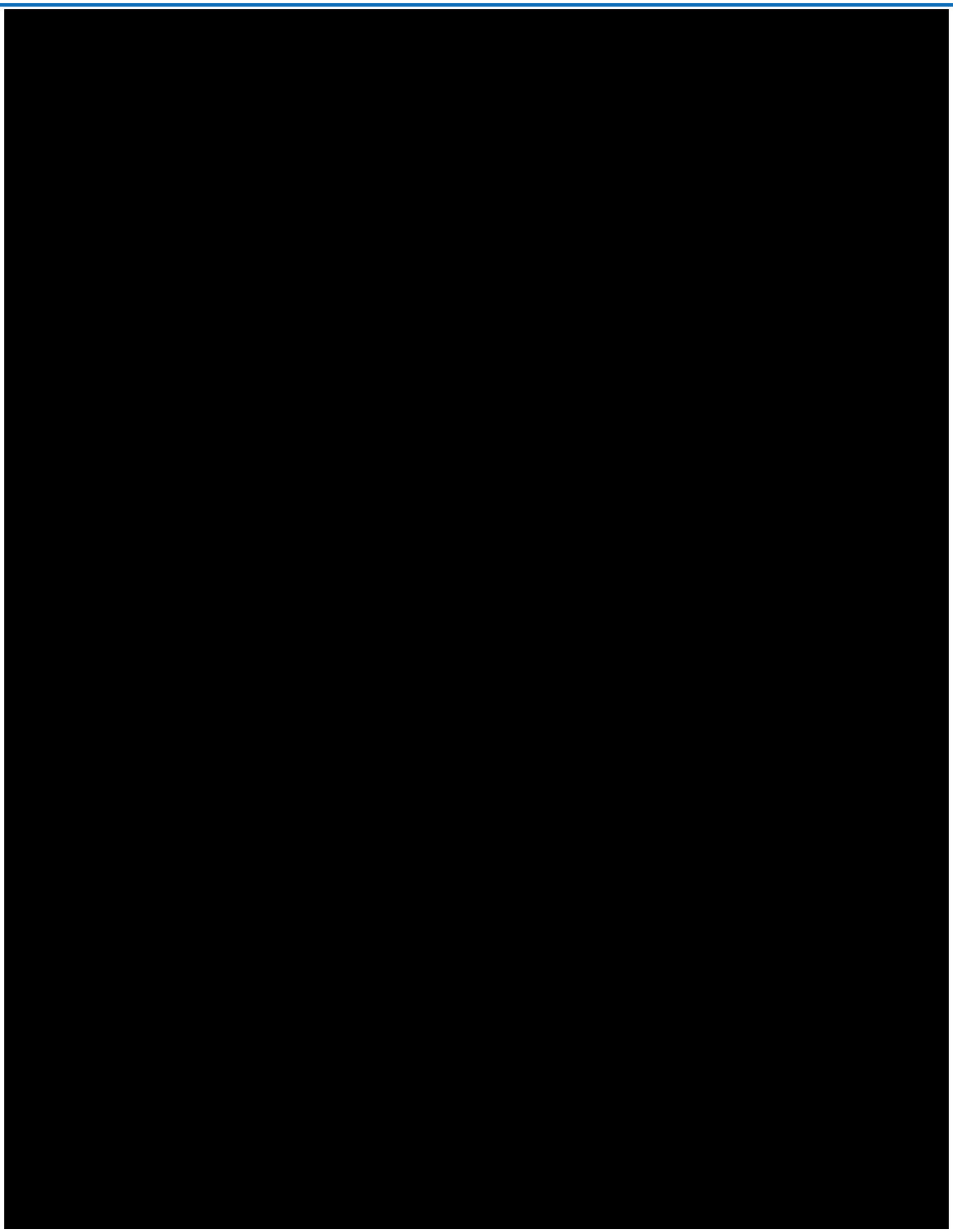


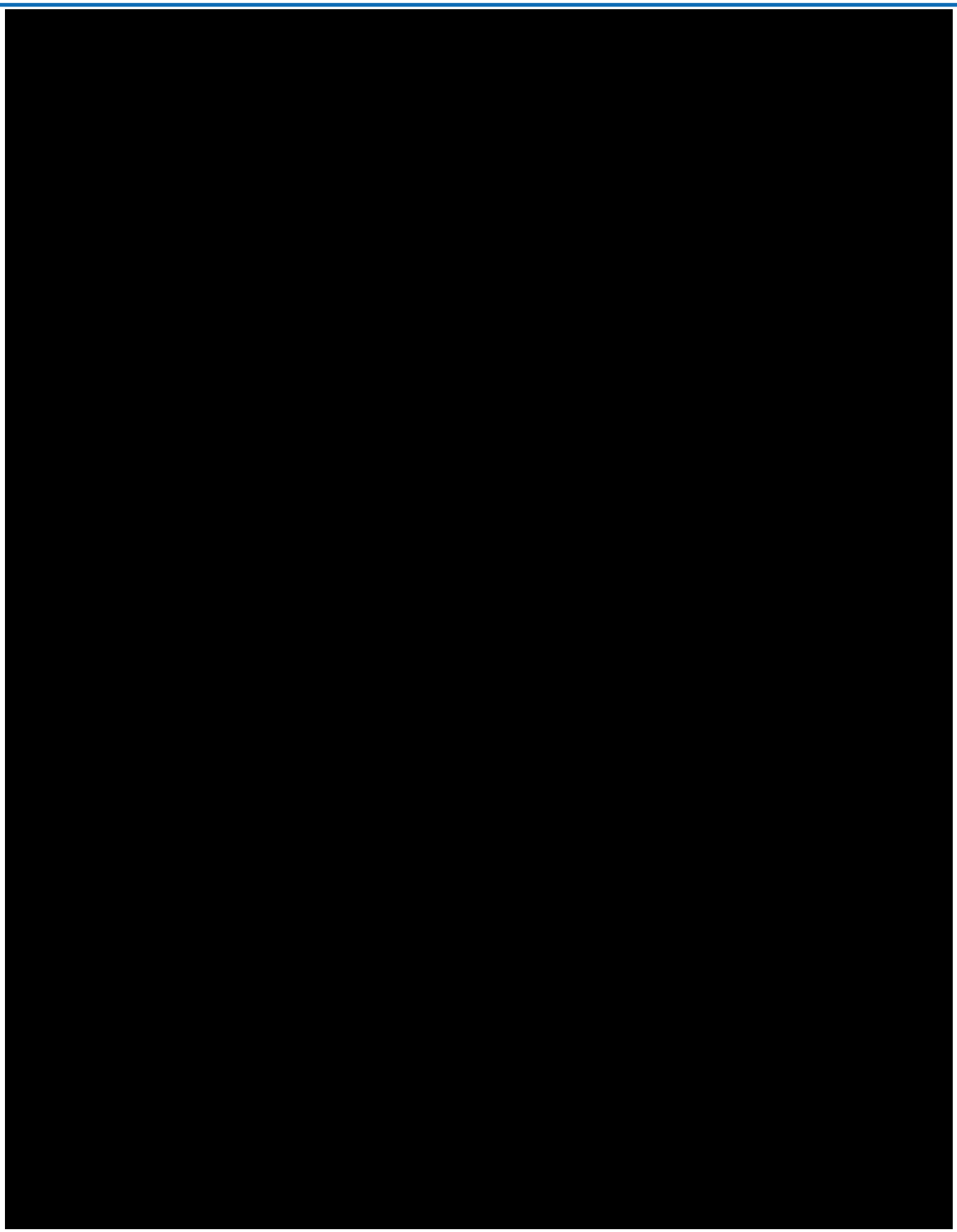


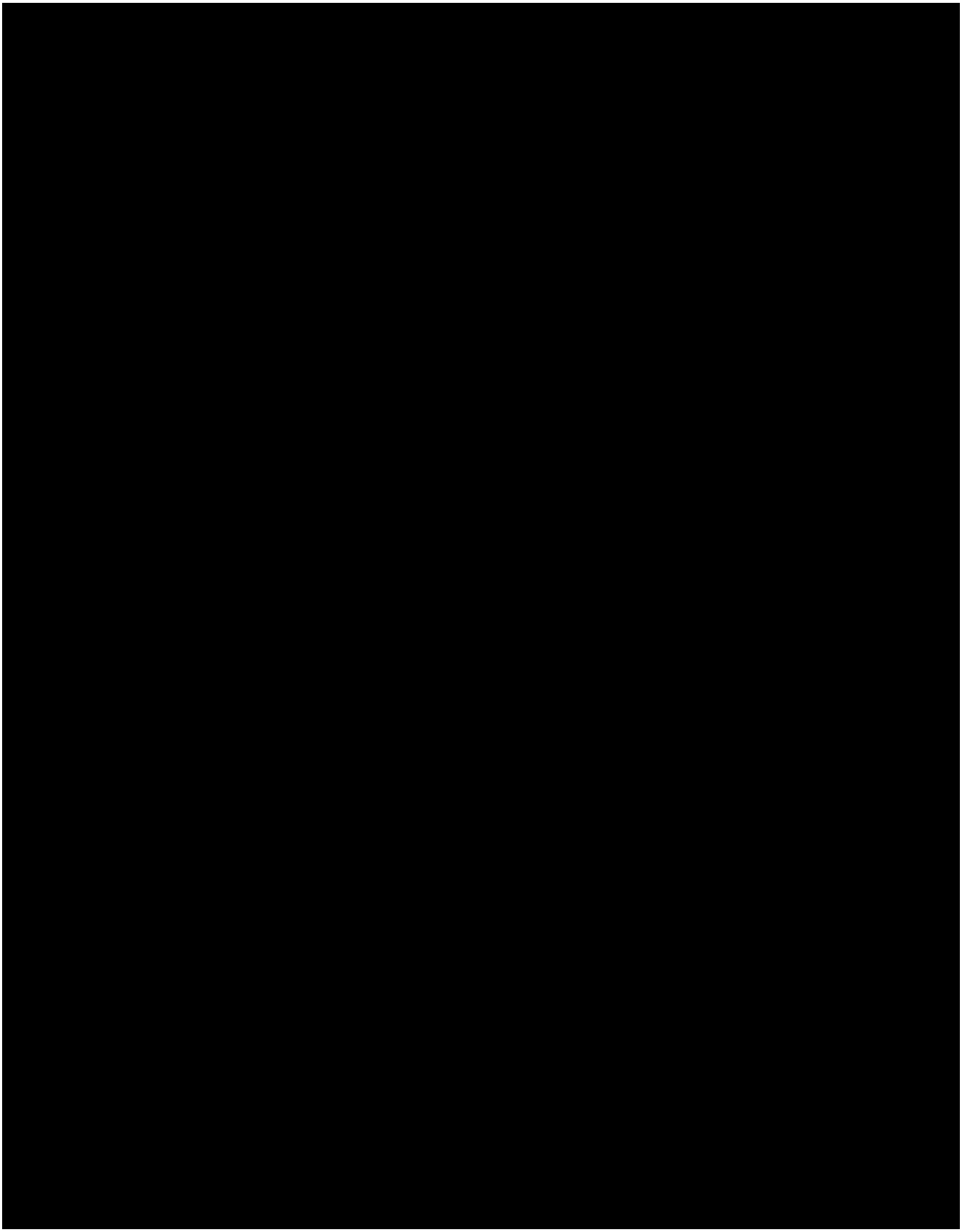


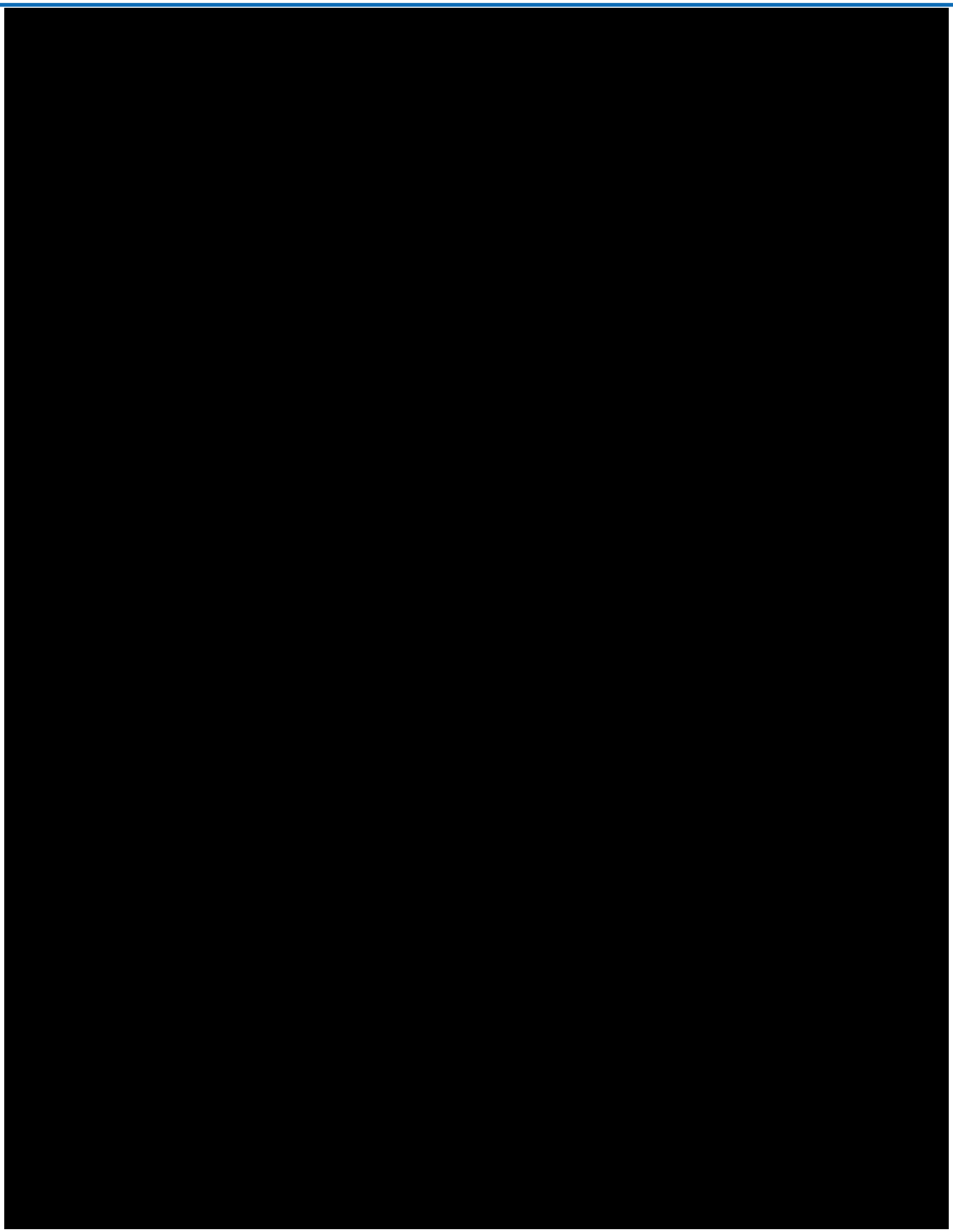


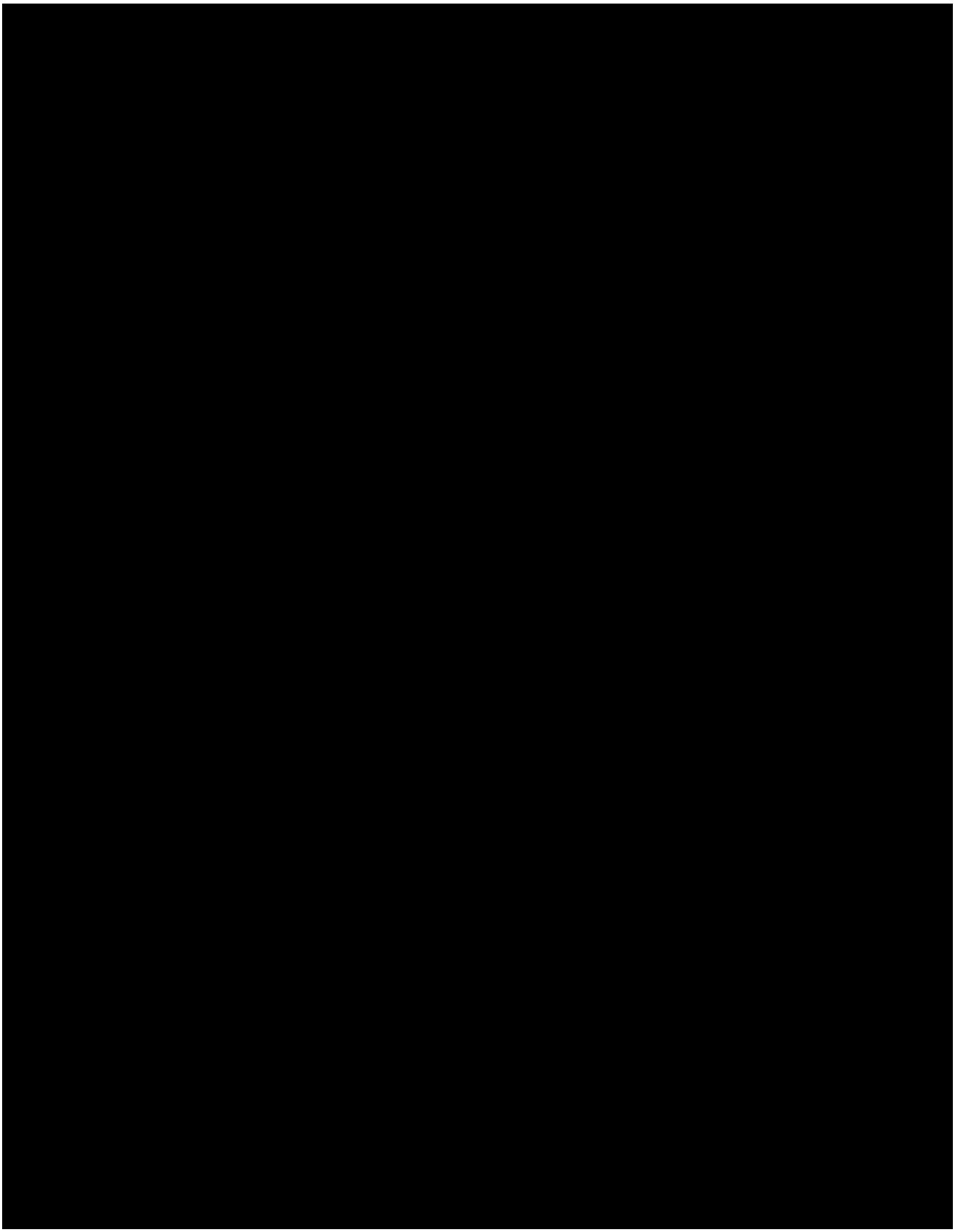


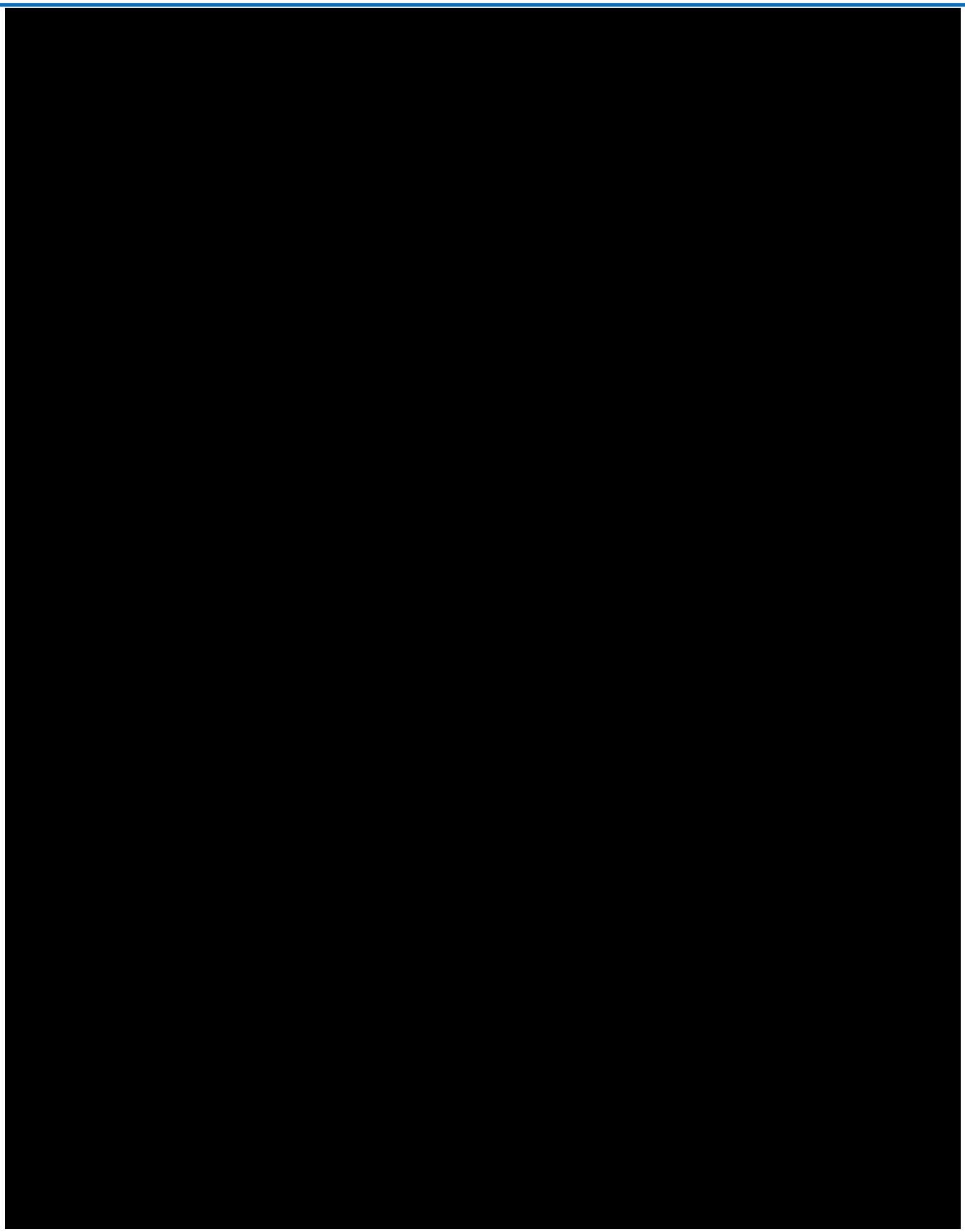


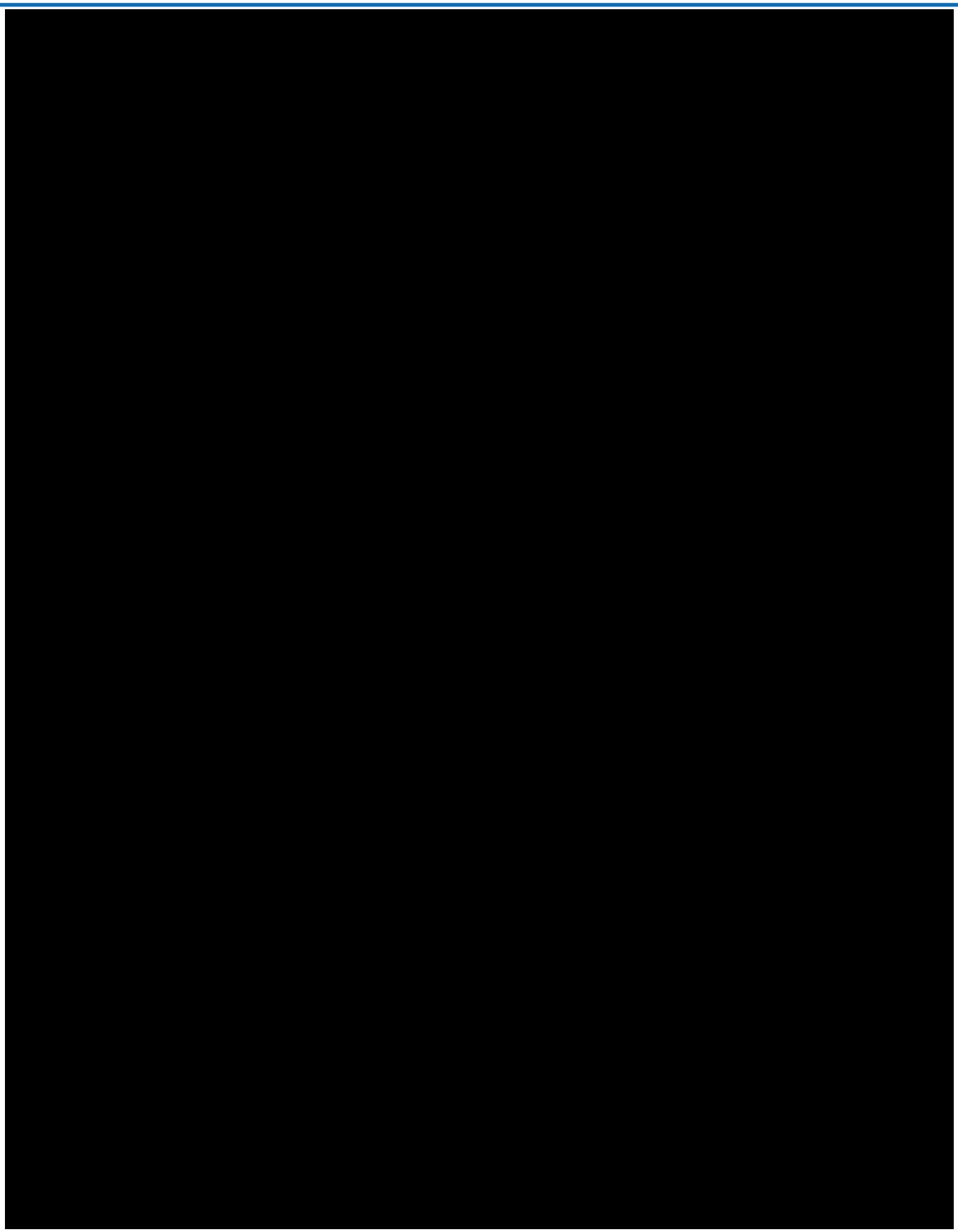


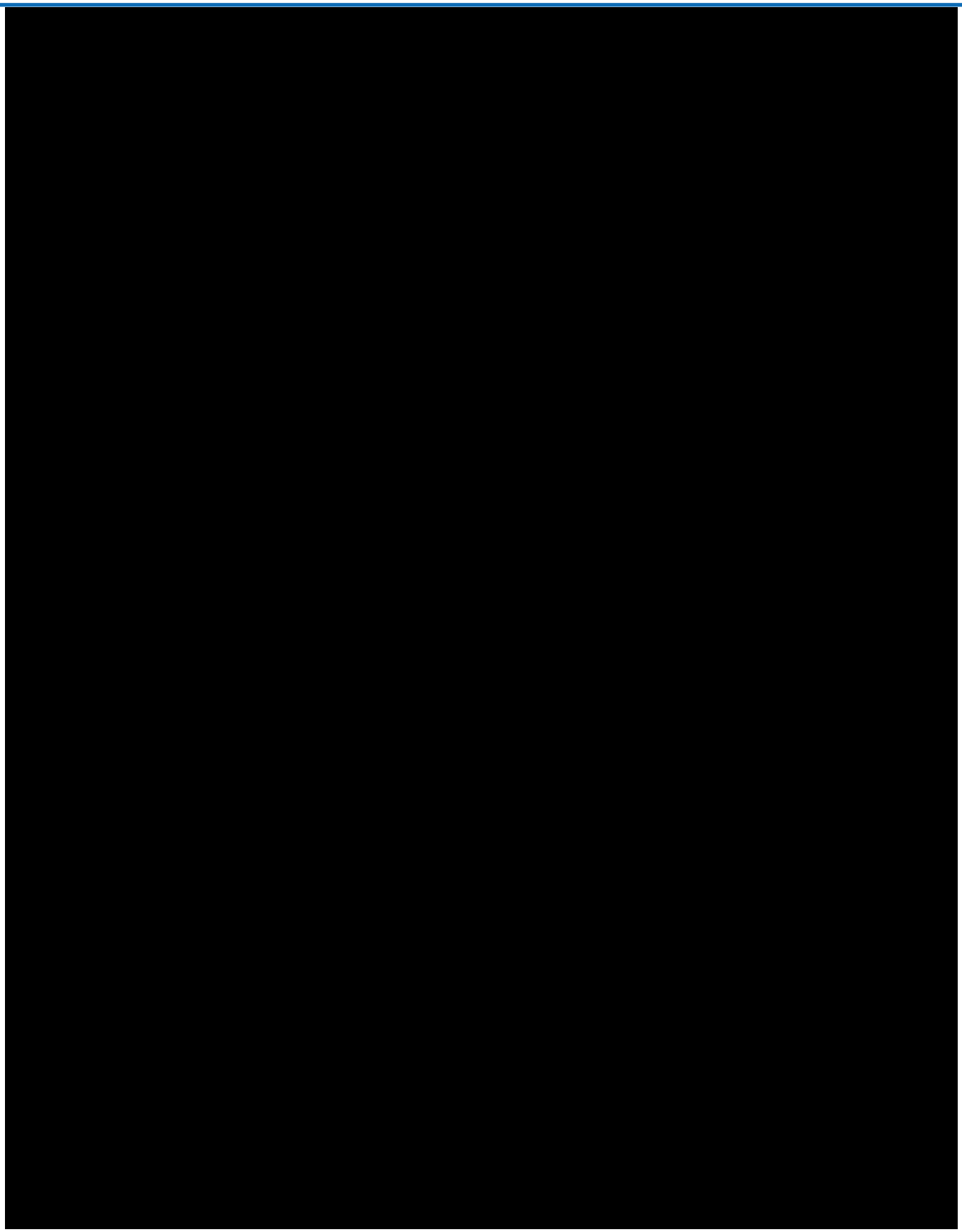


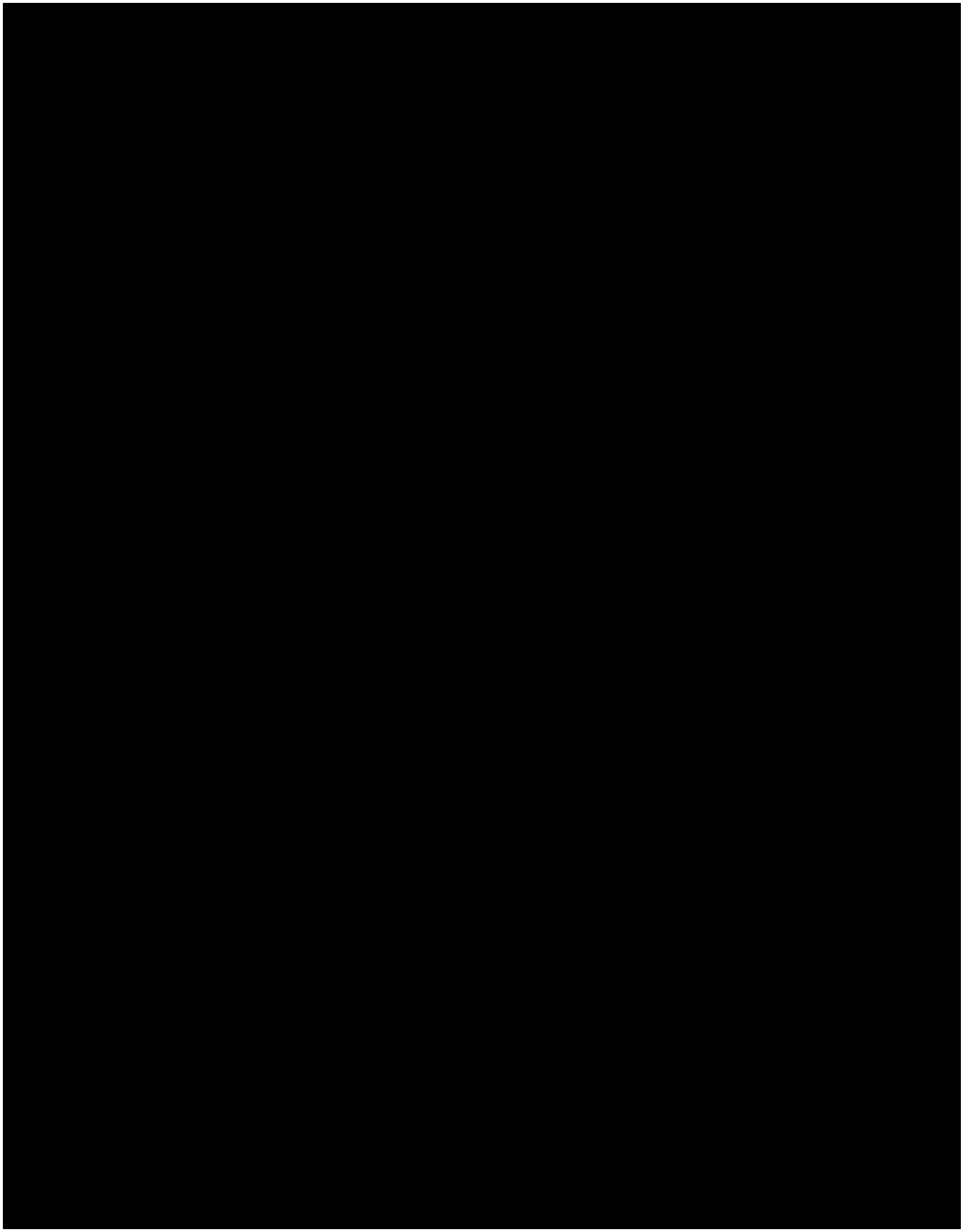


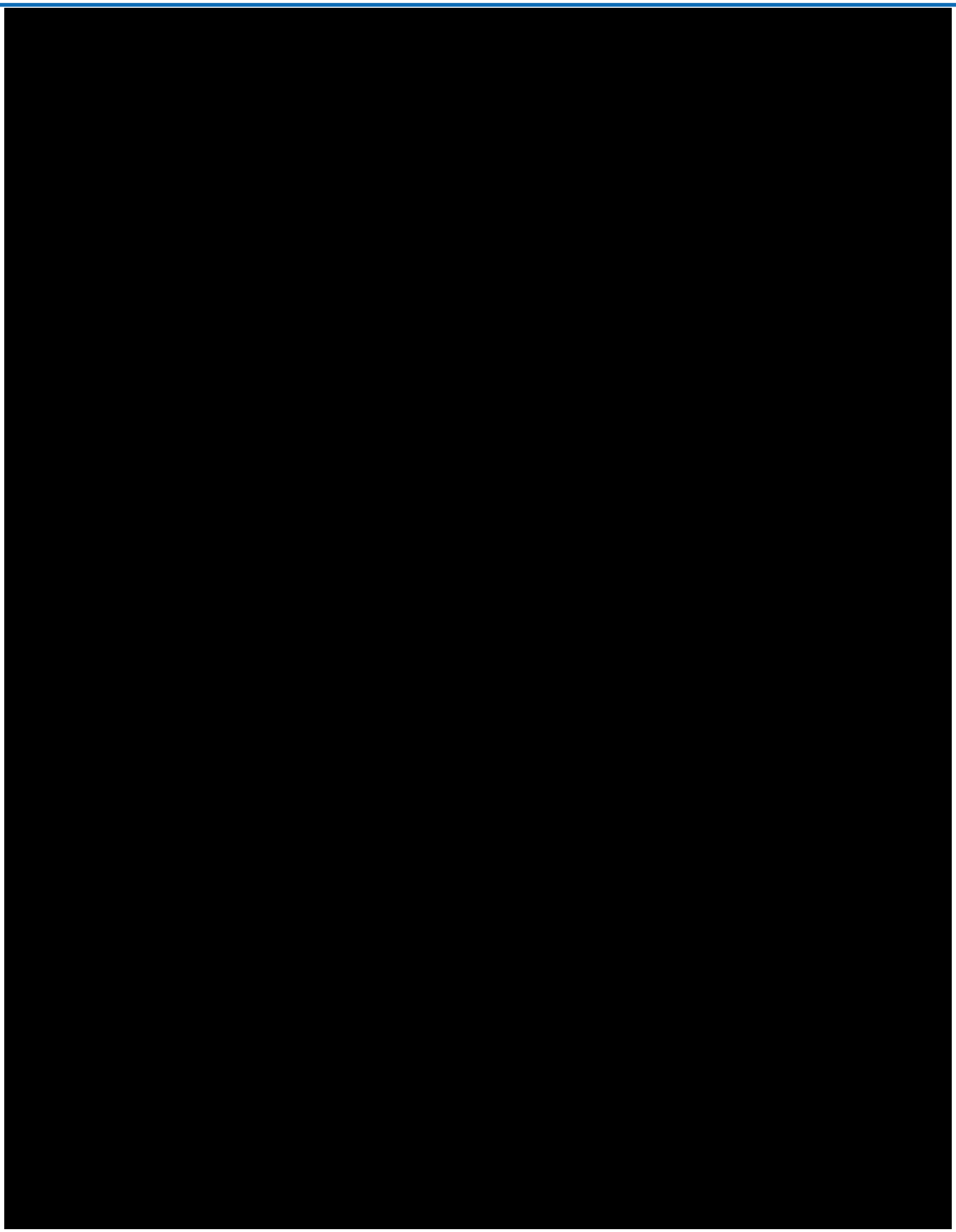


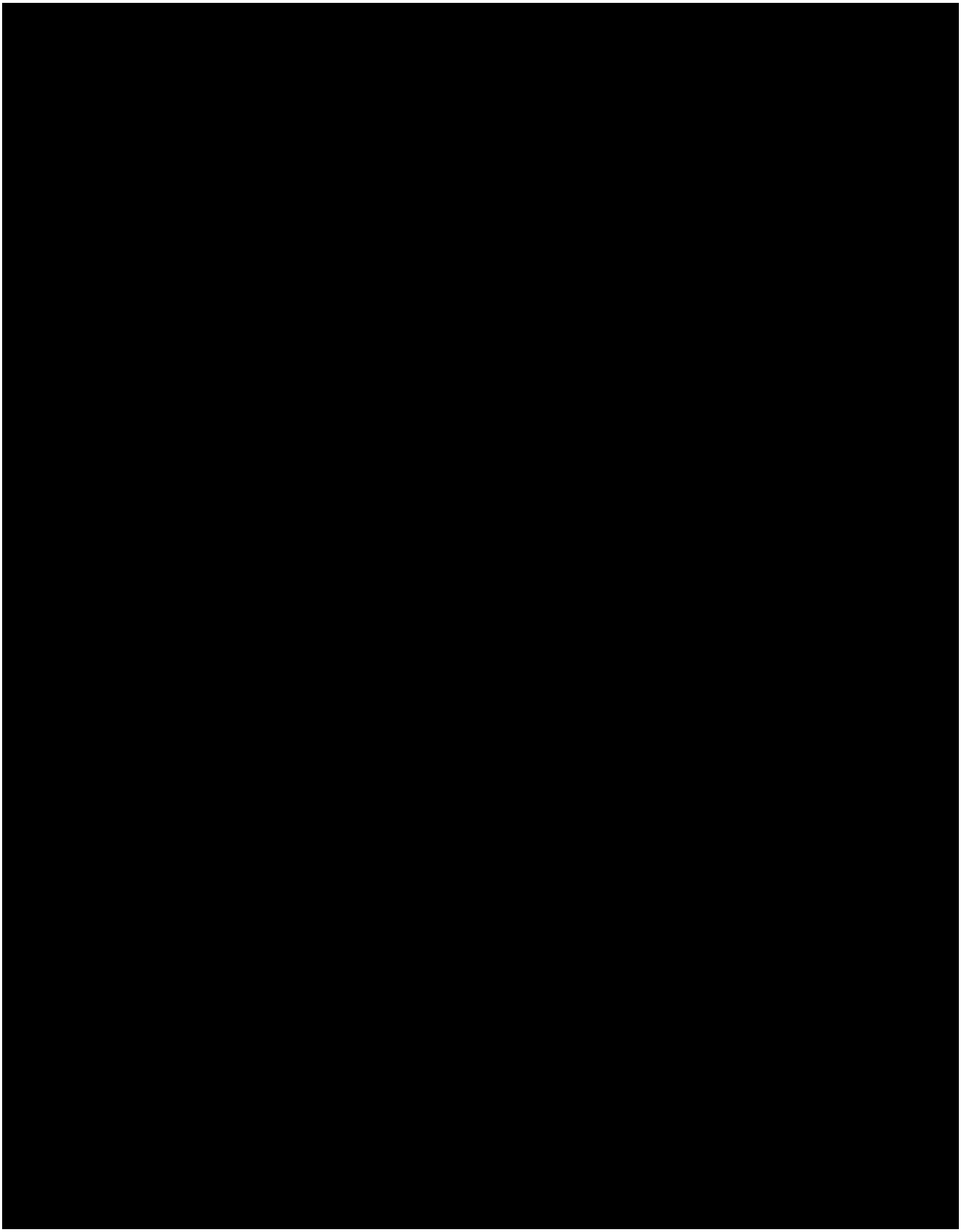


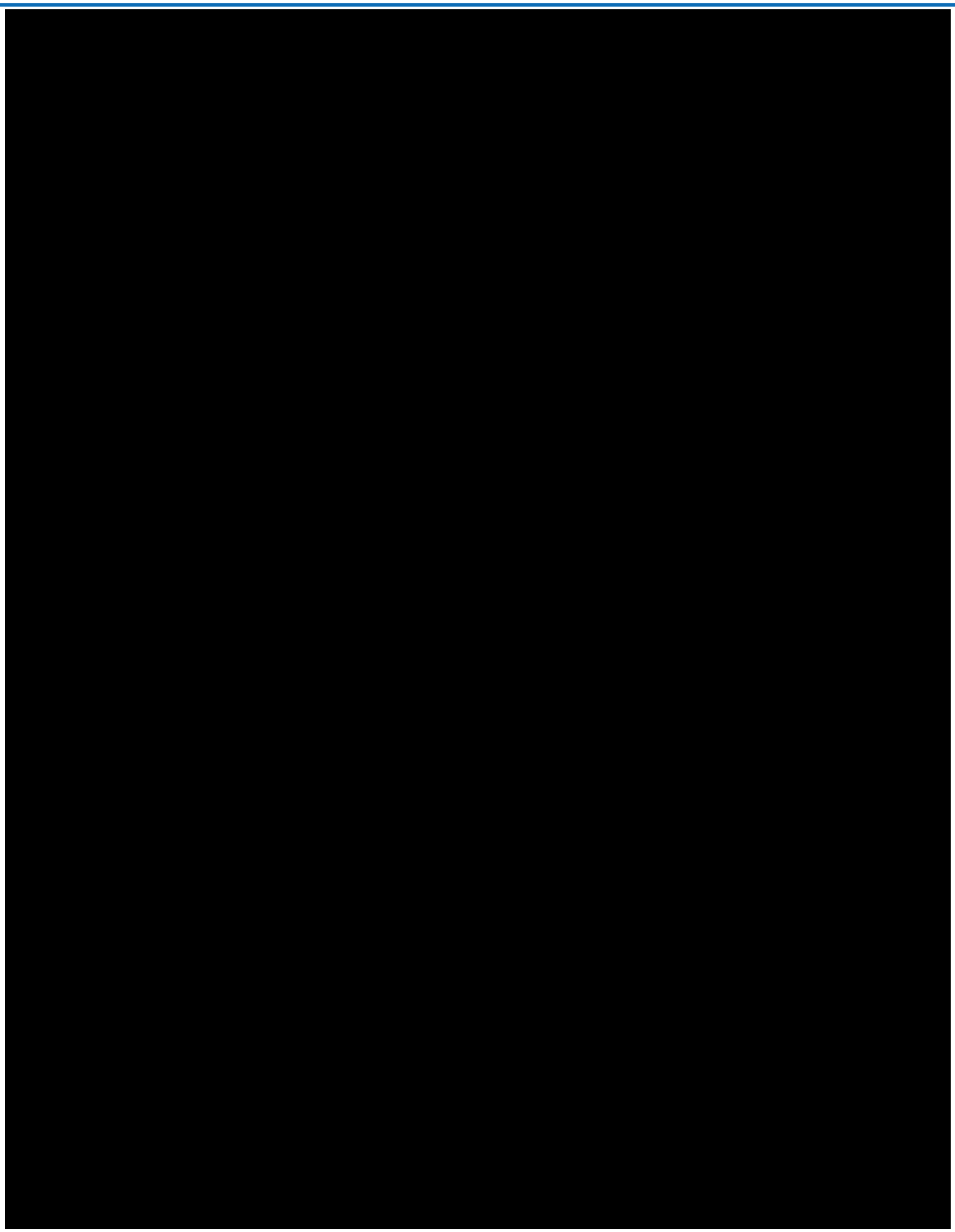


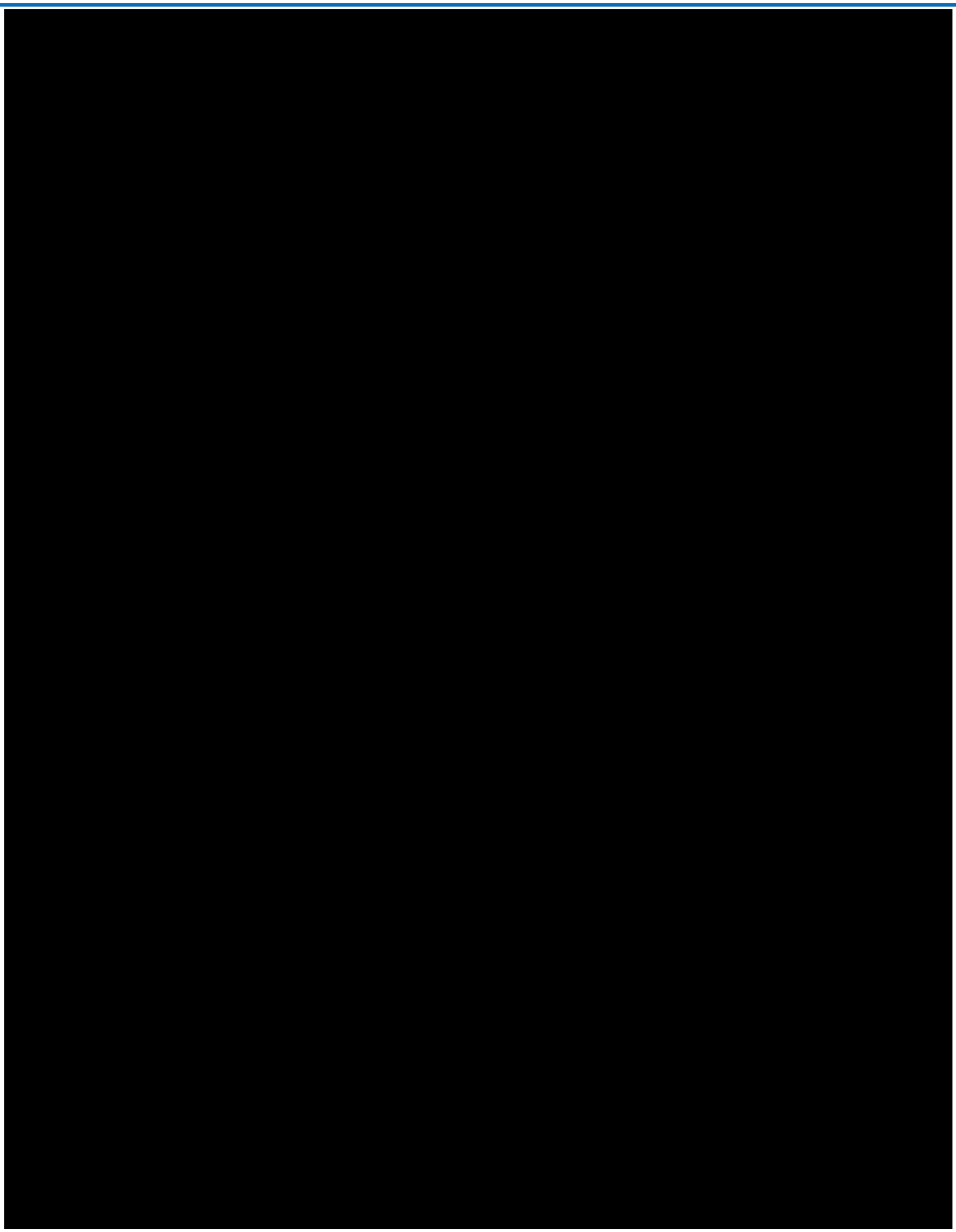


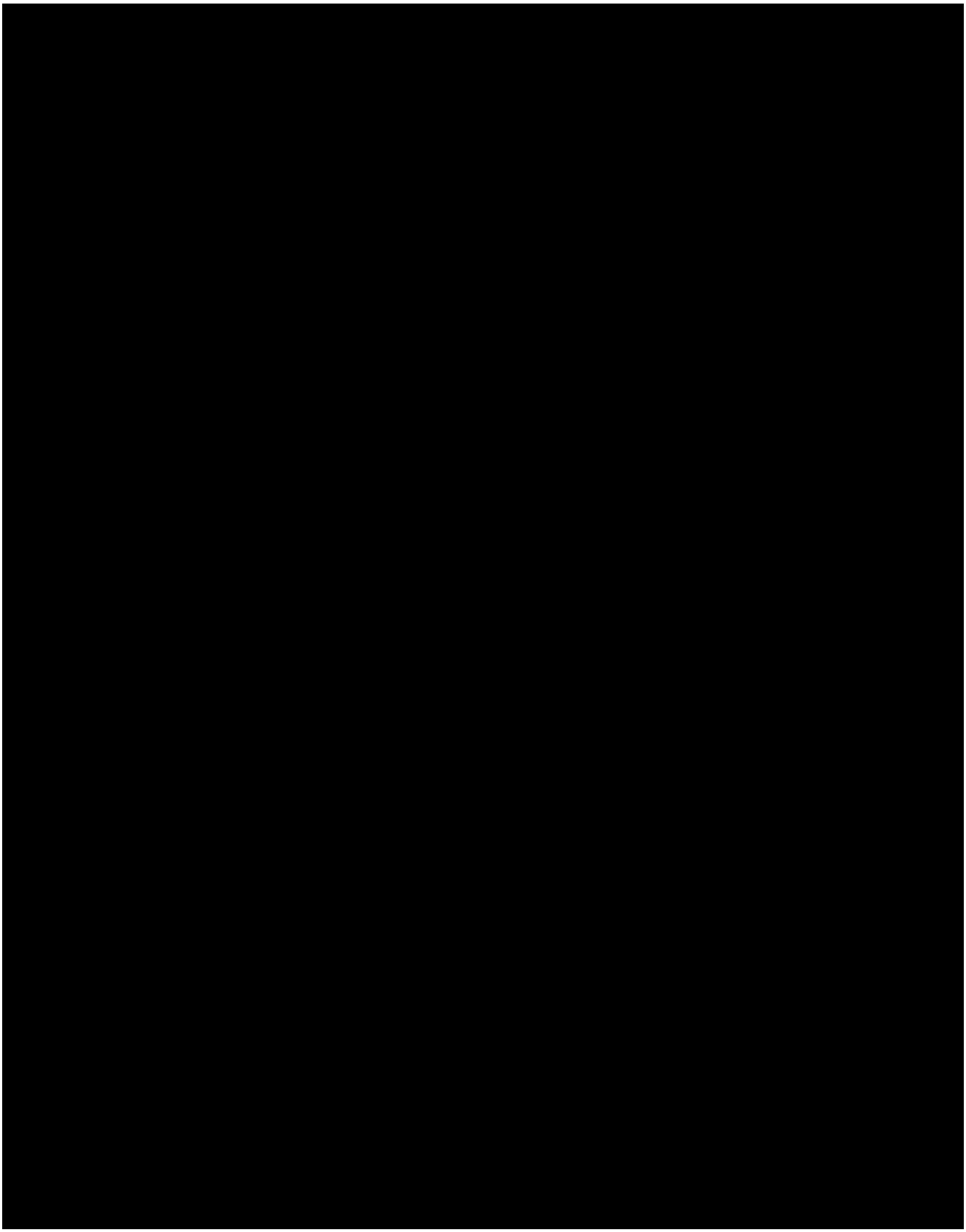


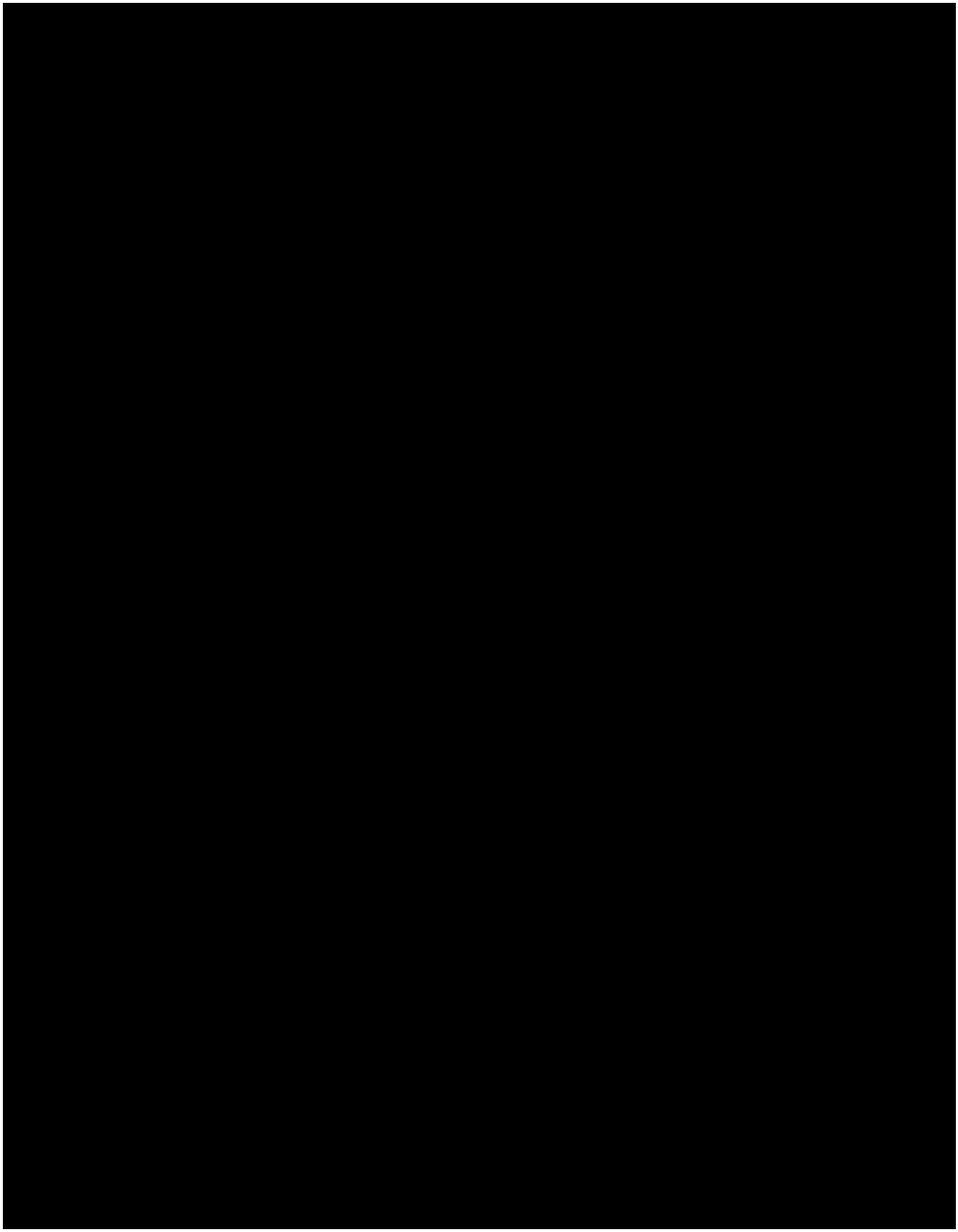


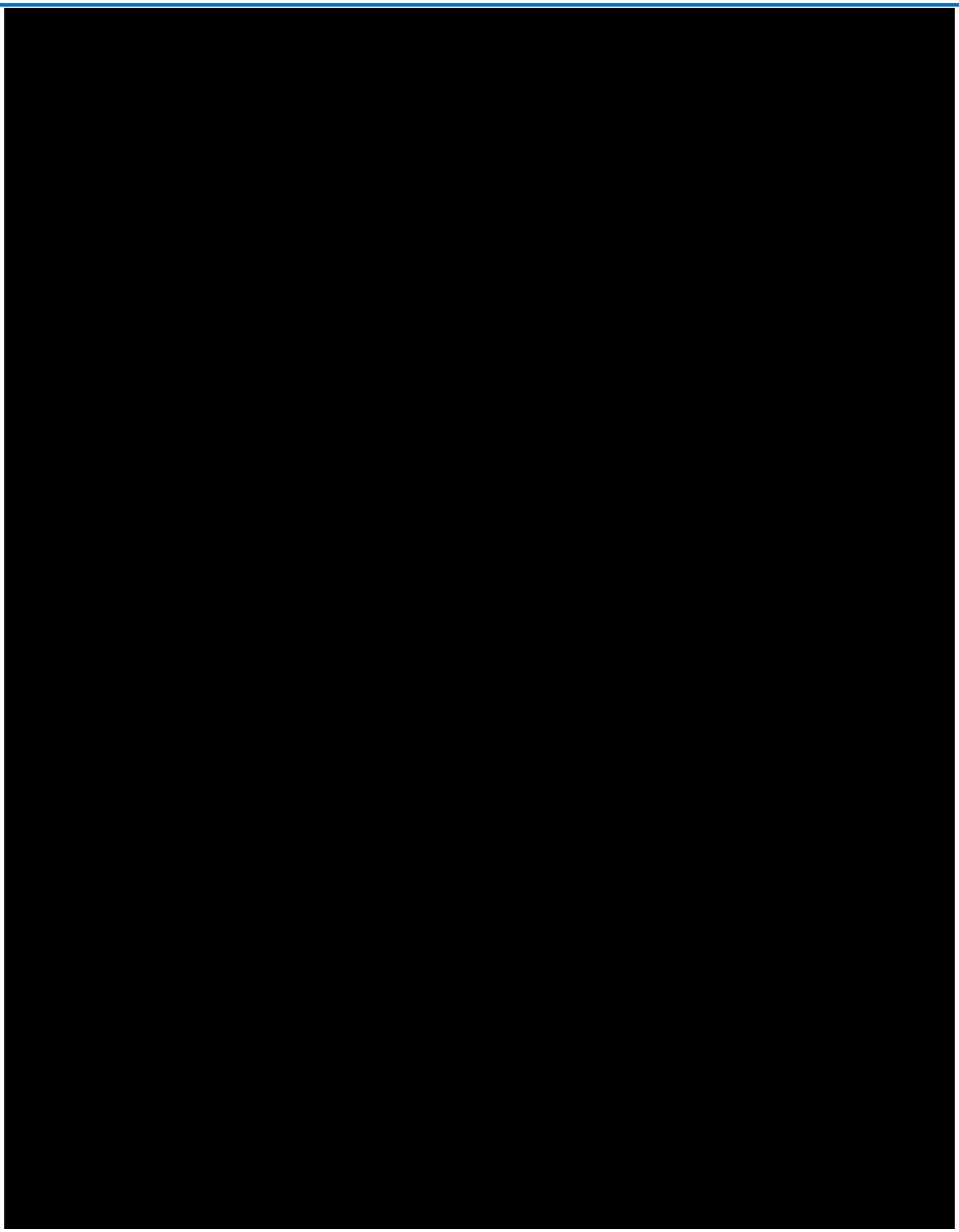


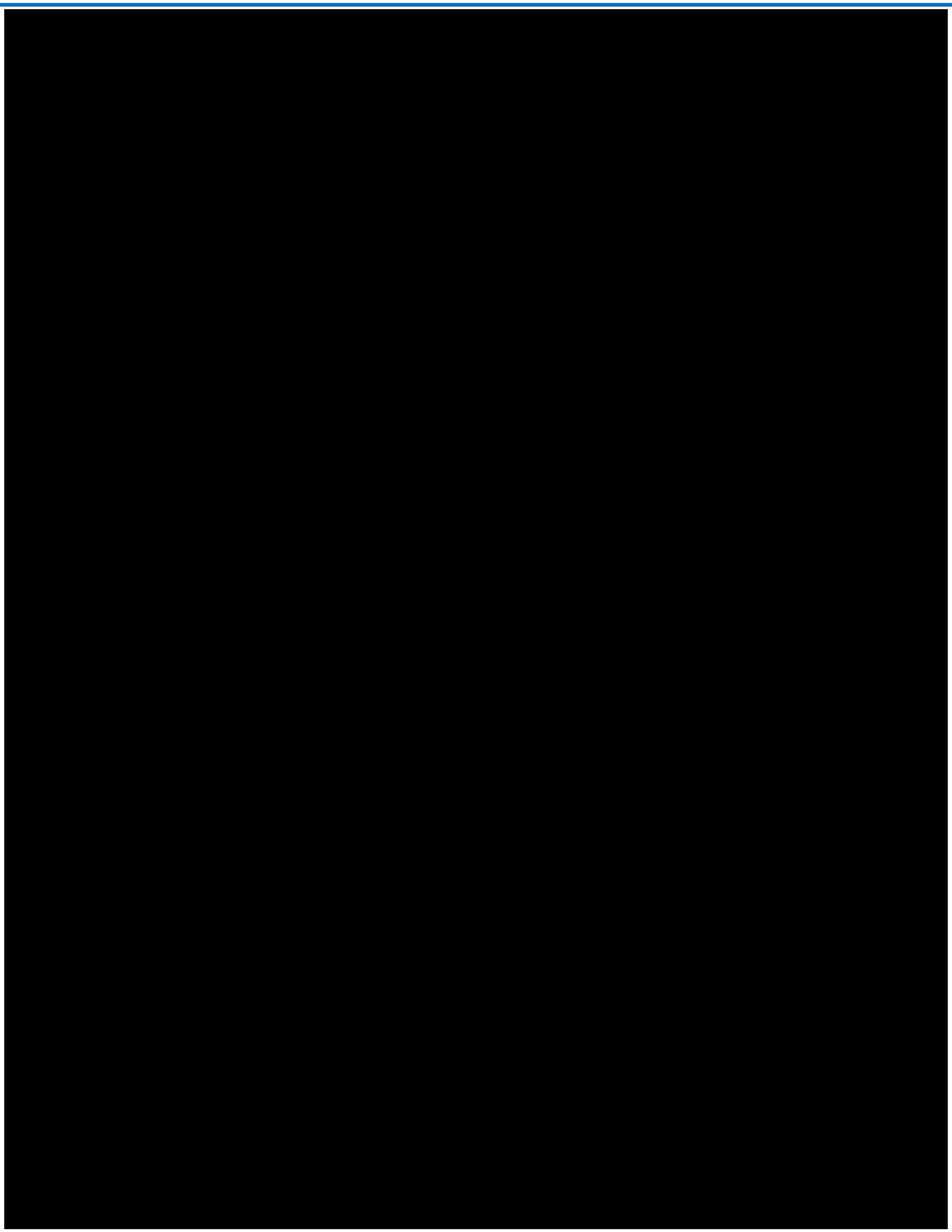


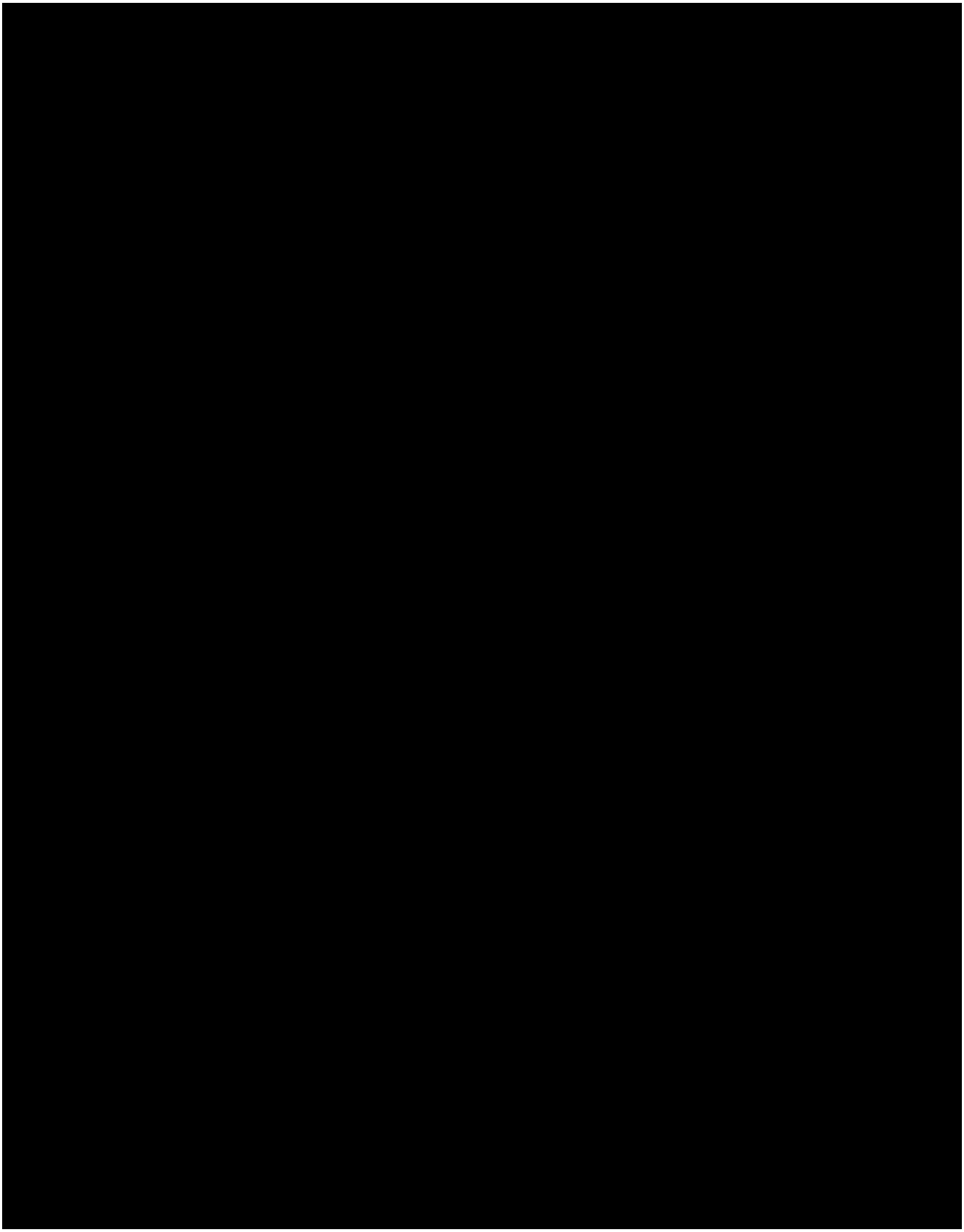


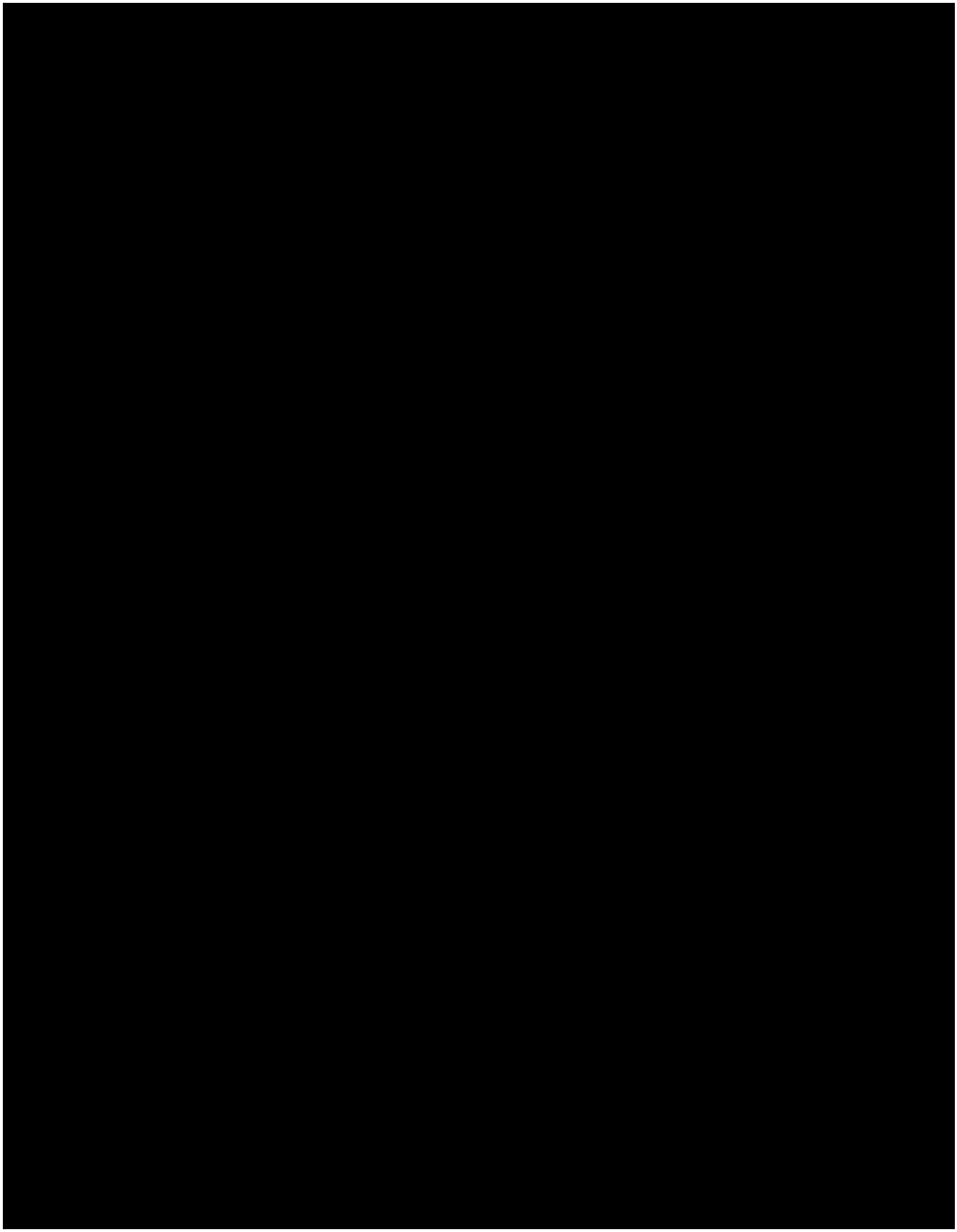












Section J: General Terms and Conditions

J.1: Inspection

J.1.01: Inspection – J.1.05 Ten (10) Year Subcontractor Audit Right

MCNA allows the State, CMS, the OIG, the Comptroller General, and their designees to inspect and audit any MCNA or subcontractor records or documents at any time. This may include inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted by MCNA or our subcontractor.

We acknowledge and understand that the right to audit under this Section J exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. MCNA and our subcontractor will furnish duly authorized and identified agents or representatives of the State and Federal governments with such information as they may request regarding payments claimed for Medicaid services. We will comply with all access and cost allocation provisions of the contract with respect to all audit provisions. Contracts between MCNA and any subcontractors that relate directly or indirectly to the performance of MCNA's obligations under this contract shall allow the State, CMS, or the DHHS Inspector General to inspect, evaluate, and audit the subcontractor at any time if there is a reasonable possibility of fraud or similar risk.

J.1.06: Scope of Audit

The Secretary, DHHS, and the State (or any person or organization designated by either) shall have the right to audit and inspect any books or records of MCNA or our subcontractor pertaining to:

a) The ability of MCNA to bear the risk of financial losses.
b) Services performed or payable amounts under the contract.

J.1.07: Grievance & Appeal Records

Additionally, MCNA and our subcontractor will retain, as applicable, member grievance and appeal records in 42 C.F.R. § 438.416, base data in 42 C.F.R. § 438.5(c), MLR reports in 42 C.F.R. § 438.8(k), and the data, information, and documentation specified in 42 C.F.R. § 438.604, (except 438.604(a)(2)), 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.

J.2: Compliance with State and Federal Laws

J.2.01: Compliance with Laws

MCNA will comply with all applicable Federal and State laws and regulations including:

a) Title VI of the Civil Rights Act (CRA) of 1964.
b) The Age Discrimination Act of 1975.
c) The Rehabilitation Act of 1973.
d) Title IX of the Education Amendments of 1972 (regarding education programs and activities).
e) The Americans with Disabilities Act.
f) Section 1557 of the PPACA.

J.2.02: Enrolled Member Rights

MCNA will comply with any applicable Federal and State laws that pertain to member rights and ensure that its employees and contracted providers observe and protect those rights.

We inform members about their rights and responsibilities. For example, based on the Agency's model Enrolled Member Handbook, MCNA's Member Handbook includes information about member rights and responsibilities, including members' right to:

a) Receive information on beneficiary and plan information.
b) Be treated with respect and with due consideration for his or her dignity and privacy.
c) Receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand.
d) Participate in decisions regarding his or her health care, including the right to refuse treatment.
e) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
f) Request and receive a copy of their medical records at no cost and request that they be amended or corrected.

[redacted]

[redacted]

J.3: Subcontracts

Attachment J, J.3.a: Proposed Subcontracts

[redacted]

Attachment J, J.3.b: Subcontracts Worth at Least 5% of Capitation

[redacted]

Attachment J, J.3.c: Subcontractor Metrics and Evaluation

MCNA has a written agreement with each material subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. All subcontractors are monitored in accordance with our MCO Subcontractor Monitoring Report and Calendar which is completed on an annual basis.

J.3.01: Integrated Subcontracting

Any subcontracting relationship shall provide for a seamless experience for MCNA's members and providers. MCNA understands that if we use subcontractors to provide direct services to members, the subcontractors shall meet the same requirements as we meet, and we must be able to demonstrate our oversight and monitoring of the subcontractor's compliance with these requirements.

J.3.02: Contractor Responsibility

We maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this contract, notwithstanding the use of a subcontractor.

J.3.03: Subcontractor Qualifications

We acknowledge that MCNA is accountable for any functions and responsibilities that are delegated to a subcontractor and is required to certify and warrant all subcontractor work. Prior to delegation, MCNA evaluates a prospective subcontractor's ability to perform the activities to be delegated, including firm and staff qualifications. We ensure that a Business Associates Agreement is in place as necessary. MCNA will notify the Agency in writing of all subcontracts relating to deliverables to be provided under this contract prior to the time the subcontract becomes effective. We will submit for Agency review and approval agreements for any subcontractor whose payments are equal to or greater than five percent (5%) of capitation payments under the contract. We understand that the Agency reserves the right to review and approve any subcontracts, and all subcontracts shall be accessible to the Agency and provided within three (3) business days of a request. All material changes to a subcontractor agreement previously approved by the Agency shall be submitted in writing to the Agency for approval at least sixty (60) days prior to the effective date of the proposed amendment. Additionally, the Agency shall have the right to request the removal of a subcontractor for good cause, and subcontractors will be bound to the same contractual terms and conditions as MCNA.

J.3.04: Subcontractor Delegation

If any of MCNA's activities or obligations under the contract with the state are delegated to the subcontractor:

a) The activities and obligations, and related reporting responsibilities, shall be specified in the contract or written agreement between MCNA the subcontractor.
b) The contract or written arrangement between MCNA and the subcontractor must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or MCNA determines that the subcontractor has not performed satisfactorily.

J.3.05: Subcontractor Oversight

We have established robust policies and procedures for auditing and monitoring subcontracts, and we acknowledge that these policies and procedures are subject to review by the Agency. Any changes to these policies and procedures will be communicated to the Agency for prior approval, ensuring transparency and consistency. As part of our ongoing commitment to monitoring subcontractor performance, we will conduct formal reviews at least quarterly. These reviews will help us identify any deficiencies or areas for improvement promptly. If corrective action is required, both MCNA and the subcontractor will collaborate to address the identified issues effectively. Further, we will provide the Agency with the findings of all subcontractor performance monitoring and reviews upon request. Additionally, we will promptly notify the Agency whenever a subcontractor is placed on corrective action, allowing for appropriate measures to be taken.

J.3.06: Delegated Compliance

MCNA ensures that all contracts or written agreements relating to the performance of our obligations under the Contract incorporate provisions that mandate individuals or entities to comply with applicable CHIP laws, Medicaid laws, regulations, sub-regulatory guidance, and contract provisions.

J.3.07: Subcontractor Audit/Inspection - J.3.10: Fraud – Audit at Any Time

Contracts between MCNA and subcontractors that are directly or indirectly related to the performance of our obligations under this Contract will include provisions mandating the subcontractors to agree to the audit, evaluation, and inspection rights of the State, CMS, the DHHS Inspector General, the Comptroller General, or their Designees. These entities will have the authority to audit and inspect the books, records, contracts, computer, or other electronic systems of the subcontractors, including their contractors, pertaining to any aspect of services and activities performed or determination of amounts payable under our Contract with the State.

Furthermore, contracts with subcontractors will also require them to provide access to their premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to their members for audit, evaluation, or inspection purposes by the State, CMS, the DHHS Inspector General, the Comptroller General, or their Designees.

Additionally, subcontractors will be obligated to maintain the audit right of the State, CMS, the DHHS Inspector General, the Comptroller General, or their Designees for a period of ten (10) years from the final date of the Contract period or the date of completion of any audit, whichever is later.

Finally, we acknowledge that if the State, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of Fraud or similar risk, the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

[redacted]

J.4: Third Party Liability (TPL) Activities

Attachment J, J.4.a: Third Party Liability Activities

MCNA's coordination of benefits (COB), third-party liability (TPL), and subrogation processes are designed to ensure that Medicaid is the payer of last resort and any other available TPL resource is pursued. We exercise full assignment rights, as applicable. We understand that MCNA must demonstrate to the Agency that reasonable effort has been made to seek, collect, and report TPL, and our cost avoidance and recovery efforts. Further, we acknowledge that the Agency has the sole responsibility for determining whether reasonable efforts have been demonstrated, and this determination will consider reasonable industry standards and practices.

[redacted]

MCNA also identifies the existence of potential TPL using diagnosis and trauma code editing in accordance with 42 CFR § 433.138(e). [redacted]

[redacted]

[redacted] We acknowledge that TPL amounts collected may be retained in accordance with the RFP provisions, and the TPL recoveries will be considered during the Agency rate setting process. MCNA understands the importance of adapting to evolving TPL landscapes. We are committed to continuously improving our processes, staying up to date with industry best practices, and leveraging emerging technologies.

[redacted]

[redacted] We understand that all encounters for claims that are recouped in full must be voided, and partial recoupments must be submitted as adjusted encounters.

TPL Reporting Requirements

MCNA currently provides any third-party resource information to the Agency in the frequency and format specified. We fully cooperate with the Agency and its vendors or designees. Our reporting includes all confirmed and suspected TPL collections, status of open receivables, closed receivables, total amounts collected, amounts written off, and total amount cost avoided. Any money recovered from third parties is retained by MCNA and reported to the Agency as specified.

We post all third-party payments to claim level detail by the member. Our encounter data includes the collections and claims information, including any retrospective findings via encounter adjustments.

J.4.01: Subcontractor TPL Delegations

MCNA understands and acknowledges that we are the delegated entity responsible for all TPL-related activities listed in J.4.01.

J.4.02: TPL Responsibility

MCNA understands that the Agency is the payer of last resort for all covered services. To the extent of medical assistance paid by MCNA, the Agency assigns all of its rights to recover for such medical assistance against liable third parties under Iowa Code Ch. 249A, including but not limited to the rights of the Agency under Iowa Code §§ 249A.37 and 249A.54. MCNA shall, upon request of the Agency, release the assignment to the Agency. We acknowledge that the Agency reserves the right to identify, pursue, and retain any recovery of third-party resources that remain uncollected.

[redacted] We follow all activities laid out in the most recent Agency Medicaid TPL Action Plan, and most recent CMS handbook called Coordination of Benefits and Third-Party Liability (COB/TPL) In Medicaid.

J.4.02.1: Sources of TPL

MCNA acknowledges that applicable liable third parties include any insurance company, individual, corporation or business that can be held legally responsible for the payment of all or part of the medical costs of a member. Examples of liable third parties can include: (i) Health Insurance, including Medicare, and TRICARE; (ii) worker's compensation; (iii) homeowner's insurance; (iv) automobile liability insurance; (v) non-custodial parents or their insurance carriers; or (vi) settlements or court awards for casualty/tort (accident) claims including settlements paid through insurance. MCNA also identifies trauma and accident cases where funds expended can be recovered from liable third parties and recover the funds.

J.4.03: TPL Data

MCNA shares information regarding its members with these other payers as specified by the Agency and in accordance with 42 C.F.R. § 438.208(b). In the process of coordinating care, MCNA protects each member's privacy in accordance with the confidentiality requirements stated in 45 C.F.R. Parts 160 and 164.

MCNA understands that the Agency will provide information to MCNA on member TPL that was collected at the time of Medicaid application. We then report any new TPL to the Agency on a weekly basis, in the Agency's preferred method and format. The information collected on members shall contain the following:

a) First and last name of the policyholder
b) Social security number of the policyholder
c) Full insurance company name
d) Group number, if available
e) Name of policyholder's employer (if known)
f) Insurance carrier ID
g) Type of policy and coverage

Additionally, MCNA implements Agency approved strategies and methodologies to ensure the collection and maintenance of current TPL data, for example, recoveries from direct billing, disallowance projects, and yield management activities.

J.4.04: Cost Avoidance

MCNA recognizes that if a member is covered by another insurer, MCNA coordinates benefits so as to maximize the utilization of third-party coverage. In accordance with 42 C.F.R. § 433.139, if the probable existence of third-party liability has been established at the time a claim is filed, MCNA will reject the claim and direct the provider to first submit the claim to the appropriate third party. When the provider resubmits the claim following payment by the primary payer, we then pay the claim to the extent that payment allowed under our reimbursement schedule exceeds the amount of the remaining patient responsibility balance.

J.4.05: Provider Education

MCNA educates our network providers about the claim payment process, including the need to capture and document any other coverage (third-party liability) on the claim form. We provide detailed written billing procedures that include the process for submitting claims with TPL for payment consideration. This includes any requirements related to the inclusion of an EOB from the primary insurer for paper claims or any applicable requirements surrounding HIPAA Remittance Advice Remark Codes.

[redacted]

J.4.06: Cost Avoidance Requirements.

MCNA acknowledges that if insurance coverage information is not available or if one (1) of the cost avoidance exceptions described below exists, MCNA will make the payment and make a claim against the third party, if it is determined that the third party is or may be liable. We always ensure that cost-avoidance efforts do not prevent a member from receiving medically necessary services in a timely manner.

J.4.07: Cost Avoidance Exceptions – Pay and Chase Activities

We honor all cost avoidance exceptions in accordance with 42 C.F.R. § 433.139 including the following situations in which MCNA first pays the provider and then coordinates with the liable third party:

- the claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency; or
- the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program.

Following reimbursement to the provider in these cost avoidance exception cases, MCNA will actively seek reimbursement from responsible third parties and adjust claims accordingly.

J.4.08: Collection and Reporting

MCNA will identify, collect, and report TPL coverage and collection information to the Agency. As third-party liability information is a component of capitation rate development, we maintain records regarding TPL collections and report these collections to the Agency in the timeframe and format determined by the Agency. MCNA retains all third-party liability collections made on behalf of our members; we do not collect more than we have paid out for any claims with a liable third party. MCNA will provide the Agency information on members who have newly discovered health insurance or dental coverage, in the timeframe and manner required by the Agency. MCNA provides members and providers instructions on how to update TPL information on file and shall provide mechanisms for reporting updates and changes. Reports include, but are not limited to:

a) Monthly amounts billed and collected, current and year-to-date.
b) Recoveries and unrecoverable amounts by carrier, type of coverage, and reason (quarterly).
c) TPL activity reports (quarterly).
d) Internal reports used to investigate possible third-party liability when paid Claims contain a TPL amount and no resource information is on file.
e) Monthly Quality assurance sample to the Agency verifying the accuracy of the TPL updated applied during the previous month.
f) Monthly pay-and-chase carrier bills.

J.4.09: COBA Obligations

MCNA will enter into a Coordination of Benefits Agreement (COBA) with Medicare for the purpose of coordinating crossover payment, and we will participate in the automated Claims crossover process. We understand that we have the responsibility for coordination of benefits for individuals dually eligible for Medicaid and Medicare. We will send eligibility information to CMS and receive Medicare Claims data for processing supplemental insurance benefits from CMS' national crossover contractor.

J.4.10: Coordination with Medicare

MCNA provides medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare. We will ensure that services covered and provided under the Contract are delivered without charge to members who are dually eligible for Medicare and Medicaid. MCNA will coordinate with Medicare payers, Medicare

Advantage Plans, and Medicare Providers as appropriate to coordinate the care and benefits of our members who are also enrolled with Medicare. Our Dual Eligible Coordination program is documented in the PPM.

J.4.11: Lesser of Logic

MCNA ensures that the total reimbursement for any reimbursable Medicare Claim is limited to the Medicaid reimbursement amount under authority of federal law §1902(n)(2) of the Social Security Act. We acknowledge and understand that, effectively, Iowa Medicaid pays for the lesser of the following:

a) The cost sharing (deductible and/or coinsurance) that, absent Medicaid eligibility, would have been owed by the Medicare beneficiary, or
b) The difference between the sum of what Medicare and all other third-party insurers paid and the Medicaid fee for the same services or items.

We understand that the financial obligation of Iowa Medicaid for services is based upon Medicare and all other third-party insurer amounts, not the provider's charge. Further, MCNA recognizes that Medicaid will not pay any portion of Medicare Part A, Part B, or Part C deductibles and coinsurance when payment that Medicare and all other third-party insurers has made for the services or items equals or exceeds what Medicaid would have paid had it been the sole payer.

J.5: Sanctions

J.5.09: Additional State Sanctions

MCNA acknowledges that the State may impose additional sanctions provided for under State statutes or regulations to address noncompliance.

J.6: Termination

J.6.01: Termination Right

We understand that the State may terminate this contract, and place members into a different dental plan or provide Medicaid and/or CHIP benefits through other State Plan authority, if the State determines that MCNA has failed to carry out the substantive terms of its contracts or meet the applicable requirements of sections 1932, 1903(m) or 1905(t) of the Social Security Act.

J.7: Insolvency

J.7.01: Enrolled Members Not Liable for Contractor Insolvency

As a current dental plan for Iowa's DWP program, MCNA complies will all licensure and reporting requirements. MCNA's ultimate parent is UnitedHealth Group which has an estimated net worth in excess of $443 billion. As such, MCNA assures the Agency that we are adequately protected against the risk of insolvency, and we ensure that our members will not be held liable for our debts should we become insolvent.

J.7.02: No Enrolled Member Liability on Unpaid Claims

Our Participating Provider Agreement clearly identifies and explains that member liability is limited only to what is permitted by our contract with the Agency, and under State and federal law. Should MCNA become insolvent, our Medicaid and CHIP members will not be held liable for our debts.

J.7.03: Limitation on Enrolled Member Liability – Referrals/Other Arrangements

Members are not liable for covered services for which the State does not pay MCNA nor in situations where MCNA does not pay the provider that furnished the service under a contractual, referral, or other arrangement. Members are not liable for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if MCNA covered the services directly.

J.7.04: Assurances Against Insolvency

MCNA will provide assurances satisfactory to the State that its provision against the risk of insolvency is adequate to ensure that Enrolled Members will not be liable for MCNA's debt if MCNA becomes insolvent.

J.7.06: Financial Stability

MCNA is licensed and in good standing as an HMO in the State of Iowa and complies with all applicable insurance regulations. MCNA complies with rules regarding deposit requirements at Iowa Admin. Code r. 191-40.12 and reporting requirements at Iowa Admin. Code r. 191-40.14. MCNA will copy the Agency on all required filings with the Iowa Insurance Division and comply with Agency established financial reporting requirements.

Attachment J, J.7.07.a: Compliance with Reinsurance Requirements

MCNA maintains a strong capital base and we assume 100% of risk on our dental insurance products. We will submit a plan of self-insurance rather than relying on a reinsurance contract with an unaffiliated third party.

J.7.07: Reinsurance

MCNA complies with all reinsurance requirements at Iowa Admin. Code r. 191-40.17 and will file with the Agency all contracts of reinsurance or a summary of the plan of self-insurance. MCNA will provide to the Agency the risk analysis, assumptions, cost estimates and rationale supporting its proposed reinsurance arrangements.

J.7.08: Enrolled Member Liability on Unpaid Claims and ABM

Notwithstanding Section J.7.02, members are liable for services provided that normally are covered services under the contract when the member has met or exceeded their ABM. Members must be informed of the liability before services were delivered and must have expressly accepted the liability in writing noting that the liability was due to meeting or exceeding the ABM.

J.8: Contractual Non-Compliance

[redacted] Our plan addresses each aspect of the readiness requirements set forth in the RFP. [redacted]

We acknowledge and understand all non-compliance provisions, corrective actions, and liquidated damages outlines in Section J.8 of this RFP. We agree to fully comply with all provisions therein.

J.8.01: Disaster Recovery

[redacted] Our Disaster Recovery and Business Continuity (DR/BC) plan, which serves as our detailed contingency plan, governs all disaster recovery and continuity of operations activities that MCNA undertakes before, during, and after a catastrophic event. [redacted]

MCNA executes all activities needed to recover and restore operation of information systems, data and software at an existing or alternate location under emergency conditions within twenty (24) hours of identification or a declaration of a disaster. We understand that failure to recover within this timeframe can lead to liquidated damages, penalties, corrective action plans, and reassignment of members to another plan.

[redacted]

For additional information, please see our response to sections K.35-K.36.

J.8.02: Non-Compliance with Reporting Requirements

In addition to any liquidated damages for reporting non-compliance as described in the relevant Special Contract Exhibit rate sheet, MCNA understands that in the event of our non-compliance with reporting requirements stipulated in the Contract or the Reporting Manual, which subsequently impacts the Agency's ability to monitor our solvency and necessitates the transfer of to pay any difference between the capitation rates that would have been paid to the Contractor and the actual rates being paid to the replacement contractor as a result of member transfer to another contractor, we will be held responsible for the financial repercussions associated with such transfer. This entails covering the difference between the capitation rates that would have been paid to us and the actual rates being paid to the replacement contractor as a result of the member transfer. We acknowledge that any costs incurred by the Agency in facilitating the transfer of members will be our responsibility to bear and that the Agency will withhold all capitation payments or require corrective action until MCNA provides satisfactory financial data.

J.8.04: Non-Compliance with Provider Network Requirements

In addition to any liquidated damages for Provider Network requirements, as described in the Special Contract Exhibit rate sheets, MCNA acknowledges that if the Agency determines that we have not met the network access standards established in the Contract, we will be required to submit a Corrective Action Plan within ten (10) business days of notification by the Agency. In addition, we acknowledge that the determination of failure to meet network Access standards may be made following a review of the MCNA’s Network Geographic Access Assessment Report, or other information that may be collected by the Agency. The frequency of required report submission will be outlined in the Reporting Manual. Upon discovery of noncompliance, MCNA will be required to submit monthly Network Geographic Access Assessment Reports, and other information as may be required by the Agency, until compliance is demonstrated for sixty (60) consecutive days. The Agency may also require MCNA to maintain an open network for the provider type for which MCNA’s network is non-compliant. Further, should MCNA be out of compliance for three (3) consecutive months as a result of failure to meet network Access standards, the Agency will immediately suspend auto-Enrollment of members with MCNA, until such time as MCNA successfully demonstrates compliance with the network Access standards.

J.8.05: Non-Compliance with Accreditation Requirements

MCNA has been accredited by NCQA since 2011, and we were the first dental plan to become fully accredited by URAC in 2014. We have maintained full accreditation status through every review since, and we acknowledge and understand the accreditation requirements and penalties for failure to maintain accreditation status.

J.8.06: Non-Compliance with Readiness Review Requirements

In addition to any liquidated damages for Readiness Review non-compliance, as described in the relevant Special Contract Exhibit rate sheet, MCNA understands that if we fail to pass the Readiness Review satisfactorily at least thirty (30) days prior to the scheduled member enrollment or any other deadline determined solely at the Agency's discretion, the Agency has the authority to delay member enrollment and/or impose other remedies, including but not limited to Contract termination. In such cases, we acknowledge that we will be held responsible for covering all costs incurred by the Agency as a result of the delay. **MCNA has passed every Readiness Review we have undergone, and we have met every operational start date flawlessly.**

J.8.07: Non-Compliance Remedies

MCNA understands that it is the Agency's primary goal to ensure that MCNA is delivering quality care to members. To assess attainment of this goal, the Agency monitors certain quality and performance standards, and holds MCNA accountable for being in compliance with Contract terms. The Agency accomplishes this by working collaboratively with MCNA to maintain and improve programs, and not to impair MCNA stability.

In the event that MCNA fails to meet performance requirements or reporting standards set forth in the Contract or other standards established by the Agency, the Agency will provide MCNA with a written notice of non-compliance and may require any of the corrective actions or remedies discussed below. The Agency will provide written notice of non-compliance to MCNA ninety (90) calendar days of the Agency's discovery of such non-compliance.

If the Agency elects not to exercise a corrective action clause contained anywhere in the Contract in a particular instance, this decision shall not be construed as a waiver of the Agency's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the Contract, may be retroactively assessed.

J.8.08: Corrective Actions

MCNA understands that the Agency may require corrective action(s), take contractual action to enforce contractual obligations, or implement intermediate sanctions when MCNA has failed to provide the requested services. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, any action listed in J.8.08 of the contract.

J.8.09: Liquidated Damages

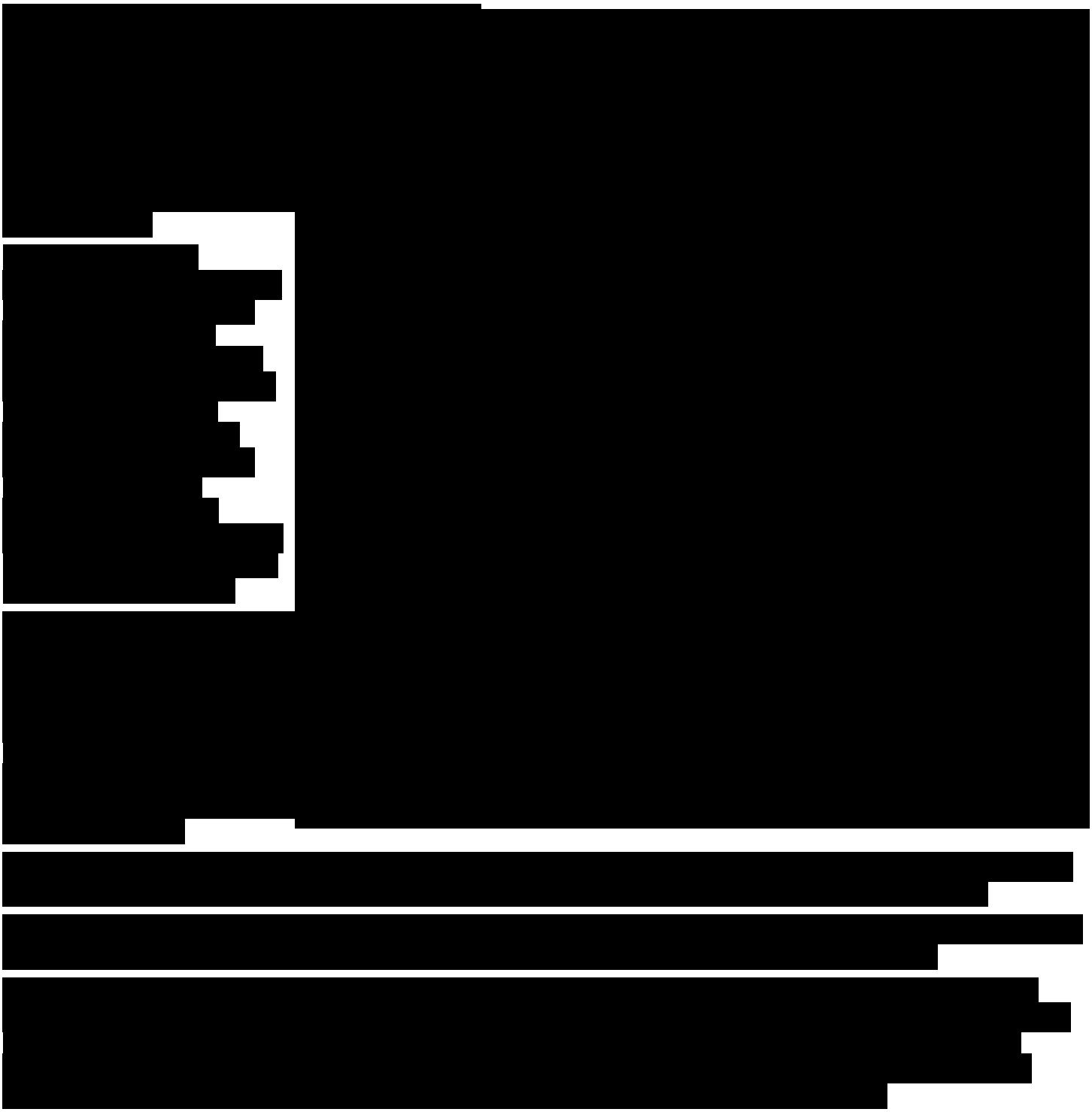
MCNA understands that if we fail to meet performance requirements or reporting standards set forth in the contract, or other standards set forth by the Agency, it is agreed that damages shall be sustained by the Agency, and MCNA shall pay to the Agency its actual or liquidated damages according to the provisions stated in J.8.09 of the contract.

Section K: Health Information Systems and Enrollee Data

We have read, understand, and will comply with Iowa Dental Wellness Plan (DWP) and Healthy and Well Kids in Iowa (Hawki) RFP# MED-24-004. In our response below, we address key requirements from RFP Attachment K: Health Information Systems and Member Data K.01-K.49.

K.01: Health Information Technology in General

[redacted]



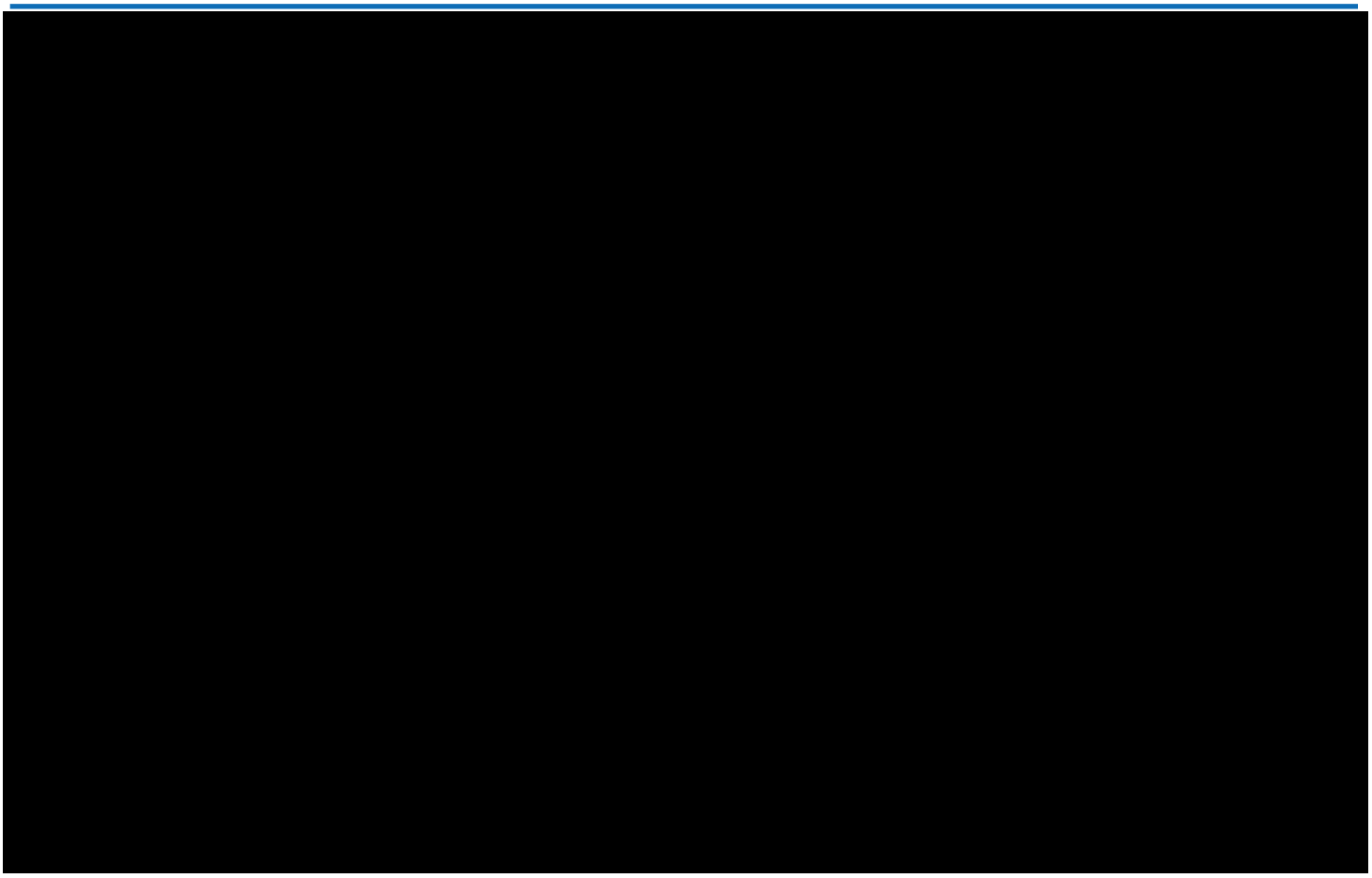
K.02: Health Information System – Capabilities

MCNA ensures compliance with the requirement to maintain a comprehensive health information system that encompasses data collection, analysis, integration, and reporting. We understand the significance of this responsibility as outlined in the regulations, specifically 42 C.F.R. § 438.242(a) and 42 C.F.R. § 457.1233(d).

[redacted]

Using MCNA's proprietary MIS, our Reporting and Analytics team can generate reports according to a schedule or on demand via custom queries. All reports can be delivered in a variety of formats, including flat files, PDF, and Microsoft Word and Excel files, as well as displayed on electronic dashboards updated in real-time.

[redacted]



K.03: Health Information System – Areas of Information

MCNA's health information system is designed to provide comprehensive information across various areas, including utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility. We understand the importance of fulfilling this requirement as indicated in the regulations, specifically 42 C.F.R. § 438.242(a) and 42 C.F.R. § 457.1233(d), referenced in CMSC K.1.02.

K.04: Health Information System – Compliance

MCNA's team of dedicated professionals ensures that our systems comply with 6504(a) of the ACA and are designed and implemented to collect data elements necessary to enable mechanized claims processing and information retrieval systems, allowing the state to comply with 1903(r)(1)(F) of the Social Security Act. In addition, we prioritize staying updated on regulatory changes and industry standards to maintain ongoing compliance.

K.05: Health Information System – Encounter Data Compliance

MCNA has successfully implemented robust systems and processes that effectively collect the necessary data on member and provider characteristics, as specified by the State and all services furnished to members through an encounter data system in accordance with 42 C.F.R. § 438.242(b)(2) and 42 C.F.R. § 457.1233(d).

K.06: Accuracy and Timeliness of Data

MCNA is committed to compliance with the relevant regulations outlined in 42 C.F.R. § 438.242(b)(3)(i) and 42 C.F.R. § 457.1233(d). We acknowledge the importance of ensuring accurate and timely data reported by providers, including those compensated based on capitation payments. MCNA will undertake the necessary steps to verify the accuracy of the data provided by network providers.

MCNA contractually requires all providers to submit claims data which includes service-level detail for all procedures performed at a dental visit. We reimburse network providers on a fee-for-service basis; we do not capitate providers. However, if we were to capitate providers, they are contractually required to submit zero-pay encounters for services delivered to our members. [redacted]

[redacted]

K.07: Screening of Data

MCNA affirms its commitment to adhere to the regulations specified in 42 C.F.R. § 438.242(b)(3)(ii) and 42 C.F.R. § 457.1233(d), as referenced in CMSC K.1.06. will thoroughly screen the data received from providers to ensure completeness, logic, and consistency. We understand the criticality of this screening process in maintaining accurate and reliable information. MCNA is dedicated to implementing robust procedures and protocols to effectively validate the data, ensuring its integrity and contributing to the delivery of high-quality services.

All incoming data including, but not limited to, eligibility/enrollment, providers, claims, service authorizations, grievances, complaints and appeals, financial transactions, Current Dental Terminology (CDT) codes, health assessment forms, and radiograph data are logged and monitored following established procedures and quality control processes, allowing us to confirm the completeness and accuracy of all transmissions.

K.08: Standardized Formats

MCNA acknowledges the importance of adhering to the regulations specified in 42 C.F.R. § 438.242(b)(3)(iii) and 42 C.F.R. § 457.1233(d), as referenced in CMSC K.1.07. We will collect data from providers in standardized formats, wherever feasible and appropriate. We recognize the significance of standardized formats in ensuring consistency and compatibility of data. MCNA is committed to utilizing secure information exchanges and relevant technologies as required for quality improvement and care coordination efforts. We will actively work towards establishing efficient data collection processes that meet the necessary standards while safeguarding the integrity and confidentiality of the information exchanged.

DentalTrac™ currently complies with all requirements associated with HIPAA. We have designed and implemented a complete set of controls to govern the accuracy and completeness of our receipt and transmission of data. Our EDI subsystem is fully compliant with HIPAA ASC X12 5010 standards as well as other industry standards, such as XML. Our currently supported file format standards are listed below:

- **HIPAA ASC X12 270/271** – Health Care Eligibility Benefit Inquiry and Response
- **HIPAA ASC X12 276/277** – Health Care Claim Status Request and Response
- **HIPAA ASC X12 277CA** – Health Care Claims Acknowledgement
- **HIPAA ASC X12 277U** – Health Care Claims Status Response
- **HIPAA ASC X12 278** – Health Care Services - Request for Review and Response; Health Care Services Notification and Acknowledgment
- **HIPAA ASC X12 820** – Payroll Deducted and Other Group Premium Payment for Insurance Products
- **HIPAA ASC X12 834** – Benefit Enrollment and Maintenance
- **HIPAA ASC X12 835** – Health Care Claim Payment/Advice
- **HIPAA ASC X12 837D** – Health Care Claim: Professional, Institutional, and Dental, including coordination of benefits (COB) and subrogation claims
- **HIPAA ASC X12 997** – Functional Acknowledgement
- **HIPAA ASC X12 999** – Functional Acknowledgement
- **NSF** – National Standard Format
- **HL7** – Health Level Seven
- **XML** – Extensible Markup Language
- **UDF** – User Defined File

K.09: Availability of Data

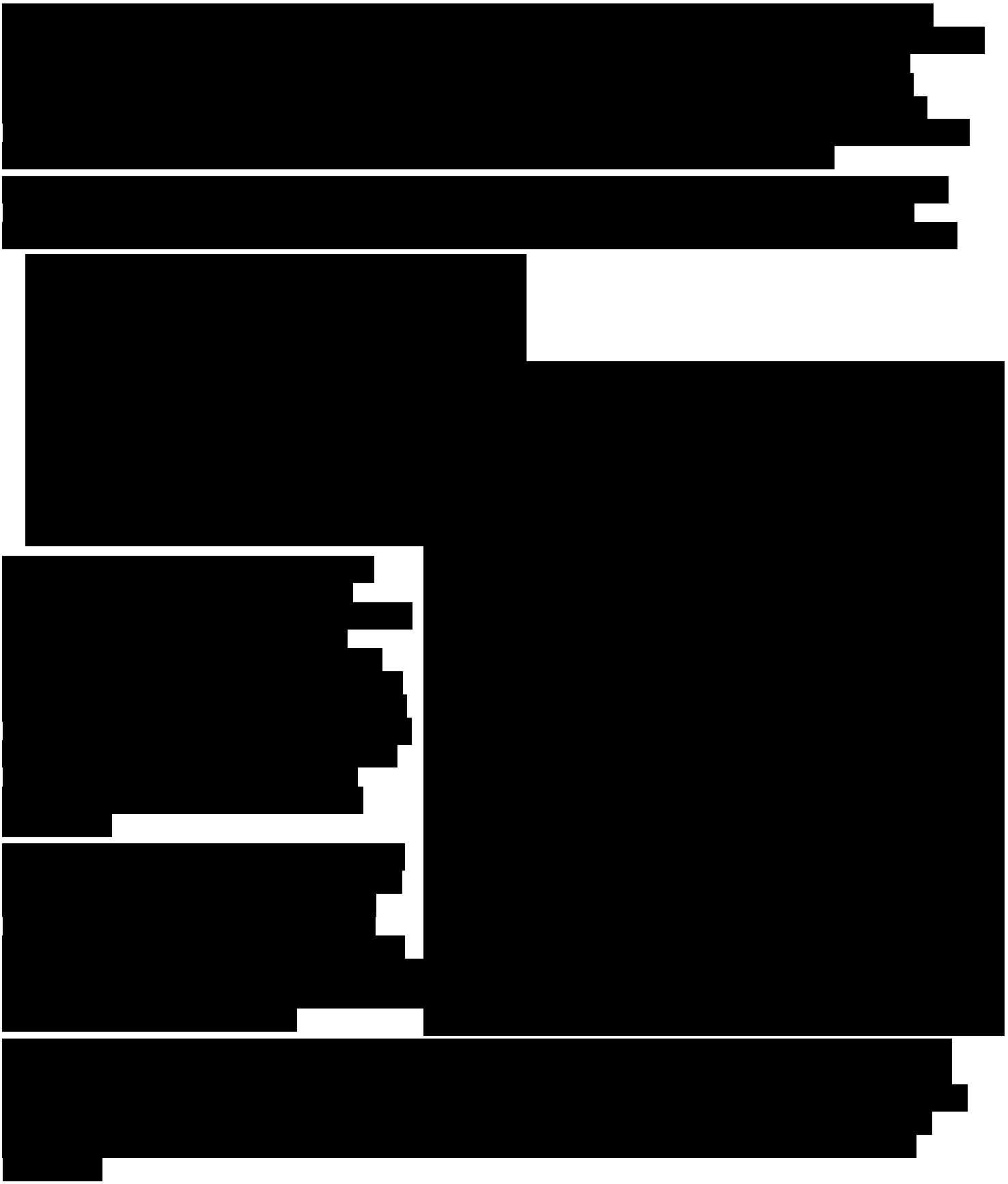
MCNA will make all collected data available to the State and upon request to CMS in accordance with 42 C.F.R. § 438.242(b)(4); 42 C.F.R. § 457.1233(d). [redacted]

[redacted]

K.10: Health Information System Capabilities

MCNA acknowledges and accepts the responsibility to ensure compliance with the requirements outlined in 42 C.F.R. § 438.242(c)(1) - (4), 42 C.F.R. § 438.818, and 42 C.F.R. § 457.1233(d), as referenced in CMSC K.1.11 - K.1.14. To meet these obligations, MCNA's data systems will adhere to the following:

- Our data systems will collect and maintain sufficient member encounter data to accurately identify the providers involved in delivering any item(s) or service(s) to members.
- We will enable the submission of member encounter data to the State at a frequency and level of detail as specified by CMS and the State. This flexibility will allow us to meet program administration, oversight, and Program Integrity needs effectively.
- Our data systems will support the submission of all member encounter data that the State is required to report to CMS. We recognize the importance of fulfilling reporting requirements accurately and promptly.
- MCNA's data systems will comply with the specifications for submitting encounter data to the State. We will utilize standardized formats, specifically the Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, as well as the ASC X12N 835 format as appropriate.



[redacted]

K.11: Actual Pricing

MCNA recognizes the importance of accurately reflecting the amount actually paid to the provider in all encounter data. We are committed to ensuring that our data management processes encompass the full scope of payments, including those made by any subcontractor of MCNA. We acknowledge the significance of capturing the complete payment information to maintain transparency and accuracy in encounter data. We will implement robust mechanisms to track and reflect the actual amounts paid to providers, thereby ensuring the integrity and reliability of the data reported.

K.12: Required Functions

MCNA's DentalTrac™ system enables all information system functions identified in K.12 of the RFP. [redacted]

K.12.a: Member Database

MCNA acknowledges the requirement to maintain a member database on a county-by-county basis. This database will utilize Medicaid State ID numbers and include essential information such as:

- Eligibility begin and end dates
- Enrollment history
- Utilization and expenditure information

We understand the significance of maintaining accurate and comprehensive data to effectively track and manage members' information and healthcare utilization. MCNA is committed to implementing robust systems and protocols to ensure the integrity and reliability of the member database, enabling us to provide timely and accurate information regarding eligibility, enrollment, and utilization for effective program administration.

[redacted]

K.12.b: County of Legal Residency

MCNA acknowledges the requirement to include the county of legal residency for members in our Information System (IS). We understand the importance of accurately capturing and maintaining this information to effectively manage and administer the program. MCNA is committed to incorporating the county of legal residency as a vital data point within our IS. By doing so, we ensure that member records contain the necessary information for program coordination, service delivery, and regulatory compliance. We will implement robust data collection and management processes to accurately capture and reflect the county of legal residency for members in our IS.

K.12.c: Clinical Information

MCNA acknowledges the requirement to maintain a comprehensive database that incorporates the required clinical information included in K.30. This database will serve as a repository for clinical records, assisting in authorizing and monitoring services, providing data for quality assessment, and facilitating other evaluative activities. It is understood that, upon the conclusion of the Contract, all clinical records generated by MCNA shall become the property of the Agency. Upon request, MCNA will transfer these records to the Agency at no additional cost.

K.12.d: Reporting

MCNA acknowledges the responsibility to maintain necessary information and generate reports required for assessing performance based on established performance indicators. We understand the significance of these reports in monitoring and evaluating the effectiveness of our services. MCNA is committed to implementing appropriate systems and processes to capture the required information and generate accurate reports in a timely manner. By doing so, we aim to facilitate meaningful performance assessment, identify areas of improvement, and ensure transparency and accountability in our operations. We will meet the reporting requirements and contribute to the ongoing evaluation of our performance.

[redacted]

K.12.e: Capitation Payment

MCNA recognizes the importance of maintaining accurate and comprehensive data documenting the receipt and distribution of the capitation payment. We understand that this data serves as a critical financial record and supports the effective management of funds. MCNA is committed to robust data management processes to accurately document the receipt and distribution of the capitation payment. We will capture and maintain the necessary data to provide accurate reporting and facilitate proper financial oversight throughout the contract term.

K.12.f: Incurred Claims

MCNA actively maintains comprehensive data on incurred but not yet reimbursed claims. We recognize the significance of this data in managing financial operations and monitoring outstanding reimbursements. Through our robust data management processes, we ensure the accuracy and integrity of these records. MCNA remains committed to diligently capturing and documenting incurred but not yet reimbursed claims, enabling us to track and manage outstanding financial obligations effectively. We will continue to prioritize the accuracy and timeliness of this data, facilitating transparent reporting and financial oversight throughout the contract period.

K.12.g: Claims Processing Timeliness

MCNA recognizes the importance of maintaining accurate and comprehensive data on the time required to process and mail claims payments. We understand that this data serves as a critical indicator of our efficiency and timeliness in handling claims transactions. MCNA is committed to robust data management processes to capture and track the time required for processing and mailing claims payments. By maintaining reliable records, we ensure transparency, accountability, and timely reimbursement to providers.

K.12.h: Clinical Data

[redacted]

K.12.i: Grievance and Appeals

MCNA recognizes the importance of maintaining comprehensive data on clinical reviews, appeals, grievances, and complaints, including their outcomes. We understand that this data plays a crucial role in evaluating the quality of our services, addressing concerns, and driving continuous improvement. Through our robust data management processes, we ensure the accurate capture and maintenance of this information. MCNA remains committed to documenting and tracking clinical reviews, appeals, grievances, and complaints, as well as their respective outcomes. By maintaining reliable records, we can effectively monitor trends, identify areas for improvement, and take appropriate actions to enhance the quality of care and address any concerns raised.

K.12.j: Utilization Management

MCNA recognizes the importance of maintaining comprehensive data on services requested, authorized, provided, and denied. We understand that this data is crucial in effectively managing service delivery and ensuring appropriate utilization. Through our robust data management processes, we ensure the accurate capture and maintenance of this information. MCNA is committed to documenting and tracking services requested, authorized, provided, and denied. By

maintaining reliable records, we can effectively monitor service utilization, identify trends, and make informed decisions to optimize care delivery.

K.12.k: Ad Hoc Reporting

MCNA is dedicated to maintaining the capacity to perform ad hoc reporting on an "as needed" basis, in alignment with the Agency's requirements. We understand the importance of flexibility and responsiveness in providing timely and tailored reports to meet specific information needs. MCNA has established robust systems and resources to support ad hoc reporting, ensuring the availability of accurate and reliable data for decision-making purposes. We are committed to collaborating closely with the Agency to understand their reporting priorities and turnaround time expectations.

K.12.l: Service Referrals

MCNA recognizes the importance of maintaining comprehensive data on all service referrals. We understand that tracking and documenting service referrals are essential for coordinating care, monitoring service utilization, and ensuring continuity of care. MCNA is committed to robust data management processes that capture and maintain accurate records of all service referrals. By doing so, we effectively track the status, outcomes, and follow-up actions related to each referral.

K.12.m: Service Specific Information

MCNA understands the importance of maintaining all data in a manner that enables us to generate information specific to service type. We recognize that categorizing and organizing data based on service type allows for more targeted analysis and reporting, leading to enhanced decision-making and improved service delivery. We capture all CDT codes submitted by our dental providers.

K.12.n: Age Specific Information

MCNA understands that age-specific data analysis is crucial for understanding the unique healthcare needs and patterns among different age groups. MCNA is committed to robust data management practices that enable us to generate age-specific information accurately and efficiently. By organizing and structuring our data systems accordingly, we can extract and analyze data to gain insights into the healthcare utilization, outcomes, and trends specific to different age categories.

K.13: General Systems Requirements

MCNA’s proprietary MIS, DentalTrac™, fulfills the following general system requirements:

- Providing online access to authorized users for seamless system accessibility.
- Enabling online access to all major files and data elements within the MIS, ensuring comprehensive data availability.
- Ensuring timely processing of system operations, and optimizing efficiency in our daily activities.
- Supporting daily file updates for member records, provider records, prior authorizations, and claims, facilitating up-to-date and accurate data management.
- Facilitating weekly file updates for reference files and claim payments, ensuring the latest information is available for analysis and decision-making.

K.13.a: Edits, Audits, and Error Tracking

[redacted]

K.13.b: System Controls and Balancing

[redacted]

K.13.c: Back-Up of Processing and Transaction Files

We have established specific backup timelines to safeguard the integrity and availability of essential processes within our systems. To meet these objectives, we employ the following backup timelines:

- Twenty-four (24) hour backup of eligibility verification, enrollment/eligibility update process, and prior authorization processing, ensuring that these vital functions are backed up regularly to minimize any potential data loss and maintain real-time accuracy.
- Seventy-two (72) hour backup of claims processing, providing a backup frequency that balances data security with operational efficiency, ensuring that claims data is backed up periodically to safeguard against potential disruptions.
- Two (2) week backup of all other processes, allowing us to maintain comprehensive backups of other critical processes within our systems, ensuring the availability of historical data for analysis, auditing, and recovery purposes.

[redacted]

K.14: Data Usage and Management

[redacted]

K.15: System Adaptability

[redacted]

[redacted]

Our change management process ensures that standardized methods and processes are followed, maintaining the appropriate balance between the need and potential impact of change. If we identify a required system update, change, or "fix," MCNA submits a written notice as an alert to the Agency within 10 calendar days of identification. Changes include, but are not limited to, major changes, upgrades, modifications, or updates to application or operating software associated with core production systems. We ensure that all appropriate revisions for the documentation or manuals in support of a system update or change are completed electronically and presented to the Agency for review 30 calendar days prior to implementation.

If the Agency notifies MCNA of a system issue or defect, we respond to the inquiry within five (5) business days with either an explanation of the issue (not a defect) or our root cause analysis of the issue and plans for corrective action. MCNA will correct minor issues within fifteen (15) business days or if the issue is more complex, we will develop and publish a requirements analysis and proposed corrective action specifications document for the Agency's review and approval. This document will contain the proposed implementation date for the correction for the Agency's consideration and approval. [redacted]

K.16: Information System Plan

MCNA acknowledges the critical importance of protecting health information data and maintaining compliance with HIPAA standards for electronic exchange, privacy, and security requirements. We incorporate these comprehensive policies into our Privacy and Security Program Manual (PPM) which aligns with these HIPAA regulations. The policies and procedures adhere to the requirements outlined in 45 C.F.R. Parts 160, 162, and 164, as well as the HIPAA Security Rule at 45 C.F.R. § 164.308.

[redacted]

[redacted]

K.17: Information Services Staff

[redacted]

The technical helpdesk will serve as a central point of contact for our trading partners and business associates. Our knowledgeable support staff will provide timely assistance, address inquiries, and offer guidance on system usage and troubleshooting.

[redacted]

K.18: HIPAA Compliance

[redacted]

In compliance with HIPAA requirements, including 45 CFR § 164.520, MCNA has developed a privacy notice that explains in plain language the rights of individuals with respect to their personal health information and MCNA's privacy practices. We send our Notice of Privacy Practices to members in their New Member Welcome Packet and publish it on our website.

We maintain and enforce policies and procedures which serve as written safeguards to restrict the use and disclosure of information concerning our members for purposes directly connected with the performance of the contract. We also

ensure member privacy by requesting written member authorization before sharing or disclosing any information about the member.

[redacted]

K.19: Compliance with State Law - K.20: Compliance with State Procedures

MCNA is dedicated to upholding the highest standards of compliance and confidentiality in relation to individual medical records, health information, and enrollment information concerning our members. This commitment extends to all forms of information that identify specific members.

To ensure compliance, Company MCNA will adhere to State procedures in accordance with Subpart F of 42 C.F.R. part 431, as mandated by 42 C.F.R. § 457.1233(e), 42 C.F.R. § 457.1110(a). and 42 C.F.R. § 457.1110(b). We recognize the importance of abiding by these regulations and will take the necessary steps to comply with them effectively. In addition, our commitment to safeguarding privacy and confidentiality aligns with the requirements outlined in the CHIP checklist J.7.01 and CHIP checklist J.7.02.

[redacted]

K.21: Timely and Accurate Records

MCNA is committed to complying with State procedures to maintain the individual medical records, health information, and enrollment information of our members in a timely and accurate manner. This commitment applies to any information that identifies specific members.

To ensure compliance, MCNA will follow the State procedures outlined in 42 C.F.R. § 457.1233(e) and 42 C.F.R. § 457.1110(c). We are dedicated to maintaining the accuracy and timeliness of members' individual medical records, health information, and enrollment information. Our commitment to these practices highlights our focus on protecting the privacy and security of our members' sensitive information. We continually monitor and improve our data management processes to ensure that our members' records and information are kept up-to-date and reliable.

[redacted]

[redacted]

K.22: Purposes of Maintenance or Use

MCNA is committed to compliance and transparency when it comes to individual medical records, health information, and enrollment information of our members. This commitment extends to any information that identifies specific members.

To ensure compliance, MCNA will follow State procedures that specify and make available to any member, upon request, the purposes for which their information is maintained or used. This requirement aligns with 42 C.F.R. § 457.1233(e) and 42 C.F.R. § 457.1110(d)(1).

If a member has questions regarding the purposes for which their information is maintained or used, we will readily provide them with the necessary information in accordance with State procedures. We strive to exceed legal requirements and industry standards to ensure the confidentiality, transparency, and privacy of our members' personal health and enrollment information.

K.23: Purposes of Disclosure

MCNA is committed to complying with State procedures and ensuring transparency regarding individual medical records, health information, and Enrollment information related to our members. This commitment applies to any information that identifies specific members.

To guarantee compliance, MCNA will adhere to State procedures that clearly specify and make available, upon request by any member, information regarding to whom and for what purposes their information will be disclosed outside the State. This requirement aligns with 42 C.F.R. § 457.1233(e) and 42 C.F.R. § 457.1110(d)(2).

K.24: Timely Provision of Information to Member

MCNA is dedicated to upholding compliance and facilitating access to individual medical records, health information, and Enrollment information concerning our members. This commitment encompasses any information that identifies specific members.

To ensure compliance, MCNA will adhere to State procedures that, with the exception of provisions outlined by Federal and State law, guarantee that each member has the right to request and receive a copy of their records and information in a timely manner. This requirement aligns with 42 C.F.R. § 457.1233(e) and 42 C.F.R. § 457.1110(e).

We are dedicated to ensuring that each member has the ability to request and receive a copy of their individual medical records, health information, and enrollment information within a reasonable timeframe, except when prohibited by applicable laws. If any member wishes to obtain their records and information, we will promptly facilitate the process in compliance with State procedures.

K.25: Supplementing and Correcting Records

MCNA is committed to compliance and empowering members by providing access to their individual medical records, health information, and Enrollment information. This commitment applies to any information that identifies specific members.

To ensure compliance, MCNA will adhere to State procedures that, with the exception of provisions outlined by Federal and State law, guarantee each member's right to request and receive a copy of their records and information pertaining to them. Additionally, members have the right to request supplementation or correction of their records or information. These requirements are in accordance with 42 C.F.R. § 457.1233(e) and 42 C.F.R. § 457.1110(e).

If any member wishes to obtain their records, request updates, or corrections, we will promptly facilitate the process in compliance with State procedures. Our commitment is to exceed legal requirements and industry standards in ensuring the confidentiality, transparency, and accessibility of our members' personal health and enrollment information.

K.26: Interface with State Systems

K.26.a: The Agency MMIS

MCNA has the capacity to submit encounter data, as described in Section K.42, to the MMIS in the manner and timeframe specified by the Agency.

K.26.b: The Agency Title XIX Eligibility System

MCNA has the capability to electronically receive enrollment information through a file transfer process.

[redacted]

[redacted] MCNA has been exchanging data with the Agency through the use of HIPAA-compliant transaction code sets, HL7, and we can accommodate other proprietary data exchange formats.

[redacted]

K.27: Use of Common Identifier

MCNA acknowledges the importance of utilizing a common identifier to establish a linkage between databases and computer systems, as required by the contract. We are committed to the protection of members' sensitive information. Therefore, we strictly adhere to the policy that prohibits the publication, distribution, or any form of availability of members' social security numbers.

K.30: Clinical Records

MCNA recognizes the importance of maintaining comprehensive information within its Information System (IS) to support the authorization and monitoring of services, as well as to provide essential data for quality assessment and other evaluative activities. All clinical records generated by the MCNA will become the property of the Agency upon the conclusion of the contract. MCNA will transfer clinical records upon request, without incurring any additional costs. Our clinical record maintained in the Information System (IS) encompasses various essential components, including but not limited to the following:

- **Diagnosis**: Comprehensive documentation of diagnoses.
- **Services Authorized**: Documentation of clinical services requested, services authorized, services substituted, and services provided. This documentation shall accurately reflect the application of utilization management (UM) criteria.
- **Services Denied**: Documentation of services not authorized, including reasons for the non-authorization based on the Agency Administrative Code citations, as well as any substitutions offered.
- **Missed Appointments**: Documentation of missed appointments and subsequent efforts made to follow up with the member.
- **Treatment Planning**: Documentation of joint treatment planning, clinical consultation, or any other interaction involving the member, providers, and/or funders responsible for providing or seeking to provide services to the member.
- **Joint Treatment Planning**: Identification of the key individuals involved in the treatment planning process for members who access multiple services.

[redacted]

We view participating in HIE as paramount to the proper and fiscally responsible delivery of care for our members. MCNA will actively participate in the Iowa health information exchange and leverage the system's capabilities to ensure providers and members have seamless access to the most relevant information at the right time. We look forward to working with the Agency to promote the use of these technologies and to sharing our knowledge and experience in making these solutions work for the state, providers, and members.

[redacted]

K.31: System Problem Resolution - K.32: Escalation Procedures

[redacted]

[redacted]

K.33: Release Management

[redacted]

[redacted]

When implementing a planned system change, MCNA ensures that system unavailability is scheduled during hours that will not compromise or prevent critical business operations. [redacted]

In all cases, any planned system change will meet all notification requirements stated in this RFP.

K.34: Environment Management

[redacted]

When implementing a planned system change, MCNA ensures that system unavailability is scheduled during hours that will not compromise or prevent critical business operations. [redacted]

In all cases, any planned system change will meet all notification requirements stated in this RFP.

K.35: Contingency and Continuity Plan - K.36: Information Systems Contingency Planning and Execution

K.35.a: Continuity Planning

MCNA has established comprehensive continuity planning and execution processes to ensure the seamless provision of mission-critical business functions and processes in the event of a Disaster. These activities encompass all necessary elements, including activities, processes, and resources required to sustain essential operations. At MCNA, continuity planning is closely coordinated with information system contingency planning to ensure alignment and effectiveness. In addition, MCNA has developed processes and strategies for restoring critical business functions. These processes outline the steps to be taken to resume operations, whether at the existing location or an alternate site if necessary.

K.35.b: General Responsibilities

MCNA has developed comprehensive contingency and continuity planning documents, which have been submitted and documented in its PPM. We are committed to ongoing maintenance and execution of the Agency-accepted contingency and continuity plans. MCNA will ensure prompt notification to the Agency in the event of any disruptions in normal business operations, accompanied by a well-defined plan outlining the steps to be taken to resume normal operations, minimizing any potential impact on participants receiving services. MCNA prioritizes the safeguarding and accessibility of data during any disruptions, ensuring that data remains secure and available for continued operations. This includes implementing appropriate measures to protect sensitive information and maintaining robust backup and recovery processes.

To ensure readiness and familiarity with the contingency and continuity plans, MCNA conducts regular training for its staff and stakeholders. This training ensures that all relevant parties understand their roles and responsibilities in executing the plans effectively. MCNA conducts annual exercises to test the current versions of the information system contingency and continuity plans.

K.36: IS Contingency Planning and Execution

MCNA has developed IS contingency planning in compliance with 45 C.F.R. § 164.308. Our comprehensive contingency plans include data backup plans, disaster recovery plans, and emergency mode of operation plans. We have also addressed application and data criticality analysis, as well as testing and revision procedures within these plans. Our implemented measures ensure the protection against hardware, software, and human errors, while maintaining reliable telecommunications, file backups, and disaster recovery capabilities. The execution of these activities enables us to recover and restore our information systems, data, and software within twenty-four (24) hours under emergency conditions.

[redacted]

[redacted]

[redacted]

[redacted] MCNA has the capability to continue receiving, processing, and disseminating data and reports within 24 hours of a disaster situation.

[redacted] MCNA currently provides data backup in accordance with the requirements of this RFP.

[redacted]

MCNA will provide the Agency with business resumption documents, including our comprehensive and fully tested BCDR and other facility plans, and related documents as identified by the Agency, for review and coordination with the Agency's IT business continuity/disaster recovery plans and other State solutions with which MCNA's system interfaces to ensure appropriate, complete, and timely recovery.

[redacted]

[redacted]

[redacted]

K.37: Back-Up Requirements

MCNA understands the criticality of data and software backups and is committed to maintaining full and complete copies of them in accordance with the timelines specified in Section K.13. [redacted]

At the conclusion of the contract, whether it is the end date or termination date, MCNA will be responsible for returning all Iowa DWP and Hawki-related data to the Agency. This process ensures that the Agency retains ownership and control of its data, allowing for continuity and future use as needed.

[redacted]

[redacted]

K.38: Data Exchange

MCNA recognizes the importance of data consistency and interoperability and acknowledges the Agency's requirement for standardized data formats. Therefore, when sharing data with the Agency, MCNA will adhere to the format specified by the Agency. This includes using the prescribed data format and ensuring that all code fields contain valid values that align with the Agency's accepted codes.

[redacted] MCNA can exchange data with the Agency's current MMIS and Fiscal Intermediary using HIPAA-compliant transaction code sets, HL7, and other proprietary data exchange formats.

[redacted]

The DentalTrac™ MIS can process all HIPAA-standard file formats along with custom file formats as required by trading partners.

[redacted]

MCNA understands the need for a smooth transfer of core data to support member care as specified in the CURES Act, including the United States Core Data for Interoperability (USCDI). [redacted] MCNA does not engage in practices that are considered information blocking under the CURES Act. Electronic health data will be available to members at no cost to them and our compliance with Fast Healthcare Interoperability Resources (FHIR) Application Programming Interfaces (APIs) will ensure smooth data exchange across payers, members, and other involved entities. We have designed our proprietary MIS specifically to be able to integrate with other systems seamlessly and securely for the proper management and support of managed care Medicaid programs.

K.39: Member Enrollment Data

K.39.a: Member Enrollment Data Exchange

MCNA currently receives, processes, and updates the HIPAA-compliant 834 Enrollment file from the Agency using our powerful, fully integrated MIS, DentalTrac™. Upon receiving the 834 Enrollment files, MCNA loads the member data into our systems for use in eligibility verification, claims processing, and other functions that rely on member data.

[redacted] If MCNA encounters any issues preventing the retrieval or loading of eligibility data, it will promptly notify both the sending trading partner and the Agency on the same business day of transmission.

MCNA maintains detailed documentation of the extraction, transformation, and load (ETL) processes it employs. MCNA agrees not to modify member identifiers, eligibility categories, or other member data elements without written approval from the Agency.

K.39.b: Reconciliation Process

MCNA acknowledges its responsibility to reconcile member eligibility data and capitation payments to ensure accuracy and consistency. In line with this commitment, MCNA conducts monthly reconciliations of its eligibility and capitation records. If any discrepancies in eligibility or capitation records are identified during the reconciliation process, MCNA will promptly notify the Agency using the specified communication method determined by the Agency.

In cases where MCNA identifies overpayments or discrepancies that require a return of capitation funds, MCNA will follow the procedures established by the Agency. MCNA will initiate the return of any capitation or overpayments to the Agency within sixty (60) days of discovering the discrepancy. If MCNA receives either enrollment information or capitation for a member, MCNA will be financially responsible for the member unless MCNA has not received capitation for that member ninety (90) days following notification to the Agency that a capitation was not received.

K.40: Provider Network Data

MCNA recognizes the importance of maintaining accurate and up-to-date provider network information for effective program management. In accordance with the requirements set forth by the Agency, MCNA will submit provider network information to the Agency in an electronic file format within the specified timeframe and according to the defined submission procedures.

[redacted]

[redacted] DentalTrac™'s EDI module supports the automated processing of HIPAA ASC X12N 270/271/834 transaction files as well as proprietary layout enrollment data on a daily, weekly, and monthly basis as required by our clients. [redacted]

K.41: Claims Processing

Attachment J, K.41.a: Claims Processing

[redacted]

ur claims and encounter MIS capabilities are in production today managing all our lines of business where we have met or exceeded the performance requirements specified in this SOW.

[redacted]

[redacted]

Our DentalTrac™ system and associated claims payment procedures ensure that we meet and exceed all claims requirements specified in this RFP.

Attachment J, K.41.b: Standardizing Claims Processing

[redacted]

K.41.a Claims Processing Capability

MCNA assumes responsibility for processing and reimbursing provider claims for services rendered to members, employing a comprehensive claims processing system capable of handling various types of Claims from both in- and out-of-network providers. [redacted] limits for out-of-network and in-network providers will be set at twelve (12) months and no more than one hundred and eighty (180) Days from the date of service, respectively, aligning with regulatory requirements and contractual agreements described in Section E.1.

[redacted] Our system and portals will remain available to providers and members 24 hours per day, 7 days per week, with exceptions for scheduled maintenance. Should there be any unscheduled maintenance related to a defect within our control, system availability will be restored within 48 hours.

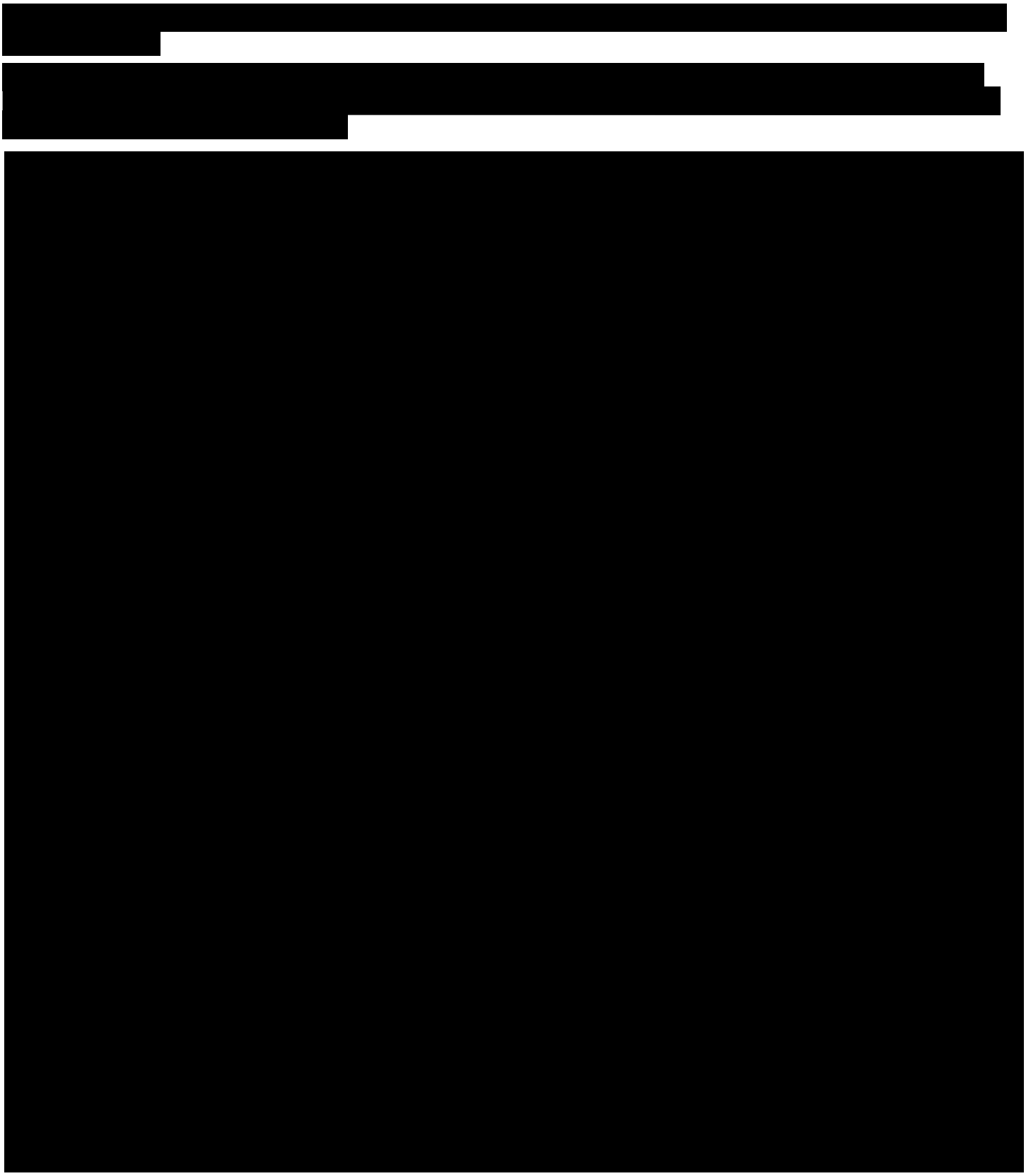
[redacted]

[redacted] Our MIS and associated claims payment procedures ensure that we continue to meet and exceed all claims requirements specified by the Agency.

[redacted]

Our fully HIPAA and ICD-10 compliant claims management system supports all HIPAA-approved code sets and industry standard taxonomies and code sets. These include National Provider Identifier (NPI), place of service codes, diagnosis codes, procedure codes (CDT and others), and Claim Adjudication Reason Codes (CARCs). Our system accepts and correctly processes International Classification of Diseases, 10th revision, (ICD-10) diagnosis codes on any claims sent in by any network provider in all current markets. Our system is highly flexible and will be configured as needed to support Iowa DWP and Hawki. This includes all needed fee schedule updates and CMS-required changes.

[redacted]



K.41.b: Claims Disputes

[redacted]

K.41.c: Compliance with State and Federal Claims Processing Regulations

We make every effort to be a responsible partner to the Agency as it completes its responsibilities and look forward to continuing our successful relationship with Iowa DWP and Hawki staff, the Iowa dental community, and key stakeholders across the state as we continue to improve the oral health of the members we serve.

MCNA is fully compliant with the requirements outlined in Iowa Admin. Code r. 441-80.2 concerning claims forms. In addition, MCNA complies with relevant federal regulations, including HIPAA regulations pertaining to transactions, code sets, confidentiality, and submission requirements for Protected Health Information (PHI). In alignment with 42 U.S.C. § 1396u-2(d)(4), MCNA requires each physician providing services to members to possess a standard unique health identifier. Additionally, MCNA mandates that all providers submitting claims have a national provider identifier (NPI) number, unless otherwise directed by the Agency, in accordance with 45 C.F.R. § 162.410.

K.41.d: Out-of-Network Claims

MCNA does not impose a requirement for out-of-network providers to establish an MCNA-specific number in order to receive payment for claims submitted.

K.41.e: Coordination Among Contractors

[redacted]

K.41.f: Member Cost Sharing

MCNA acknowledges that certain members, as outlined in Section F.8.06, may be responsible for cost sharing. MCNA is committed to reducing the payment made to providers by the exact amount of the member's cost sharing obligation. In order to facilitate this process, MCNA will establish a mechanism, subject to prior approval from the Agency, to effectively communicate a member's financial participation or cost sharing requirement to providers.

K.41.g: Audit

MCNA acknowledges and recognizes that the Agency retains the right to conduct random sample audits of all claims. In full compliance with the audit requirements, MCNA is committed to providing all requested documentation, including provider claims and encounter submissions, in the specific form, manner, and timeframe specified by the Agency.

MCNA's review auditing process is focused on ensuring that Medicaid is the payer of last resort and that all dollars allocated to the Medicaid and CHIP programs are used to benefit our members through appropriate coverage of dental care services. Our comprehensive auditing policies and procedures address elements that ensure compliance with all internal key performance metrics and regulatory requirements.

K.42: Encounter Claim Submission - K.45: Encounter Claims Policies

Attachment J, K.42.a: Building Encounter Data Files That Comport State Data File Layout

[redacted]

MCNA will transmit to the Agency or its agent complete encounter data and change history weekly or on any other schedule required by the Agency. In addition, MCNA will transmit encounter data to the state's actuary when requested. All encounter data submitted will be produced in an electronic format that adheres to Agency-approved data specification for content, content definitions, format, file structure, and data quality. [redacted]

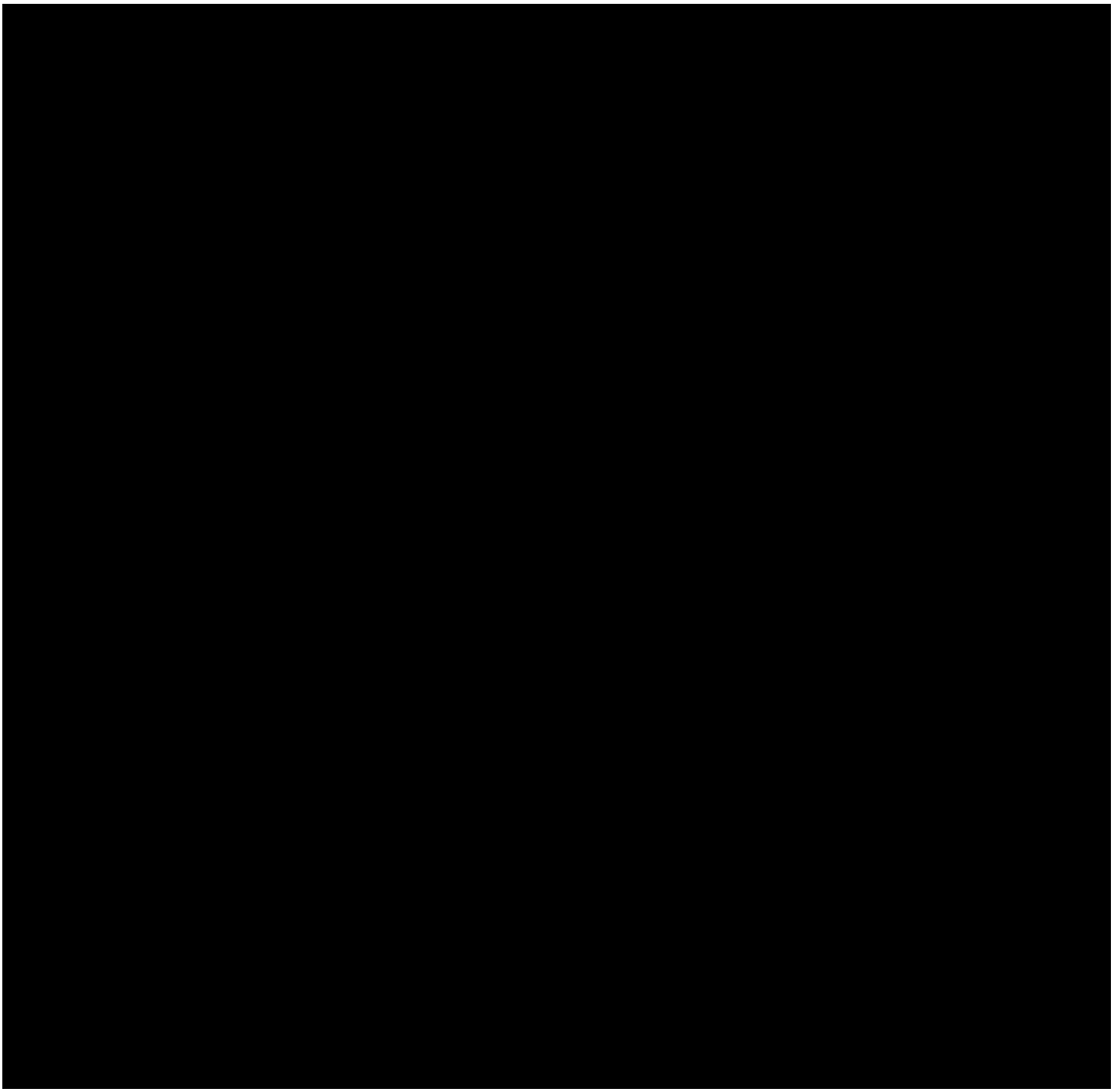
Encounter data includes all new claims and claim adjustments performed and paid to providers during the reporting period, along with value-added services without any associated costs. As a fully HIPAA- and Iowa DWP and Hawki-compliant claims and encounter management system, DentalTrac™ requires the use of HIPAA-approved and industry-standard taxonomies and code sets. These include National Provider Identifier (NPI), place of service codes, diagnosis codes (ICD-10), procedure codes (CDT and others), and Claim Adjudication Reason Codes (CARC). All encounter data elements delivered comply with industry-standard code sets for procedure codes, diagnosis codes, and provider identifiers and will comply with any other code set requirement specified by Agency.

[redacted]

[redacted]

Encounter data includes all new claims and claim adjustments performed and paid to providers during any reporting period, along with Value-Added Services without any associated costs. As a fully HIPAA-compliant MIS, DentalTrac™ requires the use of HIPAA-approved and industry-standard taxonomies and code sets. These include National Provider

Identifier (NPI), place of service codes, diagnosis codes (ICD-10), procedure codes (CDT and others), and Claim Adjudication Reason Codes (CARC).



Attachment J: K.42.b. Identifying Encounter Data Abnormalities

[redacted]

Attachment J, K.42.c: Ensuring Encounter Data Quality and Timeliness

[redacted]

[redacted]

We acknowledge that MCNA's CEO, CFO, or CIO shall certify the truthfulness, accuracy, and completeness of all enrollment information, encounter data, payment data, and other information submitted to the State for purposes of developing vendor payment in compliance with applicable certification requirements for data and documentation specified by the Agency pursuant to 42 C.F.R. §§438.604, 438.606, and 457.1201. We understand that compliance with the requirements for data certification in this agreement is a condition for payment by the government and we agree to comply with all applicable laws and regulations.

[redacted]

K.42: Encounter Claim Submission

MCNA will obtain Agency approval of all policies and procedures used to support encounter claim reporting and will strictly adhere to Agency-approved policies and procedures as well as standards defined by the Agency for items such as the file structure and content definitions.

K.43: Definition of Uses of Encounter Claims

MCNA acknowledges its responsibility to submit an encounter claim to the Agency or its designee for every service provided to a member, whether reimbursement was granted or denied. To ensure comprehensive reporting, MCNA ensures that encounter data accurately reflects individual member encounters within its provider network. These claims include detailed information on procedures, diagnoses, place of service, units of service, billed amounts, reimbursed amounts, and providers' identification numbers, mirroring the level of detail found in fee-for-service equivalent claims.

K.44: Reporting Format and Batch Submission Schedule

MCNA acknowledges its obligation to submit encounter claims in an electronic format that complies with the data Specifications established by the Agency, as well as any State or federally mandated electronic claims submission standards. MCNA will submit all encounter data by the twentieth (20th) day of the subsequent month, reflecting the data for the previous month. Any necessary corrections to the monthly encounter data submission will be completed within 45 days from the date the initial error report was issued by the Agency, or within 59 days from the original encounter data deadline. MCNA will ensure that the error rate for encounter data does not exceed 1%, and any system edits or analysis can be utilized to identify the source of errors.

K.45.a: Accuracy of Encounter Claims

MCNA has implemented robust policies and procedures to ensure the accuracy of encounter Claims submissions. MCNA will submit timely and accurate reports in the format and timeframe specified by the Agency. In case of report inaccuracies, MCNA will investigate the root cause and provide a revised report within the timeframe designated by the Agency. MCNA will fully cooperate with the audit requirements, providing all requested documentation, including medical records and prior authorizations.

[redacted]

K.45.b: Encounter Data Completeness

MCNA has established a comprehensive system for monitoring and reporting the completeness of claims and encounter data received from providers and a system to verify and ensure that providers do not submit claims or encounter data for services that were not actually provided. MCNA has established internal standards to measure the completeness of data and conducts regular completeness studies. In addition, MCNA regularly monitors the completeness of claims and encounter data to ensure compliance with Agency requirements.

[redacted]

[redacted]

K.46: PA Tracking Requirements

MCNA has implemented a system to track all Prior Authorization requests. MCNA ensures that all notes related to PA requests are signed by clinical staff and include the appropriate suffix to indicate the staff member's professional designation (e.g., DDS, RDH, RN, etc.). In cases where PAs are approved, MCNA provides a unique PA number to the requesting provider. Additionally, MCNA maintains a record of essential information, including the name and title of the individual initiating the request, the date and time of the call, fax, or online submission, the Prior Authorization number assigned, the time taken to reach a determination from the receipt of the request, and the count of approvals and denials.

[redacted]

K.47: Prior Authorization Denials

For all denials of PA requests, MCNA maintains a record of the following information in our system (i) name and title of caller or submitter, (ii) date and time of call or submission, (iii) clinical synopsis inclusive of the timeframe of illness or condition, diagnosis and treatment plan; and (iv) clinical guidelines or other rational supporting the denial (i.e. insufficient documentation).

[redacted]

K.48: Application Programming Interface (API)

MCNA has implemented an API that aligns with the criteria in 42 CFR 431.60 and includes:

- MCNA's API provides timely access to data related to adjudicated claims, including information on payment decisions that may be appealed, were appealed, or are currently in the process of appeal. Additionally, our API includes comprehensive details regarding provider remittances and member cost-sharing associated with these claims. We ensure that this data will be made available no later than one (1) business day after the processing of each claim.
- Our API also incorporates encounter data, encompassing information from network providers compensated through capitation payments, as well as adjudicated claims and encounter data received from subcontractors. This data will be accessible through our API no later than one (1) business day after receiving it from providers, facilitating efficient and seamless integration with your systems.
- MCNA will maintain clinical data no later than one (1) business day after the data is received by the Agency.
- MCNA is committed to ensuring compliance with the regulatory standards set forth in 42 CFR 431.70. Our API implementation adheres to these guidelines and includes all provider directory information specified in 42 CFR 438.10(h)(1) and (2).

[redacted] Our system will accept outbound ANSI ASC X12 834 Benefit Enrollment and

Maintenance from the Agency and the Agency's MMIS. Our Eligibility and Enrollment module is completely interoperable with all other aspects of DentalTrac™, allowing for Iowa DWP and HAWKI members to be identified uniquely across multiple populations housed in our system.

K.49: Education and Outreach

Section M: Termination

M.01: Contractor's Termination Duties

MCNA understands and acknowledges that the transition period shall begin upon any of the following triggering events:

a) Contract termination;
b) Notice issued by either party of an intent to not extend this contract for a subsequent extension period; or
c) If the contract has no remaining extension periods, ninety (90) days before the natural contract termination date.

M.02: Authority to Withhold

We acknowledge the Agency's authority to withhold our final capitation and any other payments due until MCNA has received the Agency approval of its Transition Plan and completed all the Transition Plan activities including any additional activities requested by the Agency, to the satisfaction of the Agency which retains sole discretion to determine whether MCNA has satisfactorily completed the transition responsibilities pursuant to the Agency-approved Transition Plan.

M.03: Transition Period Obligations

Our Transition Plan ensures coordination of dental services including how services will be maintained throughout the transition process. At the end of this contract, MCNA will work cooperatively with the Agency to ensure an efficient and timely transition of contract responsibilities with minimal disruption of service to members and providers. MCNA will complete all contractual obligations as set forth in RFP Attachment F: Contract and Scope of Work (SOW): M.03.a-t.

The objective of the Transition Plan is to provide for an orderly, complete, and controlled transition and to ensure uninterrupted and efficient services to members, providers, and the Agency during the transition period. The following topics are discussed and agreed upon regarding MCNA's turnover management approach:

- Designated MCNA Transition Manager responsible for transition and post-transition activities
- Assumptions and constraints
- Data transfer (specifically open prior authorizations)
- Post-transition activity
- Tasks, subtasks, and schedule for all transition activities

M.04: Post-Transition Contract Obligations

We recognize that the termination or expiration of the contract does not discharge our obligations with respect to services or items furnished before termination or expiration of the contract, nor does it discharge the Agency's payment obligations to MCNA or our payment obligations to subcontractors and providers. Upon any termination or expiration of this Contract, in accordance with the provisions in the RFP Attachment F: Contract and SOW, MCNA will:

a) Appoint a liaison for post-transition activities.

b) Provide the Agency, or its designated entity, all records related to MCNA's activities undertaken pursuant to the contract, in the format and within the timeframes set forth by the Agency, which shall be no later than 30 days of the request. We agree that such records shall be provided at no expense to the Agency or its designated entity.

c) Participate in the External Quality Review (EQR), as required by 42 C.F.R. Part 438, Subpart E, for the final year of the contract.

d) Maintain the contractual financial requirements such as fidelity bonds and insurance coverage until the Agency provides MCNA with written notice that all continuing obligations of the contract have been fulfilled.

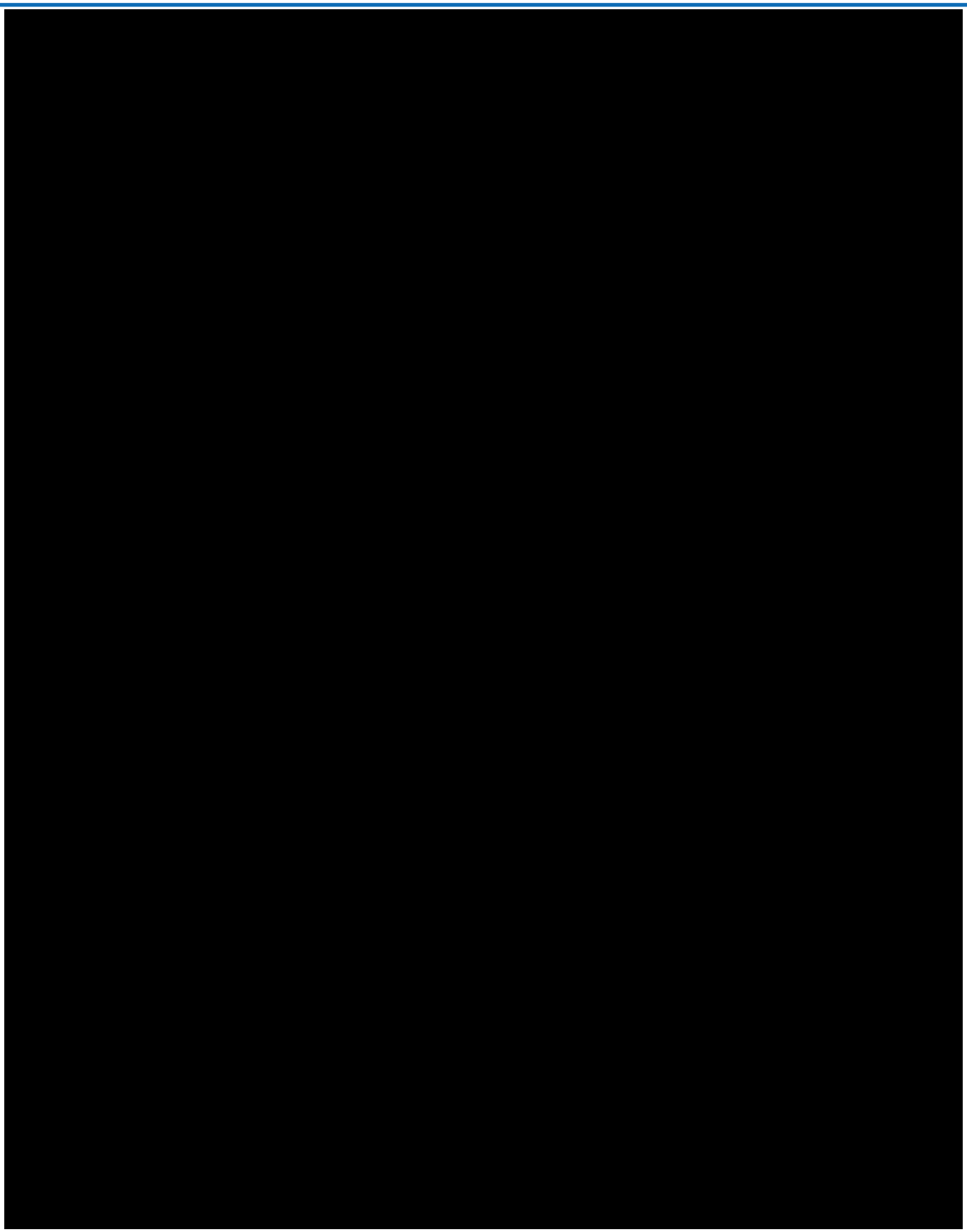
e) Submit transition progress reports to the Agency every 30 days. The Agency will notify MCNA once our revised final report evidencing that we have fulfilled all continuing obligations.

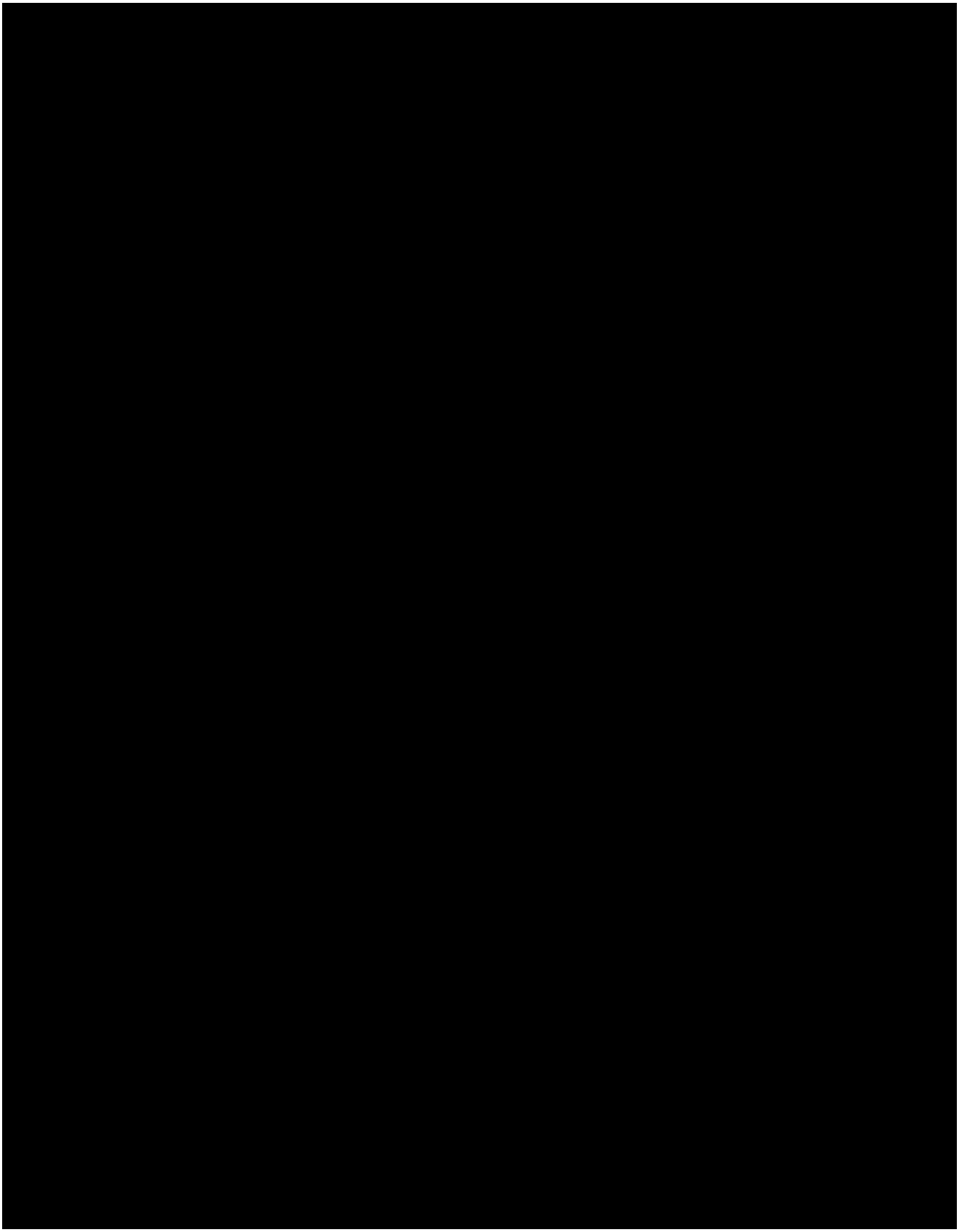
f) Remain responsible for resolving member grievances and appeals with respect to dates of service prior to the day of contract expiration or termination, including grievances and appeals filed on or after the day of contract termination or expiration but with dates of service prior to the day of contract termination or expiration.

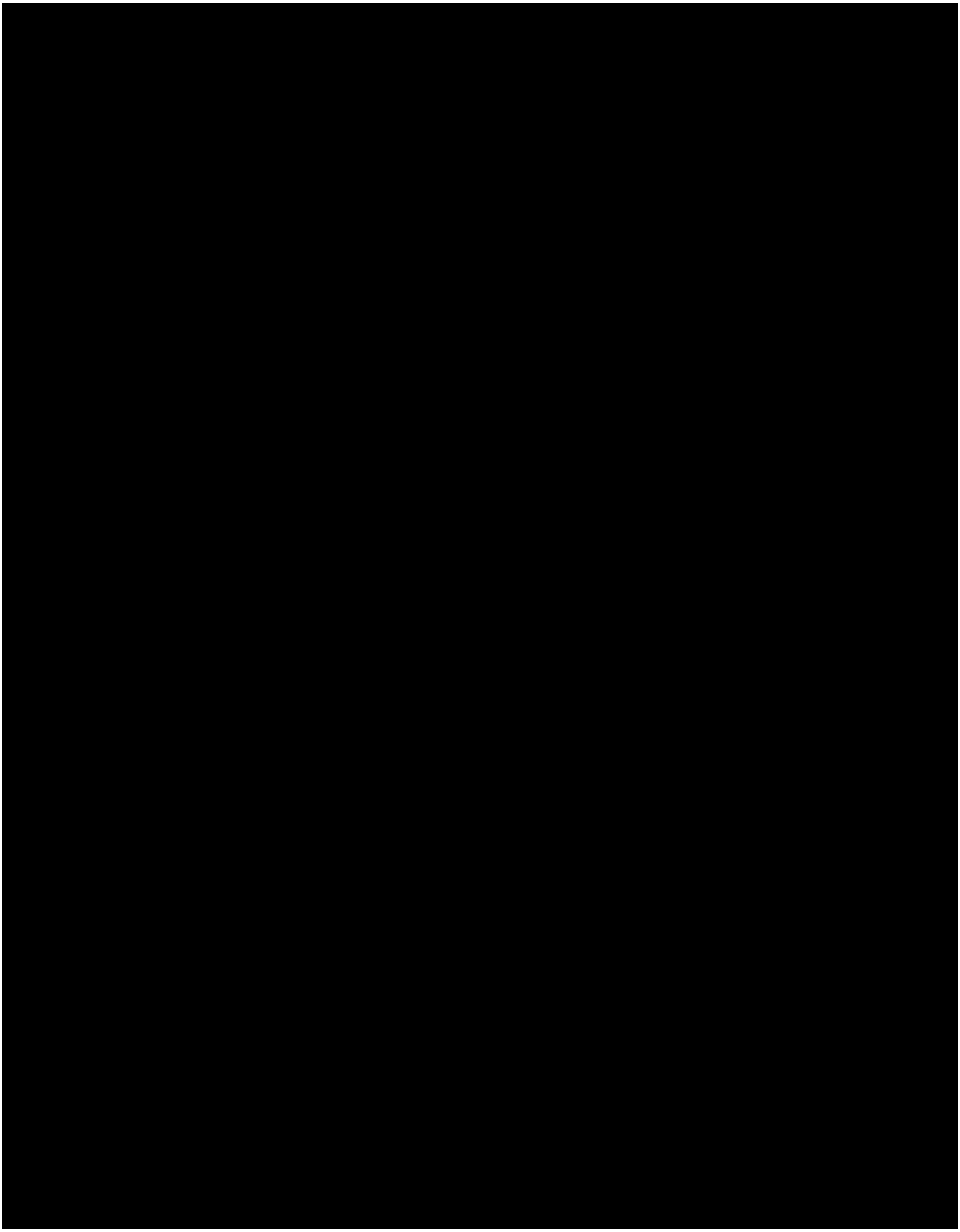
g) Maintain claims processing functions as necessary for a minimum of 12 months in order to complete adjudication of all claims for services delivered prior to the contract termination or end date, as well as any time period beyond twelve (12) months to the extent necessary to complete adjustments of all timely claims.

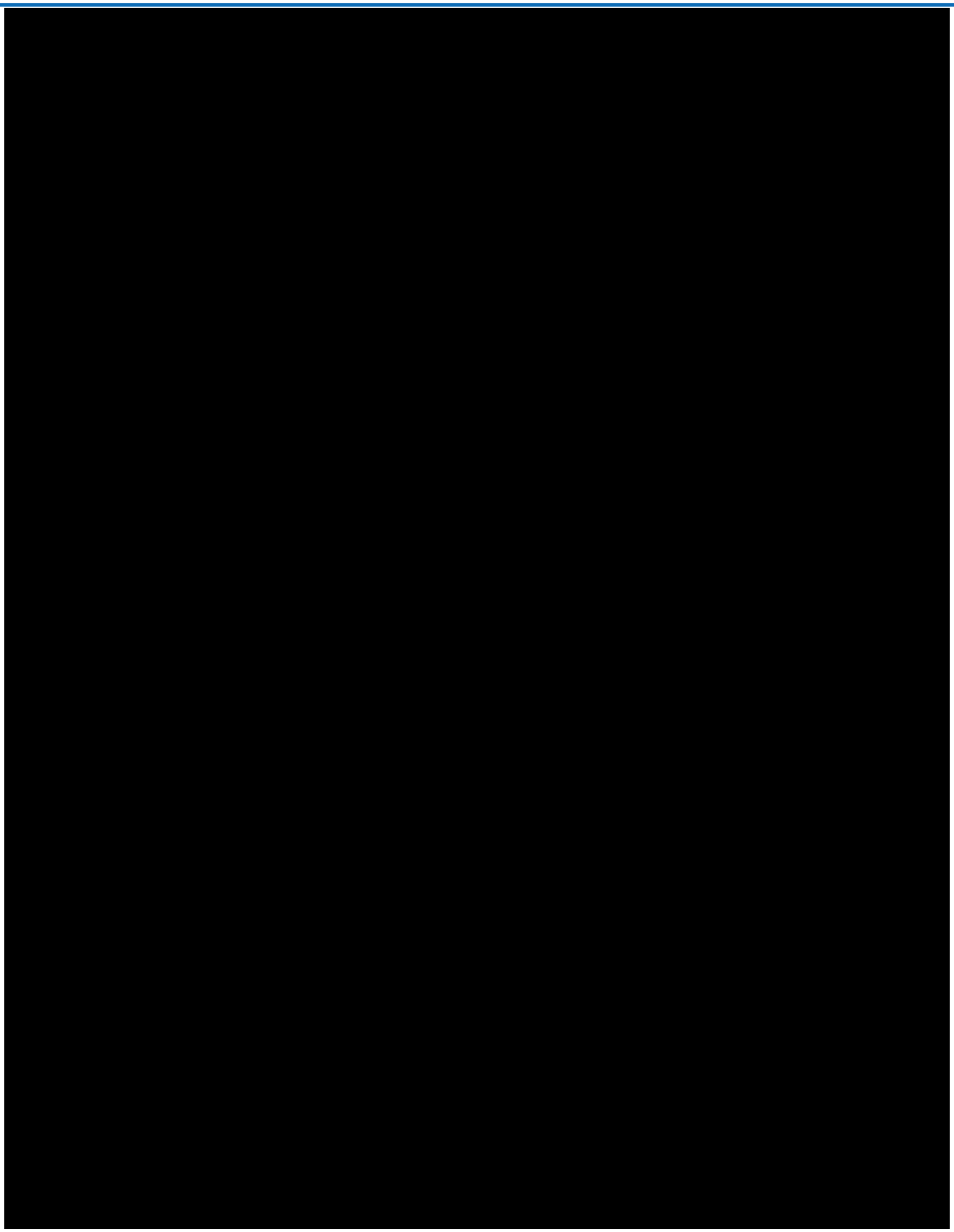
h) Cooperate with audits conducted by the Agency, CMS, the Office of the Inspector General, and their Designees, as outlined in J.1.02 and in accordance with 42 CFR 438.3(h).

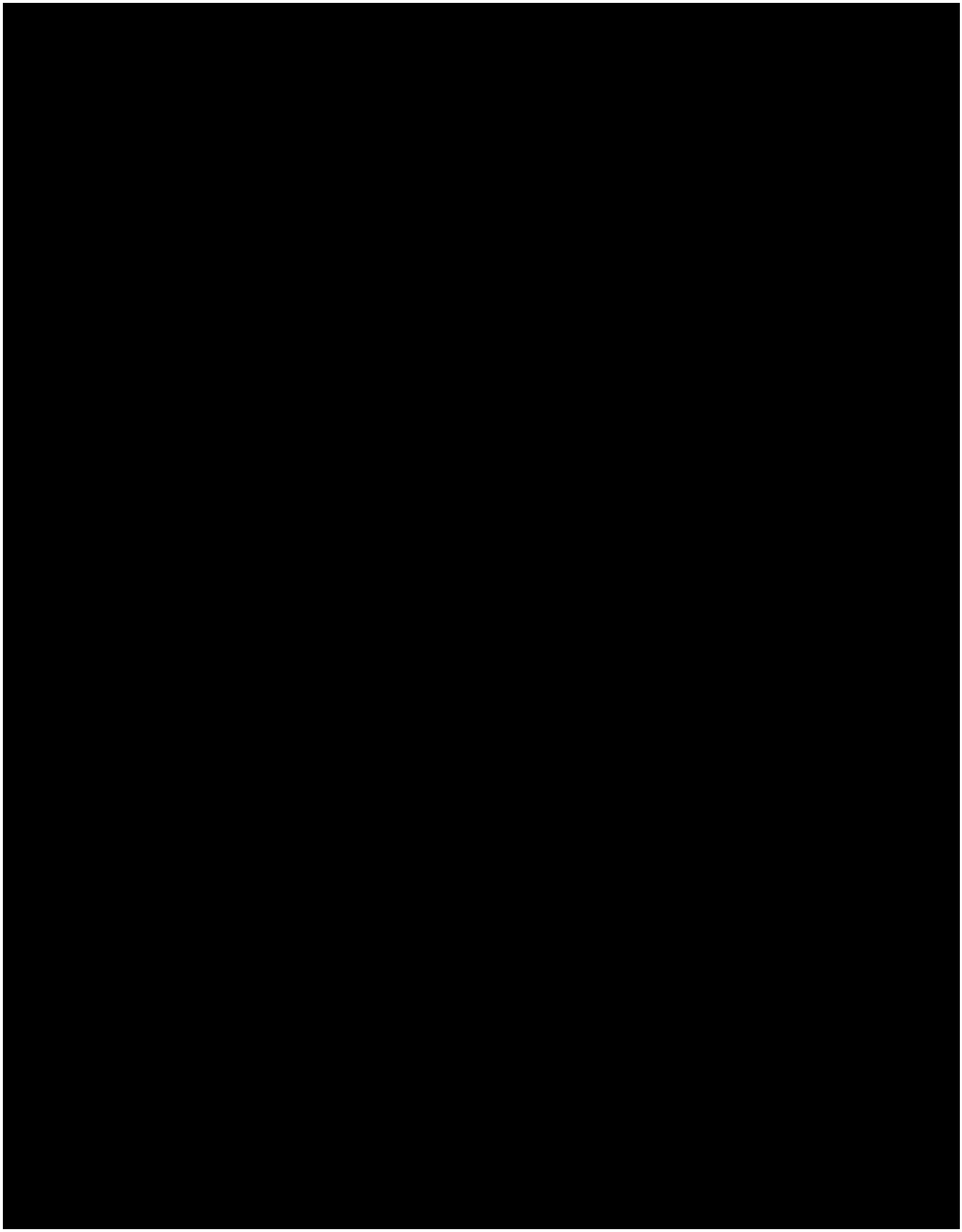
Please see the following sample MCNA Transition Plan for Nebraska Medicaid.

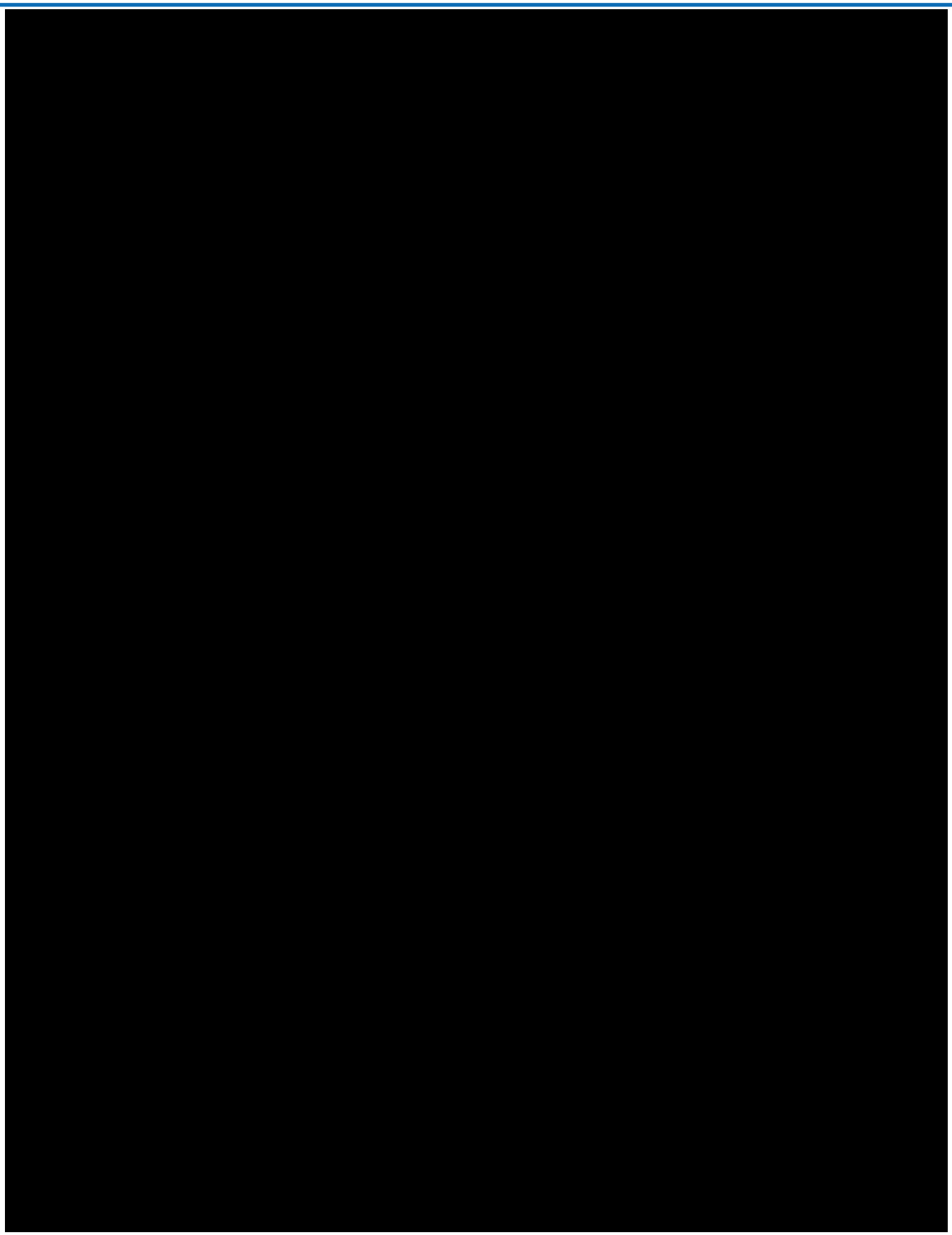


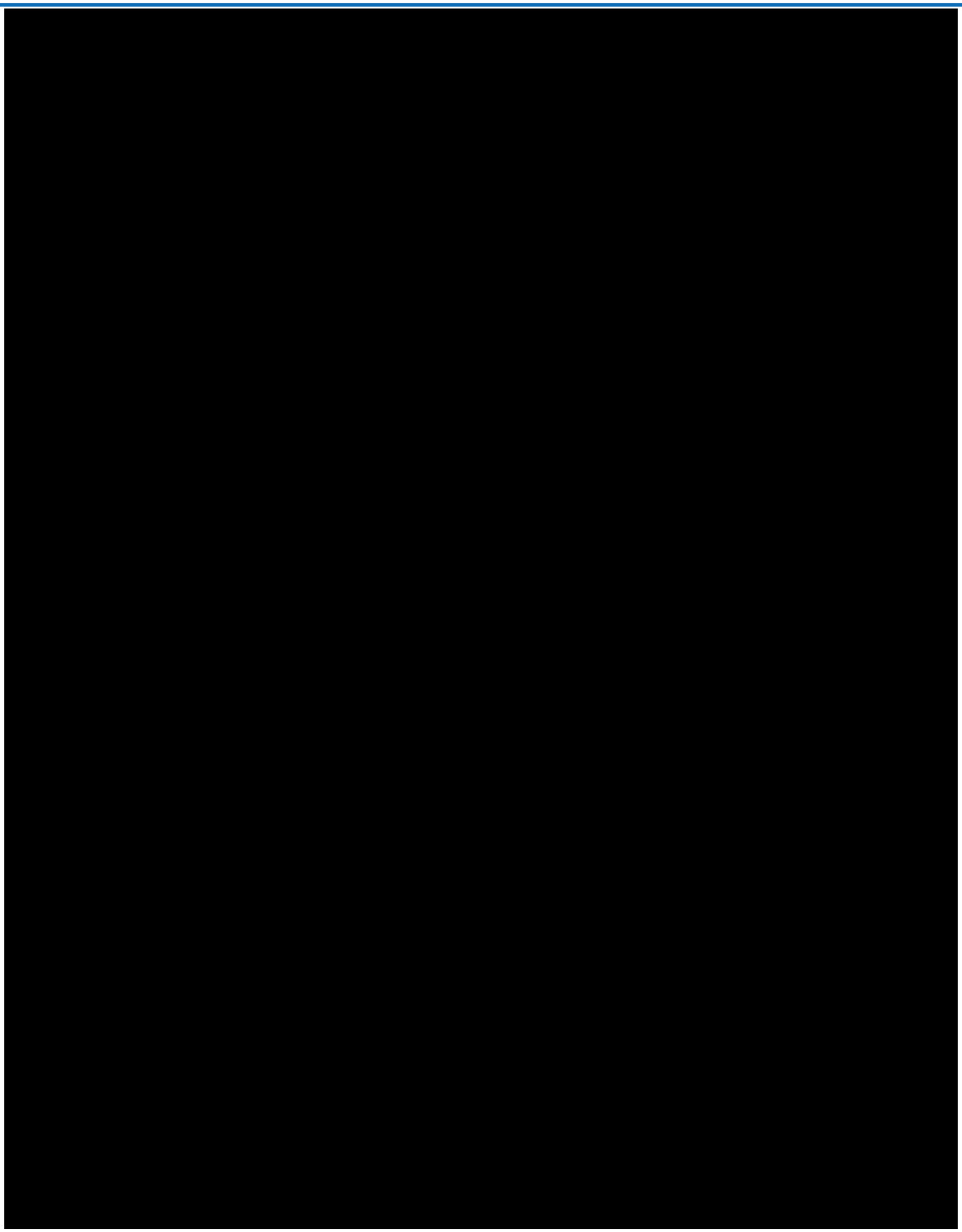


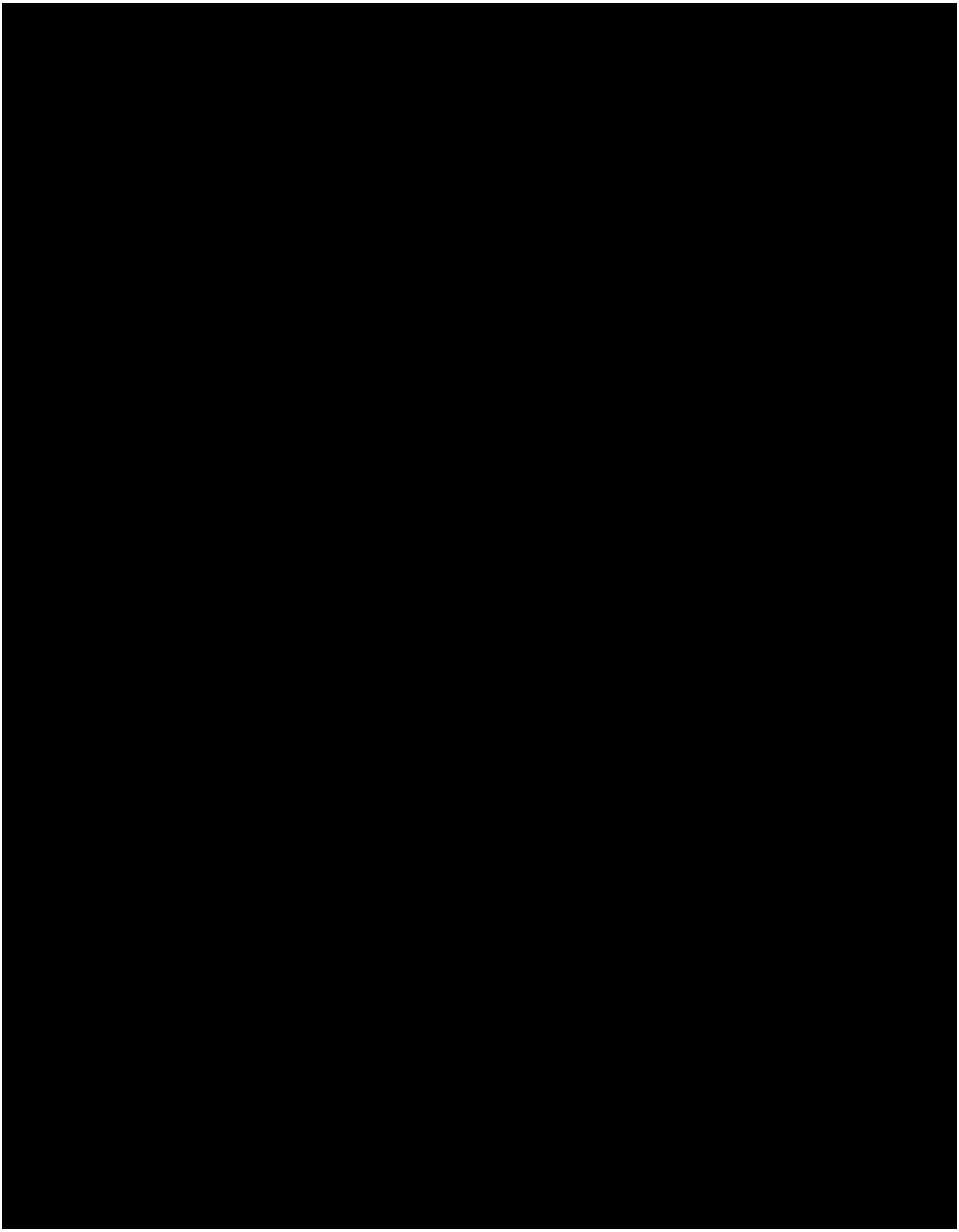


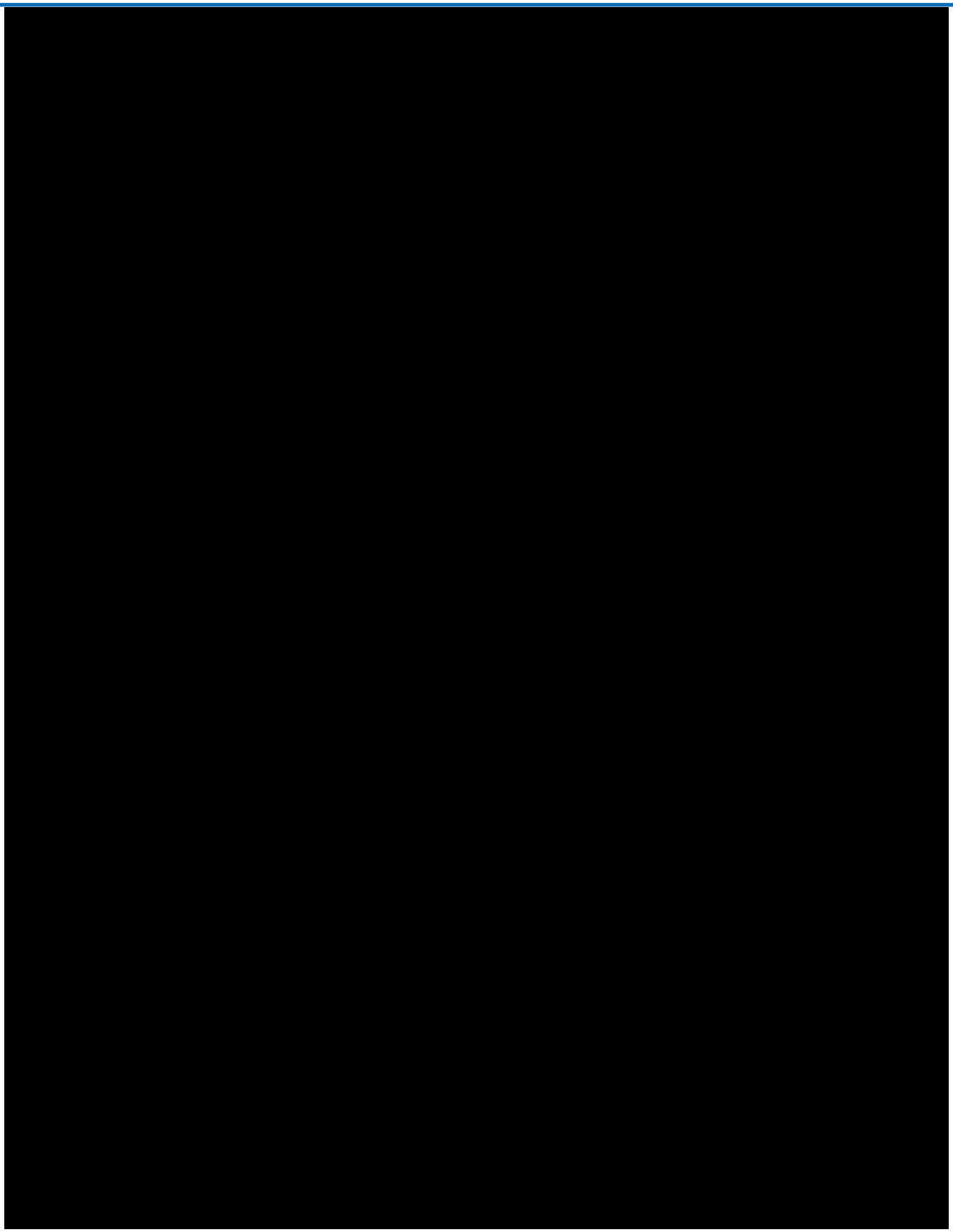












Section N: Reporting

MCNA has been an effective and accountable partner to the Agency since 2016 as an incumbent Contractor for the Iowa Dental Wellness Plan (DWP) and has thorough understanding of Iowa's dental programs and monitoring requirements. We have delivered reports based on timely and accurate data, that support the DWP and demonstrate good health outcomes for our members and will be able to do so for the Healthy and Well Kids in Iowa (Hawki) program as well.

[redacted]

We have read, understand, and will comply with Iowa Dental Wellness Plan and Hawki Dental PAHP RFP# MED-24-004. In our response below, we address key requirements from RFP Attachment F: Contract and Scope of Work Section N. Reporting N.01-N.06.

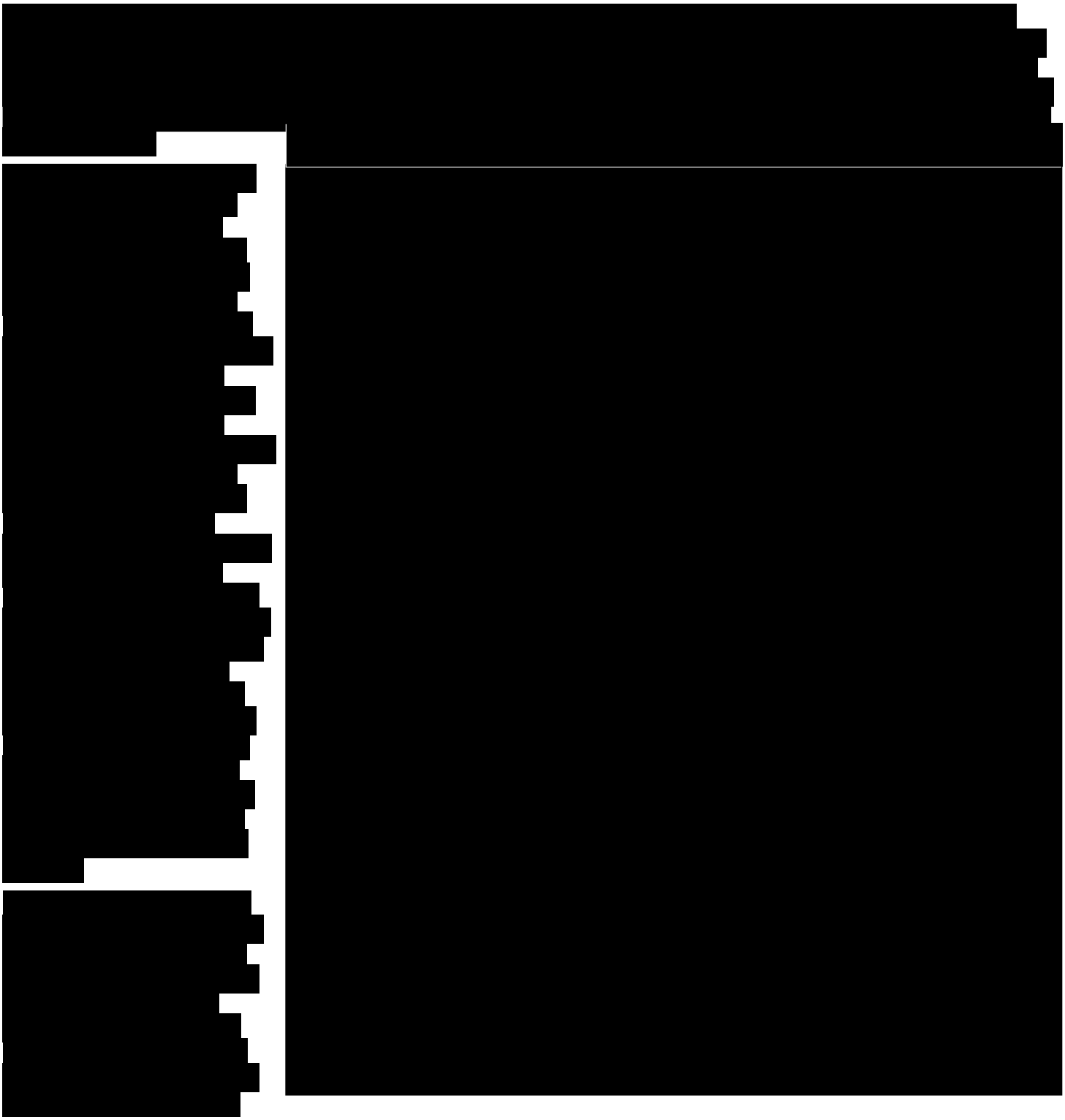
Attachment J, N.a-c: Reporting

Attachment J, N.a: Working with the Agency to Ensure Timely Quality Data

[redacted]

As an incumbent, MCNA will continue to use the policies and procedures and oversight and monitoring activities that are in place as a foundation to assure that all submitted reports are accurate, in the format prescribed, and according to the timelines provided by the Agency in support of DWP and will the same put in place in support of the Hawki program.

Attachment J, N.b: Approach to Data Quality Assurance



[redacted]

Attachment J, N.c: Dynamic and Ad Hoc Data and Reporting Requests

[redacted]

[redacted]

N.01: General

[redacted]

Reports are also submitted to the Agency as required by the Reporting Manual and DWP contract. MCNA will also comply with all guidelines and data definitions for the SFY 2025 Pay for Performance Measures, likely to be based on the pay for performance metrics detailed in the Special Contract Exhibits, Exhibit A. We acknowledge that not meeting performance targets will subject us to corrective action.

[redacted]

[redacted]

N.02: Reporting Requirements

[redacted]

We also commit to continue the transmission of data relevant for analytical purposes to the Agency, as any required reports including, but not limited to those found in the Reporting Manual on a schedule and in the format determined by the Agency.

[redacted]

[redacted] At the Agency's request, we will collaborate with and provide data to third party data warehouses or analytic vendors.

N.03: Implementation and Operational Reporting

[redacted]

N.04: Other Reporting and Changes

MCNA is committed to continuing our collaboration with the Agency to provide the complete and accurate regulatory reporting, and to doing so within the prescribed time periods. We recognize that the Agency may change or add reporting requirements throughout the course of the Contract, and will provide reasonable notice in advance. We will refer to the Reporting Manual for all guidance and instructions regarding required reporting. Regardless of the requested turnaround time, we will respond to and complete modified and ad hoc reporting requests per the Agency's needs and expectations.

[redacted]

N.05: Audit Rights and Remedies

[redacted]

[redacted]

MCNA maintains all supporting data for submitted reports and will make these data available to the Agency for review and audit [redacted]

We acknowledge that MCNA is subject to corrective action for noncompliance with any reporting requirements or performance standards.

N.06: Meeting with the Agency

[redacted] We welcome the opportunity to continue working with the Agency to deliver high quality dental care to our members.

Tab 4: Bidder's Experience

Overview of Technical Experience

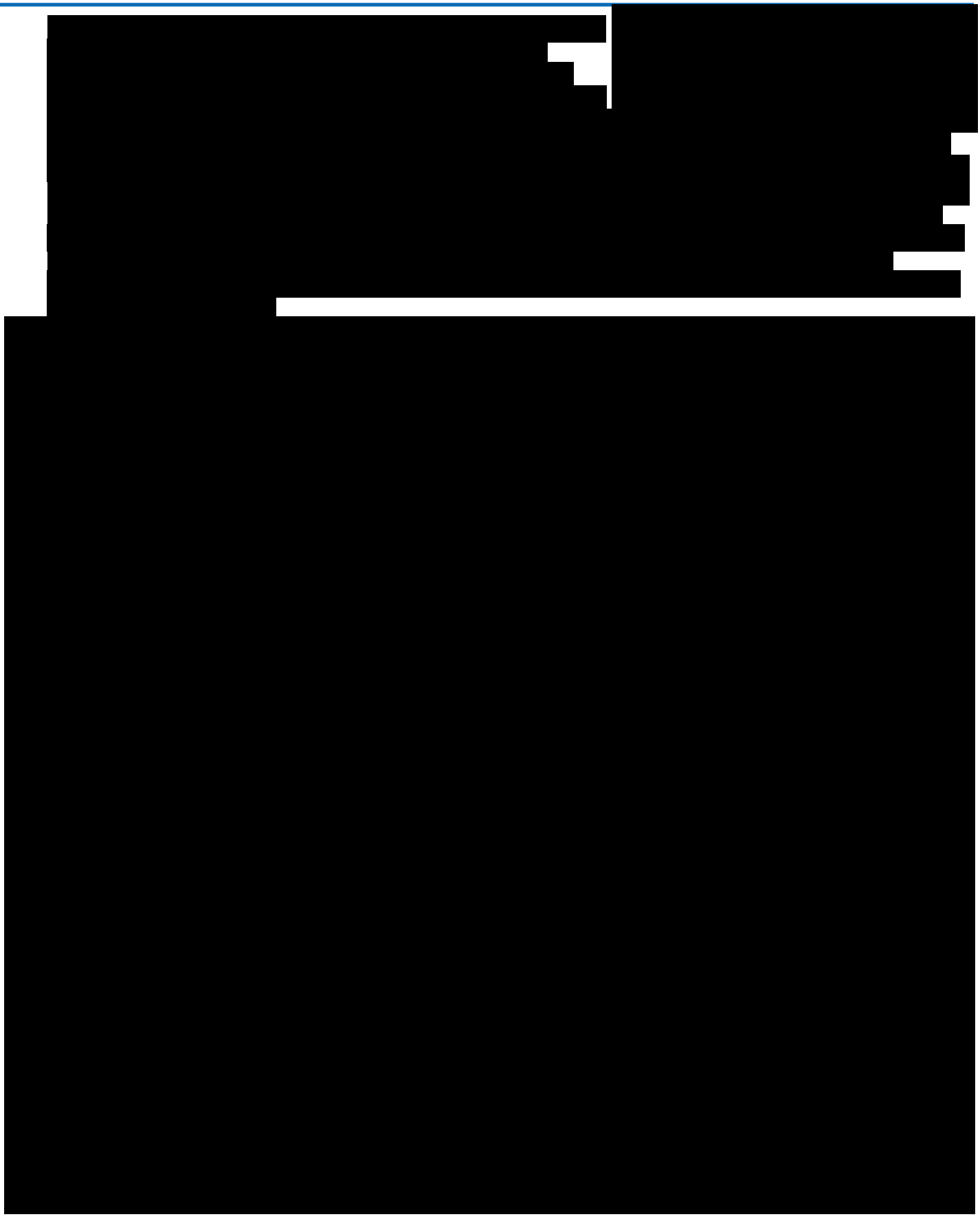
Since our founding, MCNA's mission has been delivering value to our state clients and participating dentists by providing access to quality dental care and service excellence that improves the oral health outcomes of our members. Full-risk dental managed care is rapidly becoming the standard model for delivering oral health services under state sponsored dental programs throughout the United States. With over 30 years of experience, MCNA has emerged as an industry leader in the management of state Medicaid and CHIP programs, serving **over 5 million children and adults** across the nation.

MCNA Insurance Company, the bidder, is a C corporation and has operated as a managed care plan since 2012 (licensed since 2011). The immediate parent company of MCNA Insurance Company is MCNA Health Care Holdings, LLC ("MCNA Holdings"), a Florida limited liability company. MCNA Holdings is also the parent company of Managed Care of North America, Inc., a Florida corporation licensed as a pre-paid limited health services organization. Managed Care of North America, Inc., has operated as a dental insurance administrator since January 30, 1992, and serves as a third-party administrator for MCNA Insurance Company. In 2020, UnitedHealthcare ("United"), a publicly traded Fortune 5 organization, acquired MCNA. For the purposes of this RFP, MCNA Insurance Company and its affiliate, Managed Care of North America, Inc., are collectively referred to as "MCNA."

MCNA is the largest insurer of state-sponsored Medicaid and CHIP members in the nation. Our mission is to deliver value to our clients and participating dentists by providing access to quality dental care and service excellence that improves the oral health outcomes of our enrollees. MCNA is committed to quality. In 2014, we became the first dental plan in the nation to receive **full Dental Plan Accreditation from URAC**, and successfully achieved reaccreditation in 2020. We have also been accredited by the **National Committee for Quality Assurance (NCQA) for Credentialing and Recredentialing** since 2011.

Our commitment to improving oral health outcomes, increasing access to care in urban and rural areas, and ensuring accountability of state funds have led to successful full-risk, dental managed care partnerships with state Medicaid and CHIP agencies in Iowa, Texas, Louisiana, Arkansas, Idaho, Florida, Nebraska, and Utah. In addition to the over 5 million Medicaid and CHIP members nationwide on a fully insured basis, we also provide administrative and clinical review of prior authorizations for over 1.1 million Medicaid and CHIP members covered by the Oklahoma Health Care Authority.

[redacted]



Comprehensive Experience Operating Dental Managed Care Plans

Our mission is to deliver value to our clients and providers by providing access, quality, and service excellence that improves the oral health outcomes of our members. MCNA Insurance Company is backed by a corporate organization with unparalleled experience administering large-scale dental contracts. Our proven track record in effectively transitioning enrollees to our dental managed care plans demonstrates our qualifications and makes us the best choice for the State of Iowa.

MCNA holds the most full-risk Medicaid and CHIP statewide dental managed care contracts with state agencies. We serve over 5 million children and adults similar to the Medicaid populations covered under the DWP and Hawki programs. We have successfully passed every readiness review and met every operational start date for the programs we have launched in every state we serve, including Iowa in 2016. The following list details our current Medicaid and CHIP contracts held directly with state agencies for projects similar in scope and function:

1. **Iowa Department of Health and Human Services:** MCNA provides covered dental services to nearly 270,000 children and adults statewide in the Iowa Medicaid program on an insured basis. Our contract began on July 1, 2016, for the adult population. On July 1, 2021, the program was expanded to add Medicaid children, with extensions available through June 30, 2024.
2. **Texas Health and Human Services Commission:** MCNA provides the full spectrum of covered dental services statewide to nearly 1.4 million Medicaid and CHIP members on an insured basis. Our contract began on March 1, 2012, and as a result of our most recent re-procurement, will continue through August 2028.
3. **Louisiana Department of Health:** MCNA manages the full spectrum of dental care, including diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, orthodontic, and oral and maxillofacial surgery services to approximately 928,000 Medicaid and CHIP children and adults statewide on an insured basis. Our contract began on July 1, 2014, and as a result of our most recent re-procurement, will continue through June 2026. Additionally, MCNA was recently awarded an expanded benefit adult ICF population, which began on May 1, 2023.
4. **Florida Agency for Health Care Administration:** MCNA provides covered dental services to over 1,130,000 children and adults statewide in the Florida Medicaid program on an insured basis. Our contract began on December 1, 2018, with extensions available through December 2024. MCNA has administered dental benefits for Medicaid members statewide under various contracts since 2006.
5. **Florida Healthy Kids Corporation:** MCNA provides covered dental services to nearly 37,000 children statewide in the Florida CHIP program on an insured basis. Our contract began on January 1, 2005, and through many successful re-procurements has remained active for over 17 years.
6. **Idaho Department of Health and Welfare:** As the State's sole vendor, MCNA provides the full spectrum of covered dental services statewide to nearly 384,000 Medicaid and CHIP children and adults on a fully insured basis. Our contract began on February 1, 2017, and was extended through October 2025.
7. **Nebraska Department of Health and Human Services:** As the State's sole vendor, MCNA provides the full spectrum of covered dental services statewide to approximately 393,000 Medicaid and CHIP children and adults on an insured basis. Our contract began on October 1, 2017, and the program will end on December 31, 2023.
8. **Arkansas Department of Human Services:** MCNA provides the full spectrum of covered dental services to approximately 323,500 Medicaid and CHIP children and adults statewide on an insured basis. Our contract began on January 1, 2018, with extensions available through December 2024.
9. **Utah Department of Human Services:** MCNA provides covered dental services to approximately 85,500 children and adults statewide in the Utah Medicaid program on an insured basis. Our contract began on September 1, 2018, and was successfully reprocured in 2022 with extensions available through July 2027.

10. **Oklahoma Health Care Authority:** MCNA provides medical necessity determinations to over 1.1 million children and adults statewide in the Oklahoma SoonerSelect Dental program. Our contract began on January 5, 2022, and will end on January 31, 2024.

A Proven, Reliable Partner for Iowa

Throughout our over 30 years of experience, we have tailored our approach to caring for children, adults, and individuals with special health care needs, on a state-by-state basis, ensuring that every member receives superior services in a timely manner. We drive high-quality, cost-effective oral health outcomes by increasing access to care, promoting preventive services, and ensuring members receive care in the most appropriate setting.

We approach our work of developing and implementing dental service programs with dedication and commitment to excellence. MCNA's purely organic growth is the direct result of years refining our network development, quality improvement, and member services techniques to deliver best-in-class performance to the states we serve. Our management information system, DentalTrac™, was developed in-house and supports all of our business processes through its state-of-the-art modular design.

We care for our members by incorporating evidence-based practice guidelines, engaging providers and stakeholders to help remove barriers to care, and implementing data-driven quality improvement initiatives to increase preventive care utilization. MCNA is dedicated to the singular goal of improving the oral health of our members.

Our proven track record in effectively transitioning enrollees to our dental managed care plans demonstrates our qualifications and makes us the best choice for the State of Iowa. **As the incumbent for Iowa Dental Wellness Plan since 2016, we are closely attuned to the needs of Iowa and are committed to continuing to advance the Agency's efforts to improve the quality of care for the state's most vulnerable populations by providing coordinated, holistic dental care for our members.** Our extensive years of experience in Iowa and with successful state Medicaid and CHIP program implementations nationwide, coupled with our experienced leadership team, allow us to "hit the ground running" to ensure a **flawless go-live** and provide the Agency a **turnkey solution** that supports the improved quality of care and cost control objectives of the DWP and Hawki dental programs.

We are humbled and grateful for our opportunity to serve Iowa's DWP and Hawki members and hope to continue our successful partnership with the Iowa Department of Health and Human Services for years to come.

Publicly Funded Dental Managed Care Contracts for Medicaid, CHIP, and Other Low-Income Populations Within the Last Five Years

Iowa Dental Wellness Plan and DWP Kids

a. Name of your plan and the State in which you provided services.	MCNA Dental, Iowa
b. Scope of work and covered benefits.	MCNA provides the full spectrum of covered dental services statewide to Medicaid children and adults on a full-risk basis.
c. Duration of the contract.	Our contract began on July 1, 2016, for the adult population (DWP-A). On July 1, 2021, the program was expanded to add Medicaid children (DWP-K), with extensions available through June 2024.
d. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s).	Starting: July 1, 2016 Current Term End: June 30, 2024
e. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The first 12 months of the contract had revenue of $5,013,098, with the most recent 12-month period having revenue of $42,708,892. This change was due to additional populations being added to the program since contract inception.
f. Contact name, phone number, and email address.	Heather Miller, 515-402-3173, hmiller2@dhs.state.ia.us
g. Number of members served by population type.	DWP-K: 120,095 DWP-A: 153,710
h. Annual contract payments and description if payment was capitated.	Payment is capitated on a PMPM basis. Please see item e for revenue information.
i. Any improvements made in utilization trends and quality indicators.	MCNA has made improvements in utilization trends and quality improvement indicators in Iowa. Below are two key highlights for our impact on the DWP population: • For the contractual performance measure "access to any dental service," MCNA improved the rate for DWP Adult members by 7% from the SFY18 rate of 20.51% to 22.03% in SFY19. • For the contractual performance measure "continued preventive utilization," MCNA improved the rate for DWP Adult members by 6% from the SFY21 rate of 75.94% to 80.47% in SFY22.
j. Overall NCQA rating (if applicable).	Fully NCQA accredited for credentialing and recredentialing.

k. Accreditation information.	Fully NCQA accredited for credentialing and recredentialing, and full URAC dental plan accreditation.
l. How the contract emphasizes member choice, access, safety, independence, and responsibility.	Members have choice in the provider they see and can access services from any provider within MCNA's network without the need for a referral. To promote independence and responsibility, MCNA makes all members aware of their member rights and responsibilities, as well as plan benefits and other key information in our accessible Member Handbook, both in hard copy via mail and available any time electronically via our website and online Member Portal.
m. The role of subcontractors, if any.	MCNA Insurance Company utilizes our affiliate subcontractor, Managed Care of North America, Inc., to provide key third-party administrative (TPA) functions.

Texas Medicaid and CHIP

a. Name of your plan and the State in which you provided services.	MCNA Dental, Texas
b. Scope of work and covered benefits.	MCNA provides the full spectrum of covered dental services statewide to Medicaid and CHIP children and adults on a full-risk basis.
c. Duration of the contract.	[redacted]
d. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s).	[redacted]
e. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	[redacted]
f. Contact name, phone number, and email address.	[redacted]
g. Number of members served by population type.	[redacted]
h. Annual contract payments and description if payment was capitated.	Payment is capitated on a PMPM basis. Please see item e for revenue information.
i. Any improvements made in utilization trends and quality indicators.	[redacted]

	[redacted]
j. Overall NCQA rating (if applicable).	Fully NCQA accredited for credentialing and recredentialing.
k. Accreditation information.	Fully NCQA accredited for credentialing and recredentialing, and full URAC dental plan accreditation.
l. How the contract emphasizes member choice, access, safety, independence, and responsibility.	[redacted]
m. The role of subcontractors, if any.	[redacted]

Louisiana Medicaid and CHIP

a. Name of your plan and the State in which you provided services.	MCNA Dental, Louisiana
b. Scope of work and covered benefits.	MCNA provides the full spectrum of covered dental services statewide to Medicaid and CHIP children and adults on a full-risk basis.
c. Duration of the contract.	[redacted]
d. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s).	[redacted]
e. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	[redacted]
f. Contact name, phone number, and email address.	[redacted]
g. Number of members served by population type.	[redacted]
h. Annual contract payments and description if payment was capitated.	Payment is capitated on a PMPM basis. Please see item e for revenue information.
i. Any improvements made in utilization trends and quality indicators.	[redacted]

	[redacted]
j. Overall NCQA rating (if applicable).	Fully NCQA accredited for credentialing and recredentialing.
k. Accreditation information.	Fully NCQA accredited for credentialing and recredentialing, and full URAC dental plan accreditation.
l. How the contract emphasizes member choice, access, safety, independence, and responsibility.	[redacted]
m. The role of subcontractors, if any.	[redacted]

Arkansas Medicaid and CHIP

a. Name of your plan and the State in which you provided services.	MCNA Dental, Arkansas
b. Scope of work and covered benefits.	MCNA provides the full spectrum of covered dental services statewide to Medicaid and CHIP children and adults on a full-risk basis.
c. Duration of the contract.	[redacted]
d. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s).	[redacted]
e. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	[redacted]
f. Contact name, phone number, and email address.	[redacted]
g. Number of members served by population type.	[redacted]
h. Annual contract payments and description if payment was capitated.	Payment is capitated on a PMPM basis. Please see item e for revenue information.
i. Any improvements made in utilization trends and quality indicators.	[redacted]
j. Overall NCQA rating (if applicable).	Fully NCQA accredited for credentialing and recredentialing.
k. Accreditation information.	Fully NCQA accredited for credentialing and recredentialing, and full URAC dental plan accreditation.

l. How the contract emphasizes member choice, access, safety, independence, and responsibility.	[redacted]
m. The role of subcontractors, if any.	[redacted]

Nebraska Medicaid and CHIP

a. Name of your plan and the State in which you provided services.	MCNA Dental, Nebraska
b. Scope of work and covered benefits.	MCNA provides the full spectrum of covered dental services statewide to Medicaid and CHIP children and adults on a full-risk basis.
c. Duration of the contract.	[redacted]
d. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s).	[redacted]
e. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	[redacted]
f. Contact name, phone number, and email address.	[redacted]
g. Number of members served by population type.	[redacted]
h. Annual contract payments and description if payment was capitated.	Payment is capitated on a PMPM basis. Please see item e for revenue information.
i. Any improvements made in utilization trends and quality indicators.	[redacted]

	[redacted]
j. Overall NCQA rating (if applicable).	Fully NCQA accredited for credentialing and recredentialing.
k. Accreditation information.	Fully NCQA accredited for credentialing and recredentialing, and full URAC dental plan accreditation.
l. How the contract emphasizes member choice, access, safety, independence, and responsibility.	[redacted]
m. The role of subcontractors, if any.	[redacted]

Idaho Medicaid and CHIP

a. Name of your plan and the State in which you provided services.	MCNA Dental, Idaho
b. Scope of work and covered benefits.	MCNA provides the full spectrum of covered dental services statewide to Medicaid and CHIP children and adults on a full-risk basis.
c. Duration of the contract.	[redacted]
d. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s).	[redacted]
e. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	[redacted]
f. Contact name, phone number, and email address.	[redacted]
g. Number of members served by population type.	[redacted]
h. Annual contract payments and description if payment was capitated.	Payment is capitated on a PMPM basis. Please see item e for revenue information.
i. Any improvements made in utilization trends and quality indicators.	[redacted]
j. Overall NCQA rating (if applicable).	Fully NCQA accredited for credentialing and recredentialing.
k. Accreditation information.	Fully NCQA accredited for credentialing and recredentialing, and full URAC dental plan accreditation.
l. How the contract emphasizes member choice, access, safety, independence, and responsibility.	[redacted]

	[redacted]
m. The role of subcontractors, if any.	[redacted]

Utah Medicaid

a. Name of your plan and the State in which you provided services.	MCNA Dental, Utah
b. Scope of work and covered benefits.	MCNA provides the full spectrum of covered dental services statewide to Medicaid children and adults on a full-risk basis.
c. Duration of the contract.	[redacted]
d. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s).	[redacted]
e. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	[redacted]
f. Contact name, phone number, and email address.	[redacted]
g. Number of members served by population type.	[redacted]
h. Annual contract payments and description if payment was capitated.	Payment is capitated on a PMPM basis. Please see item e for revenue information.
i. Any improvements made in utilization trends and quality indicators.	[redacted]

j. Overall NCQA rating (if applicable).	Fully NCQA accredited for credentialing and recredentialing.
k. Accreditation information.	Fully NCQA accredited for credentialing and recredentialing, and full URAC dental plan accreditation.
l. How the contract emphasizes member choice, access, safety, independence, and responsibility.	[redacted]
m. The role of subcontractors, if any.	[redacted]

Oklahoma Medicaid and CHIP

a. Name of your plan and the State in which you provided services.	MCNA Dental, Oklahoma
b. Scope of work and covered benefits.	MCNA provides clinical review for dental prior authorizations.
c. Duration of the contract.	[redacted]
d. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s).	[redacted]
e. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	[redacted]
f. Contact name, phone number, and email address.	[redacted]
g. Number of members served by population type.	[redacted]
h. Annual contract payments and description if payment was capitated.	[redacted]
i. Any improvements made in utilization trends and quality indicators.	[redacted]
j. Overall NCQA rating (if applicable).	Fully NCQA accredited for credentialing and recredentialing.
k. Accreditation information.	Fully NCQA accredited for credentialing and recredentialing, and full URAC dental plan accreditation.
l. How the contract emphasizes member choice, access, safety, independence, and responsibility.	[redacted]
m. The role of subcontractors, if any.	[redacted]

Florida Medicaid

a. Name of your plan and the State in which you provided services.	MCNA Dental, Florida
b. Scope of work and covered benefits.	MCNA provides the full spectrum of covered dental services statewide to Medicaid children and adults on a full-risk basis.
c. Duration of the contract.	[redacted]
d. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s).	[redacted]
e. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	[redacted]
f. Contact name, phone number, and email address.	[redacted]
g. Number of members served by population type.	[redacted]
h. Annual contract payments and description if payment was capitated.	Payment is capitated on a PMPM basis. Please see item e for revenue information.
i. Any improvements made in utilization trends and quality indicators.	[redacted]

	[redacted]
j. Overall NCQA rating (if applicable).	Fully NCQA accredited for credentialing and recredentialing.
k. Accreditation information.	Fully NCQA accredited for credentialing and recredentialing, and full URAC dental plan accreditation.
l. How the contract emphasizes member choice, access, safety, independence, and responsibility.	[redacted]
m. The role of subcontractors, if any.	[redacted]

Florida CHIP (Florida Healthy Kids)

a. Name of your plan and the State in which you provided services.	MCNA Dental, Florida
b. Scope of work and covered benefits.	MCNA provides the full spectrum of covered dental services statewide to Florida Healthy Kids (CHIP) children on a full-risk basis.
c. Duration of the contract.	[redacted]
d. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s).	[redacted]
e. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	[redacted]
f. Contact name, phone number, and email address.	[redacted]
g. Number of members served by population type.	[redacted]
h. Annual contract payments and description if payment was capitated.	Payment is capitated on a PMPM basis. Please see item e for revenue information.
i. Any improvements made in utilization trends and quality indicators.	[redacted]

	[redacted]
j. Overall NCQA rating (if applicable).	Fully NCQA accredited for credentialing and recredentialing.
k. Accreditation information.	Fully NCQA accredited for credentialing and recredentialing, and full URAC dental plan accreditation.
l. How the contract emphasizes member choice, access, safety, independence, and responsibility.	[redacted]
m. The role of subcontractors, if any.	[redacted]

Debarments or Suspensions, Regulatory Actions, or Sanctions

MCNA Insurance Company, along with its parent and affiliates, have not had any federal or state debarments or suspensions. Additionally, MCNA has not been found by a contracting party to be in material breach of any dental service contracts, nor have we had any of our contracts terminated in the past five years.

MCNA is a large organizational enterprise, with many clients, members, and providers. In the last five years, MCNA Insurance Company (the bidder) and its affiliate, Managed Care of North America, Inc., have only received sanctions in relation to 3 of the programs we serve in the ordinary course of business operations. Our parent, MCNA Health Care Holdings, LLC, has never received any sanctions.

MCNA submits hundreds of reports to regulatory agencies each year related to our dental contracts. We work diligently to anticipate issues that could delay timely reporting before they happen. When a reporting related issue does occur, we correct it as quickly and effectively as possible, and we use the "lessons learned" to improve our internal controls and reporting procedures to reduce the incidence of reporting errors, and to ensure that all required reports are submitted on a timely basis.

None of the assessments levied have involved quality of care, provider relations, credentialing, prior authorizations, or other such performance related issues that could compromise our ability to administer high quality dental services for our members. All monetary sanctions were paid, and the sanctions for the last five years are listed below.

Sanctions for MCNA Insurance Company (Bidder)

Date of Sanction	Contractual Period	Brief Description	Dollar Amount	Actions Taken and Plan of Correction
Contract/Program: Texas Medicaid and CHIP (HHSC)				
11/12/2019	12/2017 – 2/2018	Data Format – Ad-Hoc OIG Request	$0	Worked with OIG on a standardized template.
2/6/2020	6/2018 – 8/2018	Reporting Timeliness – Financial	$0	Filings were submitted.
2/24/2020	9/2018 – 11/2018	Reporting Certification Embedding – TPR	$0	Certification was embedded.
2/24/2020	9/2018 – 11/2018	Data Format – Ad-Hoc OIG Request	$113,250	Worked with OIG on a standardized template.
4/17/2020	12/2018 – 2/2019	Data Format – Ad-Hoc OIG Request	$90,000	Worked with OIG on a standardized template.
5/21/2020	3/2019 – 5/2019	Data Format – Ad-Hoc OIG Request	$55,000	Worked with OIG on a standardized template.
4/27/2021	6/2019 – 8/2019	Data Format – Ad-Hoc OIG Request	$4,500	Worked with OIG on a standardized template.
4/27/2021	6/2019 – 8/2019	Reporting Accuracy – Financial	$1,750	Submitted corrected reports.
4/27/2021	6/2019 – 8/2019	Reporting Certification Embedding – TPR	$4,125	Certification was embedded.
4/27/2021	CY 2020	PIP Topic Incorrect	$6,375	Topic updated.
7/7/2021	3/2021 – 5/2021	Member Hotline Performance Standards Not Met – Call Abandonment and Hold Time	$0	CAP imposed. Staff migrated to upgraded Citrix environment to better support working from home.
9/7/2021	12/2019 – 2/2020	Claims Processing Standard Not Met (98%)	$1,312.50	Overtime authorized and additional staffing added.
11/1/2021	6/2021 – 8/2021	Claims Processing Standard Not Met (98%)	$0	CAP imposed. Staff migrated to updated Citrix environment to better support working from home.

Date of Sanction	Contractual Period	Brief Description	Dollar Amount	Actions Taken and Plan of Correction
1/25/2022	9/2020 – 11/2020	Reporting Timeliness – Call Center	$0	Reports were submitted.
1/25/2022	9/2020 – 11/2020	Reporting Accuracy – Appeals	$0	Submitted corrected reports.
1/25/2022	9/2020 – 11/2020	Reporting Accuracy – Financial	$0	Submitted corrected reports.
1/31/2022	8/2019	Member Hotline Performance Standard Not Met – Hold Time	$300	Additional staffing added.
1/31/2022	12/2019	Member Hotline Performance Standard Not Met – Abandonment Rate	$0	Additional staffing added.
1/31/2022	11/2019	Provider Notification of Recoupment Initiative	$225,000	Fine paid and process modified to include prior notice to providers.
1/31/2022	12/2020	Member Hotline Performance Standard Not Met – Abandonment Rate	$50	Additional staffing added.
1/31/2022	12/2020	Member Hotline Performance Standard Not Met – Hold Time	$800	Additional staffing added.
1/31/2022	12/2020 – 2/2021	Reporting Accuracy – Encounters	$3,750	Submitted corrected encounters.
1/31/2022	12/2020 – 2/2021	Reporting Accuracy – Member Complaints	$0	Submitted corrected reports.
6/14/2022	Q3 2021	Member Hotline Performance Standard Not Met – Abandonment Rate and Hold Rate	$10,300	CAP closed 5/20/2022.
6/14/2022	Q3 2021	Claims Processing Standard Not Met (98%)	$6,375	Actual Performance was 97.42%. Increased training and timeliness monitoring.
6/14/2022	Q3 2021	Reporting Timeliness – Member Appeals	$125	Reports were submitted.
7/15/2022	Q4 2021	Member Hotline Performance Standard Not Met – Abandonment Rate and Hold Rate	$29,600	Additional staffing added.
7/15/2022	Q4 2021	Provider Hotline Performance Standard Not Met – Abandonment Rate	$450	Additional staffing added.
7/15/2022	Q4 2021	Claims Processing Standard Not Met (98%)	$51,000	Additional staffing added.
7/15/2022	Q4 2021	Reporting Timeliness and Accuracy – Financial	$8,000	Submitted corrected reports.
12/14/2022	Q1 2022	Member Hotline Performance Standard Not Met – Abandonment Rate and Hold Rate	$8,000	Determination made to implement new telephony system.
12/14/2022	Q1 2022	Provider Hotline Performance Standard Not Met – Abandonment Rate	$12,400	Determination made to implement new telephony system.
12/14/2022	Q1 2022	Claims Processing Standard Not Met (98%)	$34,000	Additional staffing added.
4/7/2023	Q2 2022	Member Hotline Performance Standard Not Met – Abandonment Rate	$4,000	New telephony system implemented 3/1/2023. Current performance meets all requirements.
4/7/2023	Q2 2022	Provider Hotline Performance Standard Not Met – Abandonment Rate and Hold Rate	$6,400	New telephony system implemented 3/1/2023. Current performance meets all requirements.
4/7/2023	Q2 2022	Claims Processing Standard Not Met (98%)	$17,000	Internal process updated.
4/7/2023	Q2 2022	Reporting Timeliness and Accuracy – Financial	$750	Submitted corrected reports.

Date of Sanction	Contractual Period	Brief Description	Dollar Amount	Actions Taken and Plan of Correction
		Contract/Program: Louisiana Medicaid and CHIP (LDH)		
3/2/2022	12/2021 – 01/2022	Provider Hotline Performance Standards Not Met	$20,000	Staff migrated to updated Citrix environment to better support working from home.
3/23/2022	Q4 2021	Reporting Timeliness – Financial	$80,000	Submitted reports.
7/7/2022	Q1 2022	Reporting Timeliness – Financial	$32,000	Submitted reports.
8/26/2022	2021	Reporting Timeliness and Accuracy – Financial	$75,000	Submitted corrected reports.
9/8/2022	2021	Dental Performance Targets	$190,000	Enhanced outreach interventions.
10/20/2022	5/2022	Reporting Accuracy – Encounters	$50,000	Submitted corrected encounters.
1/5/2023	9/2022	Reporting Accuracy – Encounters	$50,000	Submitted corrected encounters.
2/1/2023	2021	Reporting Timeliness – Financial	$2,500	Submitted reports.
5/9/2023	1/2023	Reporting Accuracy – Encounters	$50,000	Submitted corrected encounters.

Sanctions for Managed Care of North America, Inc. (Affiliate)

Date of Sanction	Contractual Period	Brief Description	Dollar Amount	Actions Taken and Plan of Correction
		Contract/Program: Florida Medicaid (AHCA)		
5/16/2019	12/2018 – 1/2019	Marketing – Provider group mailed a letter to their members stating they only participate with MCNA, and MCNA distributed nominal gifts at a health fair that were not pre-approved by AHCA.	$5,000	MCNA informed the provider group that this type of communication is not allowed, and MCNA updated its internal process to ensure prior approval for nominal giveaways at health fairs.
5/23/2019	4/2019	Network Standards – Provider Ratios	$5,000	Continual growth of MCNA network.
7/8/2019	1/2019	Claims Processing Standard Not Met	$10,000	Overtime authorized and additional staffing added.
7/25/2019	5/2019	Network Standards – Provider Ratios	$5,000	Continual growth of MCNA network.
7/25/2019	2/2019	Reporting Timeliness – Encounters	$1,000	Reports were submitted.
9/23/2019	4/2019	Timeliness of PDF Provider Directory Update on Website	$1,000	Directories were refreshed.
12/20/2019	7/2019	Network Standards – Provider Ratios	$4,000	Continual growth of MCNA network.
9/18/2020	9/2020	Reporting Accuracy – PNV	$13,000	MCNA implemented a system change to ensure that providers who do not treat Medicaid recipients appear as terminated in the PNV file.
10/16/2020	7/2020	Reporting Accuracy – Encounters	$1,000	Submitted corrected encounters.
12/3/2020	10/2020	Reporting Timeliness – Ad-Hoc AHCA Request	$500	Report was submitted.
1/8/2021	8/2020	Network Standards – Provider Ratios	$6,000	Continual growth of MCNA network.
2/5/2021	8/2020	Network Standards – Geographic Access	$4,000	Continual growth of MCNA network.

Date of Sanction	Contractual Period	Brief Description	Dollar Amount	Actions Taken and Plan of Correction
3/16/2021	8/2020	Timeliness of PDF Provider Directory Update on Website	$5,000	Directories were refreshed and an automated monthly process was introduced.
3/17/2021	3/2021	Reporting Timeliness – PNV	$250	Report was submitted. Process was automated to avoid this error.
3/7/2022	6/2021	Reporting Accuracy – Member Complaints, Grievances, and Appeals	$2,000	Submitted corrected reports.
3/9/2022	7/2021	Reporting Accuracy – Encounters	$2,000	Submitted corrected encounters.
4/22/2022	Q2 2021	Network Standards – Geographic Access, Timeliness of PDF Provider Directory Update on Website, Reporting Timeliness – PNV	$86,000	Continual growth of MCNA network. Directories were refreshed.
5/5/2022	CY 2020, FFY 2020	Dental Performance Targets – Well-Child Visit Rate Requirement	$1,339,500	Enhanced outreach interventions.
5/23/2022	5/2022	Reporting Accuracy – PNV	$250	Report was corrected and resubmitted.
9/16/2022	12/2021	Reporting Accuracy – Encounters	$2,000	Submitted corrected encounters.
3/13/2023	Q3 2021	Network Standards – Geographic Access, Timeliness of PDF Provider Directory Update on Website, Reporting Timeliness – PNV	$101,000	Continual growth of MCNA network. Directories were refreshed.
3/22/2023	2/2022	Reporting Accuracy – Encounters	$1,000	Submitted corrected encounters.
3/29/2023	6/2022, 7/2022	Reporting Timeliness – Encounters	$5,000	Reports were submitted.
4/4/2023	10/2021	State Fair Hearing Attendance and Materials	$1,000	Process changed to ensure timely attendance and submission.
4/26/2023	Q1 2022	Reporting Accuracy – Grievances and Appeals	$1,400	Submitted corrected reports.
6/30/2023	10/2022	Reporting Accuracy – Encounters	$2,000	Submitted corrected encounters.

Letters of Deficiency or Corrective Actions

Please see below our letters of deficiencies or corrective actions by state plan for the last five years.

- **Texas Medicaid and CHIP (HHSC)**
  - Issued 11/16/2018, closed 4/30/2019. HHSC issued CAPs to all health and dental plans in Texas for Medicaid and CHIP network adequacy time and distance standards for Q4 2018. HHSC approved time and distance exceptions due to lack of available providers in the identified geographic areas.
  - Issued 1/16/2019, closed 1/29/2020. Network Adequacy Time or Distance. MCNA did not meet the 75% threshold for Endodontist, Main Dentist, Oral Surgeon, Orthodontist, Pediatric Dental, Periodontist, and Prosthodontist provider types in the contracted Service Area(s), Counties, and Program(s) for SFY 2018 Q4. HHSC approved time and distance exceptions due to lack of available providers in the identified geographic areas.
  - Issued 9/12/2019, closed 11/7/2019. Corrective action was initiated to address the non-compliance identified in the 2015/2016 Agreed Upon Procedure for Financial Statistical Report Audit.

- Issued 12/4/2019, closed 7/6/2021. MCNA was placed on a CAP to address findings identified during an Operational Review as relates to finance policies, member and provider website, and member advocate staff training.
- Issued 3/5/2021, closed 1/13/2022. Corrective action was initiated to address the non-compliance identified in the 2017 Agreed Upon Procedure for Financial Statistical Report Audit.
- Issued 4/30/2021, closed 6/7/2022. MCNA did not meet the required Distance performance standards for Endodontist, Main Dentist, Orthodontist, Pediatric Dental, and Prosthodontist in the contracted Service Area(s), Counties, and Program(s) for SFY 2021 Q2. HHSC approved time and distance exceptions due to lack of available providers in the identified geographic areas.
- Issued 7/7/2021, closed 5/20/2022. Failure to meet Member Hotline performance standards for call abandonment and call hold rates.
- Issued 11/1/2021, closed 6/15/2022. Failure to meet claims processing performance requirements.
- Issued 8/1/2022, closed 8/22/2022. Corrective action was initiated to address the non-compliance identified in the 2018 Agreed Upon Procedure for Financial Statistical Report Audit.
- Issued 12/30/2022. Failure to meet Member Hotline performance standards for call abandonment and call hold rates.
- Issued 3/29/2023. Corrective action was initiated to address the non-compliance identified in the 2019 Agreed Upon Procedure for Financial Statistical Report Audit.

- **Nebraska Medicaid and CHIP (MLTC)**
  - Issued, 9/5/2019, closed 7/31/2020. Failure to submit Grievance Systems Log correctly and completely per contract requirements. Failure to comply with the State of Nebraska Personnel Recruitment Prohibition.
- **Utah Medicaid (DHHS)**
  - Issued 4/27/2021, closed 9/21/2022. Failure to meet the encounter data submission requirement.
- **Iowa Dental Wellness Plan (DHHS)**
  - Received 11/30/2021. Written warning for member helpline calls not answered timely (80% in 30 seconds); provider helpline calls not answered timely (80% in 30 seconds).
  - Received 5/31/2022. MCNA was required to submit a written plan to address timely reporting and accuracy of quarterly and monthly reporting, and timely reporting of encounter data.
  - Received 1/30/2023. MCNA was required to submit a written plan to address call center performance metrics and network adequacy.

Child or Dependent Adult Abuse Reports or Felony Convictions

MCNA Insurance Company, its owners, officers, primary partners, staff providing services or any owners, officers, primary partners, and staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, have never had a founded child or dependent adult abuse report, or been convicted of a felony.

Letters of Reference

MCNA is pleased to provide letters of reference from three of the state agencies we currently serve, listed below:

Plan/Contract	Contact Name	Contact Telephone	Contact Email
Idaho Department of Health and Welfare	Daniel Mallory	986-200-1021	daniel.mallory@dhw.idaho.gov
Arkansas Department of Human Services	Karesha Taylor	501-683-1561	karesha.taylor@dhs.arkansas.gov
Louisiana Department of Health	Brandon Bueche	225-384-0460	brandon.bueche@la.gov

Reference Letter from Idaho Department of Health and Welfare

IDAHO DEPARTMENT OF HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

DANIEL MALLORY–PROGRAM MANAGER
BUREAU OF CARE MANAGEMENT
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (986) 200-1021
FAX: (208) 332-7280

June 12, 2023

Shannon LePage
CEO
MCNA Dental
PO Box 29008
San Antonio, TX 78229

Dear Shannon:

I am writing to provide verification and reference for Idaho Medicaid's present working relationship with MCNA Dental.

Idaho Department of Health and Welfare does not rate the performance of our contractors or subgrantees. However, there is presently no issues of note, outstanding findings, or corrective action plans tied to MCNA Dental's present contractual performance.

MCNA Dental has been the managed care provider responsible for the Idaho Medicaid Dental Plan, covering approved dental benefits for the State of Idaho's Medicaid participants since October 2016.

If there are any further questions about the relationship of Idaho Medicaid and MCNA Dental, they may contact the present IDHW Medicaid Dental Team at (wolf.tom@dhw.idaho.gov or daniel.mallory@dhw.idaho.gov).

Thank you,

Daniel Mallory

Digitally signed by Daniel Mallory
DN: cn=Daniel Mallory, c=US, o=Idaho Department of Health and Welfare, ou=Division of Medicaid, email=daniel.mallory@dhw.idaho.gov
Date: 2023.06.12 13:24:51 -06'00'

Daniel Mallory
Program Manager, Idaho Medicaid Dental Program
Bureau of Care Management
Division of Medicaid

Cc: Idaho Medicaid Dental Program
MCNA Dental–Idaho Program

Last Updated: April 2022

Reference Letter from Arkansas Department of Human Services

Division of Medical Services

P.O. Box 1437, Slot S410 Little Rock, AR 72203-1437

P: 501.682.8292 F: 501.682.1197

June 21, 2023

Shannon LePage
CEO
MCNA Dental
PO Box 29008
San Antonio, TX 78229

Dear Shannon:

I am writing to provide verification for Arkansas Medicaid's present working relationship with MCNA Dental.

MCNA Dental has been one contracted managed care provider responsible for the Arkansas Medicaid Dental Plan, covering approved dental benefits for the Arkansas Medicaid participants since January 2018. The Arkansas Department of Human Services does not provide explanatory letters of reference or rate the performance of its contractors or subgrantees.

Thank you,

Karesha Taylor| Arkansas Department of Human Services

Division of Medical Services | Program Administrator - Dental/Vision/NET

501-683-1561

P.O. Box 1437, Slot S410

Little Rock, AR 72203

karesha.taylor@dhs.arkansas.gov

Reference Letter from Louisiana Department of Health

John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

June 27, 2023

To: Whom It May Concern

MCNA Insurance Company, d/b/a MCNA Dental has served as a dental benefits program manager for Louisiana's Medicaid program continuously since July 1, 2014.

There are no known issues of performance at this time.

Louisiana Department of Health departmental policy does not permit staff to provide more detailed reference or evaluation information for a current contractor.

Sincerely,

Brandon J. Bueche

Digitally signed by Brandon J. Bueche
DN: cn=Brandon J. Bueche, o=LDH MVA, ou=Program Operations & Compliance, email=brandon.bueche@la.gov, c=US
Date: 2023.06.27 10:12:57 -05'00'

Brandon Bueche
Section Chief, Medicaid Program Operations and Compliance

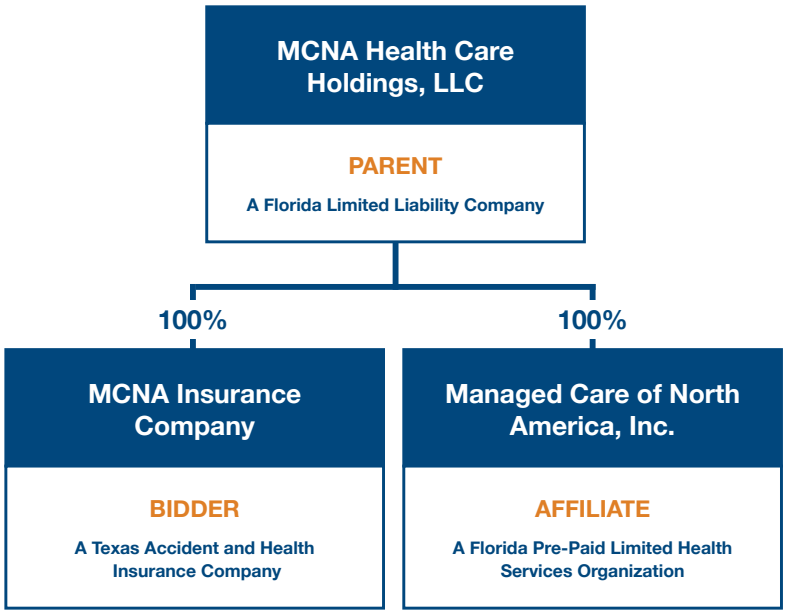
BB/sg

Bienville Building ▪ 628 N. Fourth St. ▪ P.O. Box 91030 ▪ Baton Rouge, Louisiana 70821-9030
Phone: (888) 342-6207 ▪ Fax: (225) 342-9508 ▪ www.ldh.la.gov
An Equal Opportunity Employer

Experience Managing Subcontractors

MCNA Insurance Company has contracted with our affiliate, Managed Care of North America, Inc., since 2011 to provide third-party administrative services including: claims processing and payment, credentialing, quality improvement, utilization management, network development, accounting and financial reporting, disaster recovery and overflow call center services, and information technology in all markets we serve. The information technology component consists of the use of the DentalTrac™ system, provider and member portals, file transfer and maintenance, encounter data submission, and all required reporting. We maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this contract, notwithstanding the use of a subcontractor.

Please see below a chart depicting MCNA Insurance Company's (bidder) relationship to MCNA Health Care Holdings, LLC (parent) and to Managed Care of North America, Inc. (affiliate).



Subcontractor Metrics and Evaluation

Should MCNA determine the need for a subcontractor, prior to executing a subcontract, MCNA will notify the Agency of our intended use of the subcontractor and provide the information required by the Agency, including how the work of the subcontractor will be supervise; how we will maintain channels of communication; how we will ensure compliance with contract terms and conditions, and our previous experience with the subcontractor. MCNA will perform a pre-delegation audit to evaluate the prospective subcontractor's qualifications and ability to perform the activities we will delegate.

MCNA has a written agreement with each material subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. All subcontractors are monitored in accordance with our MCO Subcontractor Monitoring Report and Calendar which is completed on an annual basis.

Monitoring to Ensure Compliance, Collaboration, and Quality

Our Quality Improvement Committee (QIC) and operational areas provide oversight of subcontractor performance on an ongoing basis according to a quarterly periodic schedule consistent with industry standards. Any deficiencies or areas for

improvement are identified, and corrective action is taken as needed. All subcontracts include the terms and conditions listed in the contract. No other terms or conditions agreed to by MCNA and its subcontractor shall negate or supersede the requirements in the contract.

MCNA performs ongoing monitoring of all approved subcontractors' performance to ensure contract compliance.

[redacted]

Termination, Litigation, and Investigation

In the past five years, MCNA Insurance Company (the bidder), MCNA Health Care Holdings, LLC (our parent company), and Managed Care of North America, Inc. (our affiliate), have not had:

- Any contract for services that was terminated for convenience, non-performance, non-allocation of funds, or any other reason for which termination occurred before completion of all obligations under the contract provisions.
- Any occurrences where the entity has either been subject to default or has received notice of default or failure to perform on a contract.
- Any settlements entered into by the entity under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by this RFP.
- Any irregularities that have been discovered in any of the accounts maintained by the entity on behalf of others.

All penalties, sanctions, fines, and monetary damages are listed earlier in the response to Tab 4, section "Debarments or Suspensions, Regulatory Actions, or Sanctions" of this RFP. MCNA, its owners, officers, primary partners, staff providing services or any owners, officers, primary partners, and staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, have never had a founded child or dependent adult abuse report, or been convicted of a felony.

MCNA Insurance Company, and our parent, MCNA Health Care Holdings, LLC, do not have any material pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of the services sought in this RFP.

Our affiliate subcontractor, Managed Care of North America, Inc., is involved in the following list of pending litigation with respect to a security incident resulting from a cybercriminal attack.

- Anson V. Managed Care of North America Inc.,
  United States District Court, Florida Southern Jun 13, 2023 0:23cv61139
- Branson V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 14, 2023 0:23cv61143
- Brown V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 09, 2023 0:23cv61112
- Buechler V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 22, 2023 0:23cv61192
- Carter V. Managed Care of North America, Inc. et al
  United States District Court, Florida Southern Jun 15, 2023 0:23cv61158
- Collins V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 27, 2023 0:23cv61226
- Crowe V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 05, 2023 0:23cv61065
- Doe Et Al V. Managed Care of North America, Inc. et al
  United States District Court, Florida Southern Jun 23, 2023 0:23cv61200
- Gonzalez V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 21, 2023 0:23cv61186
- Hanekom Et Al V. Managed Care of North America Inc.
  United States District Court, Florida Southern Jun 14, 2023 0:23cv61151

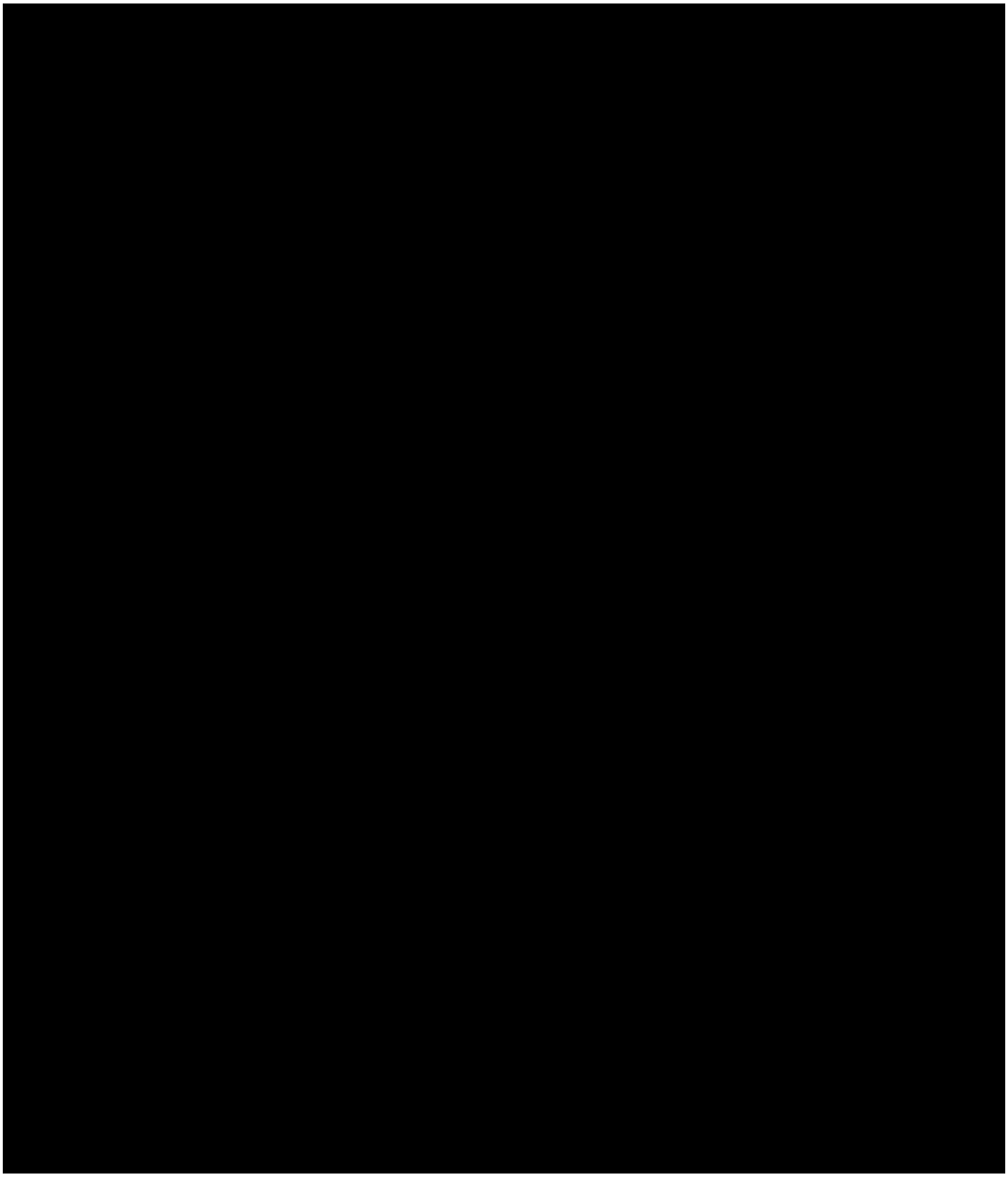
- Jackson V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 16, 2023 0:23cv61173
- Landry V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 16, 2023 0:23cv61171
- Manning V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 14, 2023 0:23cv61146
- Menendez V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 14, 2023 0:23cv61149
- Nelson V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 07, 2023 0:23cv61087
- Sheppard Et Al V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 26, 2023 0:23cv61222
- Shores V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 22, 2023 0:23cv61191
- Shuey Et Al V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 12, 2023 0:23cv61132
- Williams Et Al V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jun 22, 2023 0:23cv61193
- Conley Et Al V. Managed Care of North America, Inc.
  United States District Court, Florida Southern Jul 7, 2023 0:23cv61298

Tab 5: Personnel

Tables of Organization

Overall Operations

Staff Who Will Provide Services Under This RFP



Names and Credentials of Key Corporate Personnel and Information About Project Manager and Key Project Personnel

Owners and Executives

[redacted]

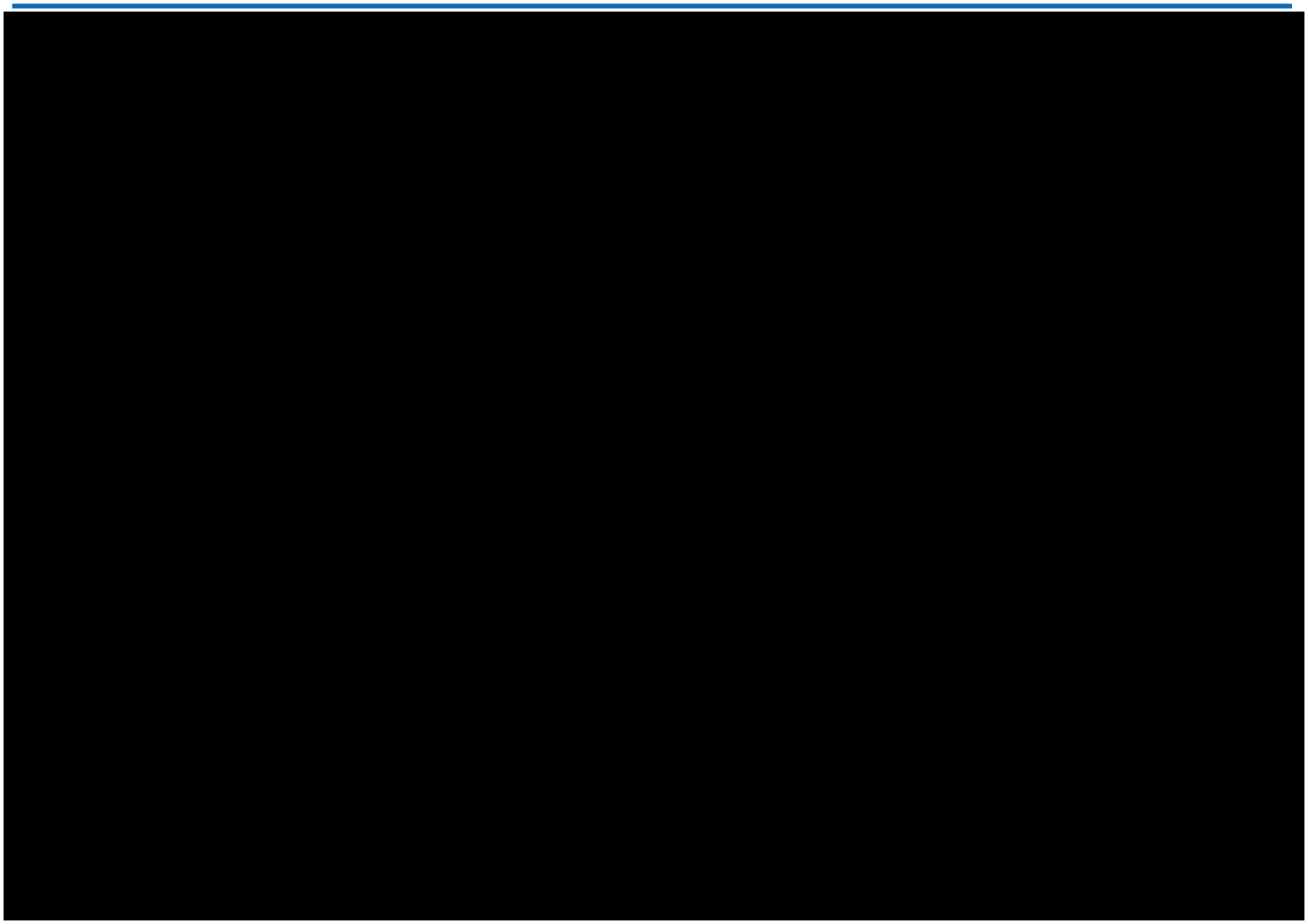
[redacted]

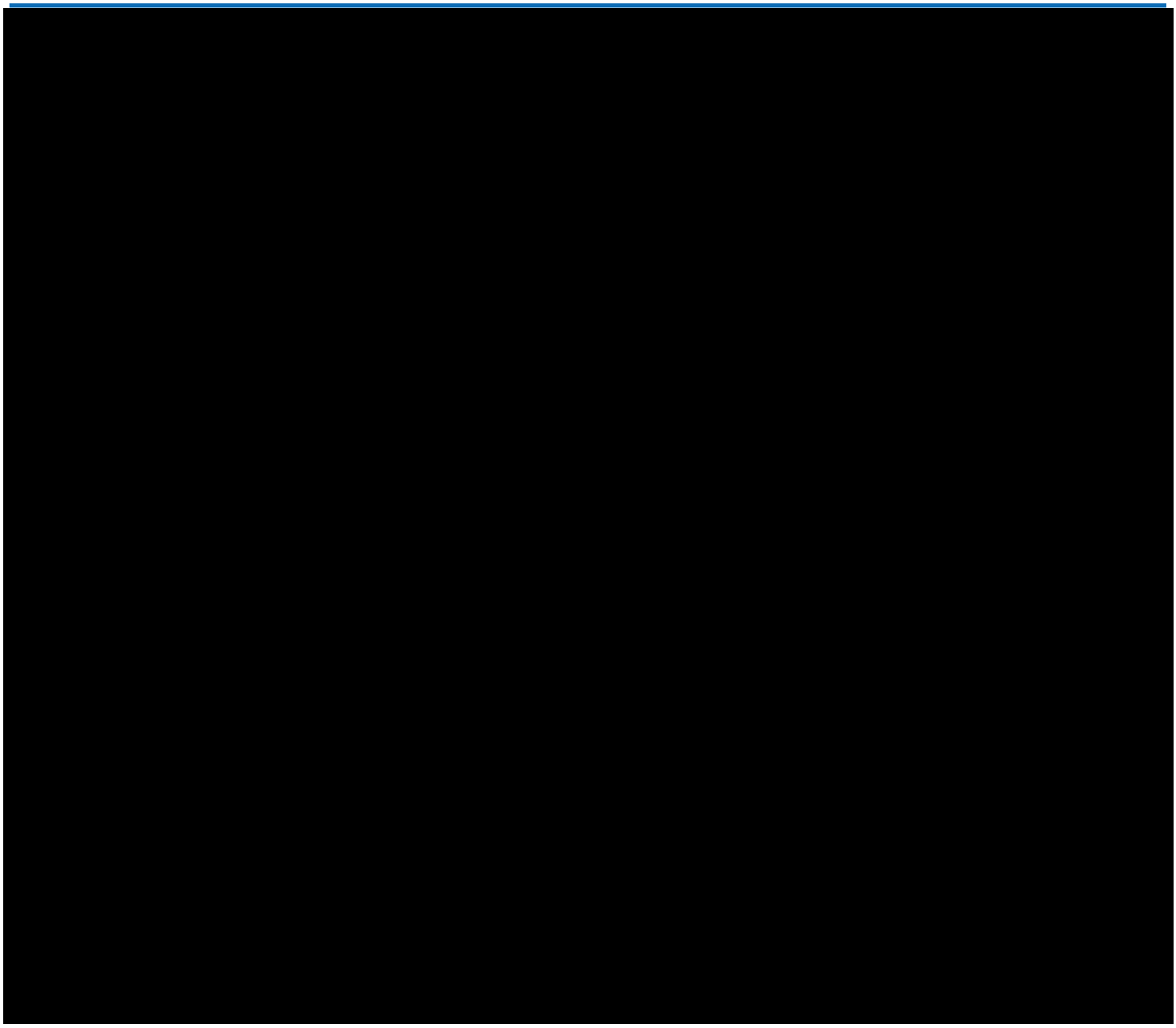
Board of Directors

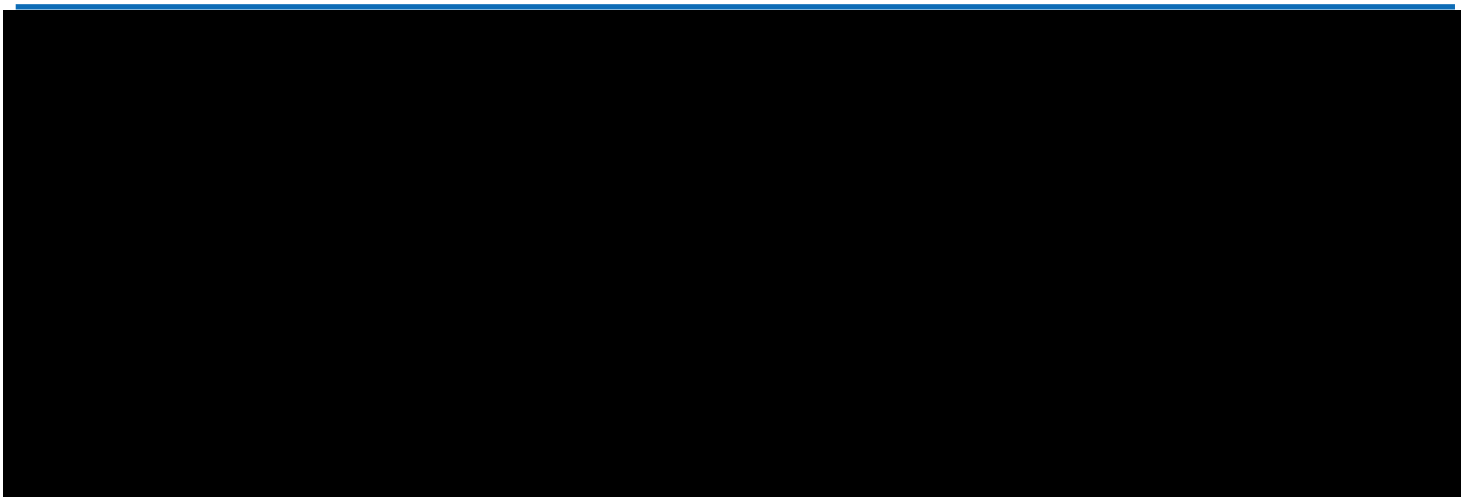
[redacted]

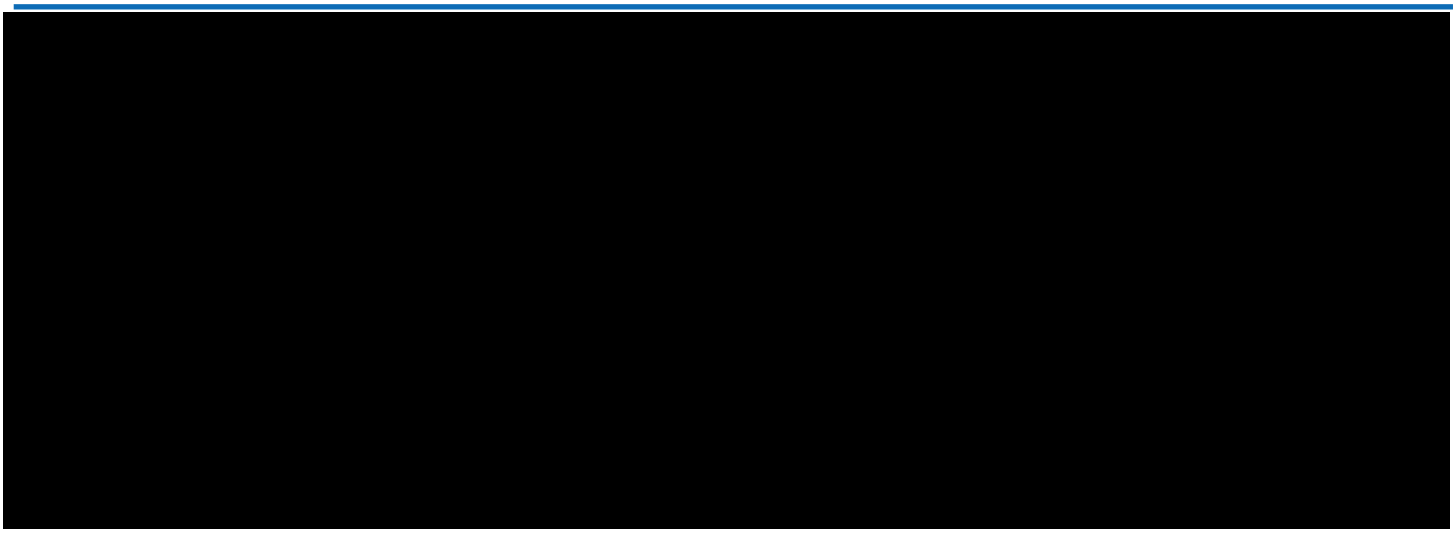
Resumes for Key Corporate, Administrative, and Supervisory Personnel & Resumes for Key Project Personnel

[redacted]









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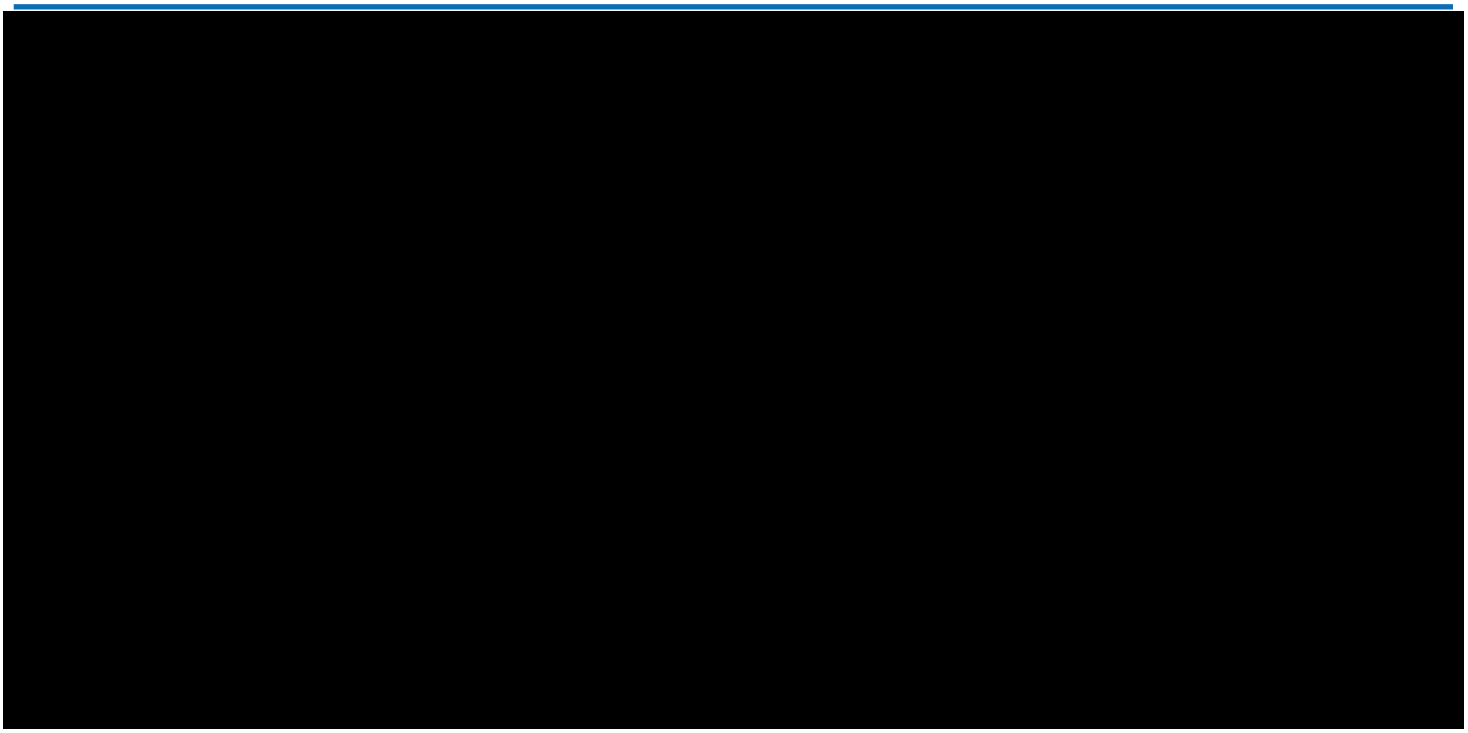

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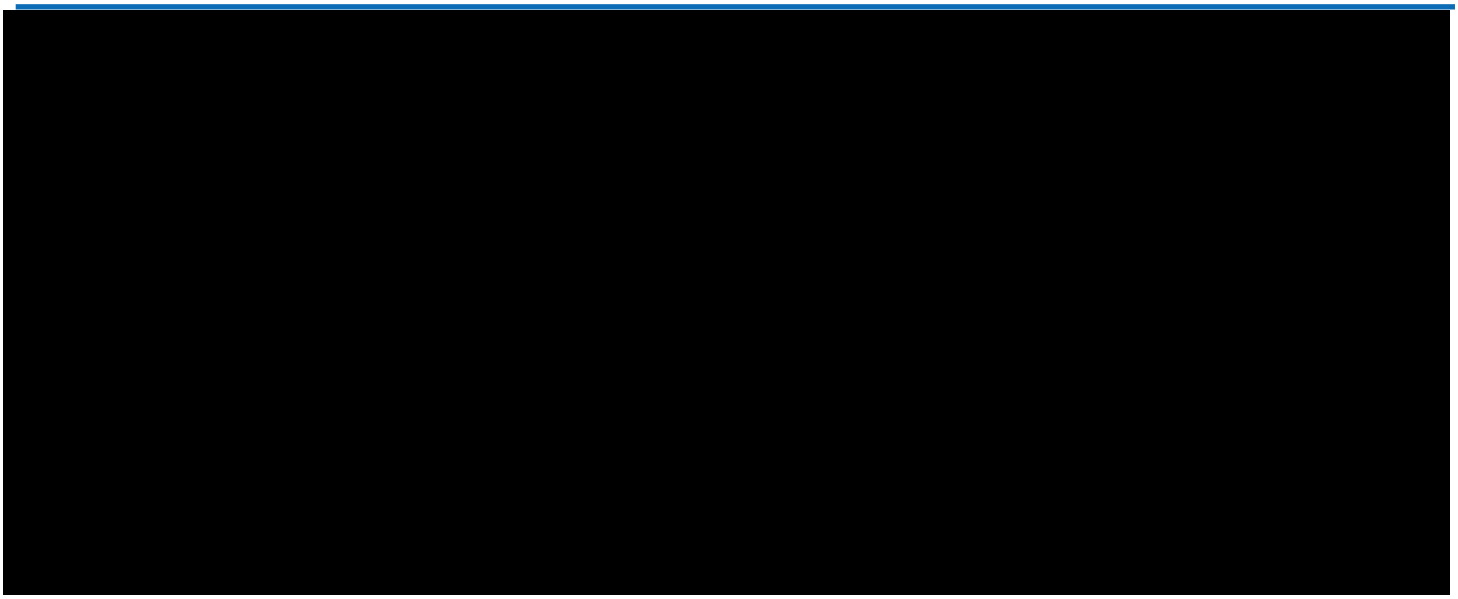

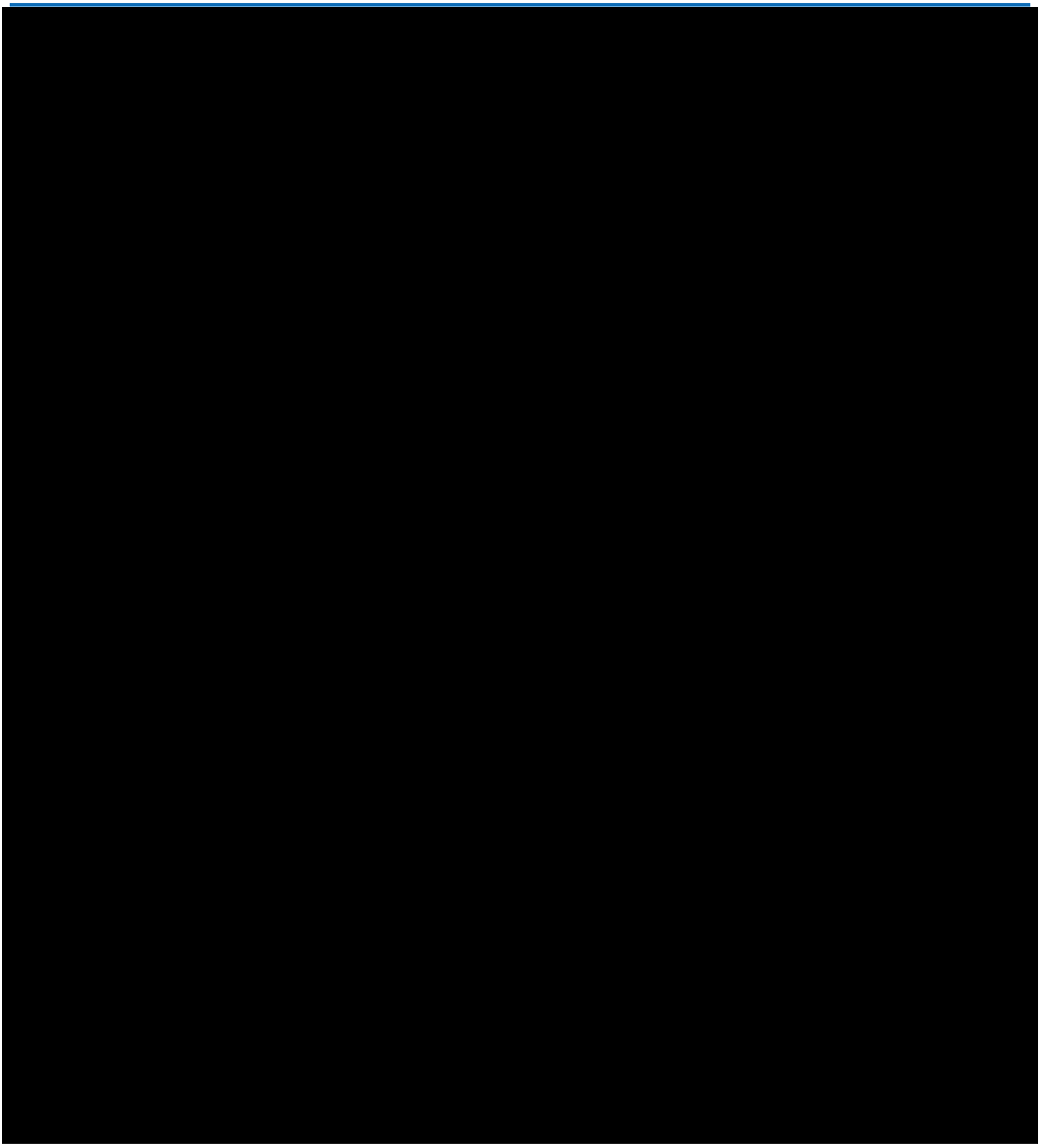

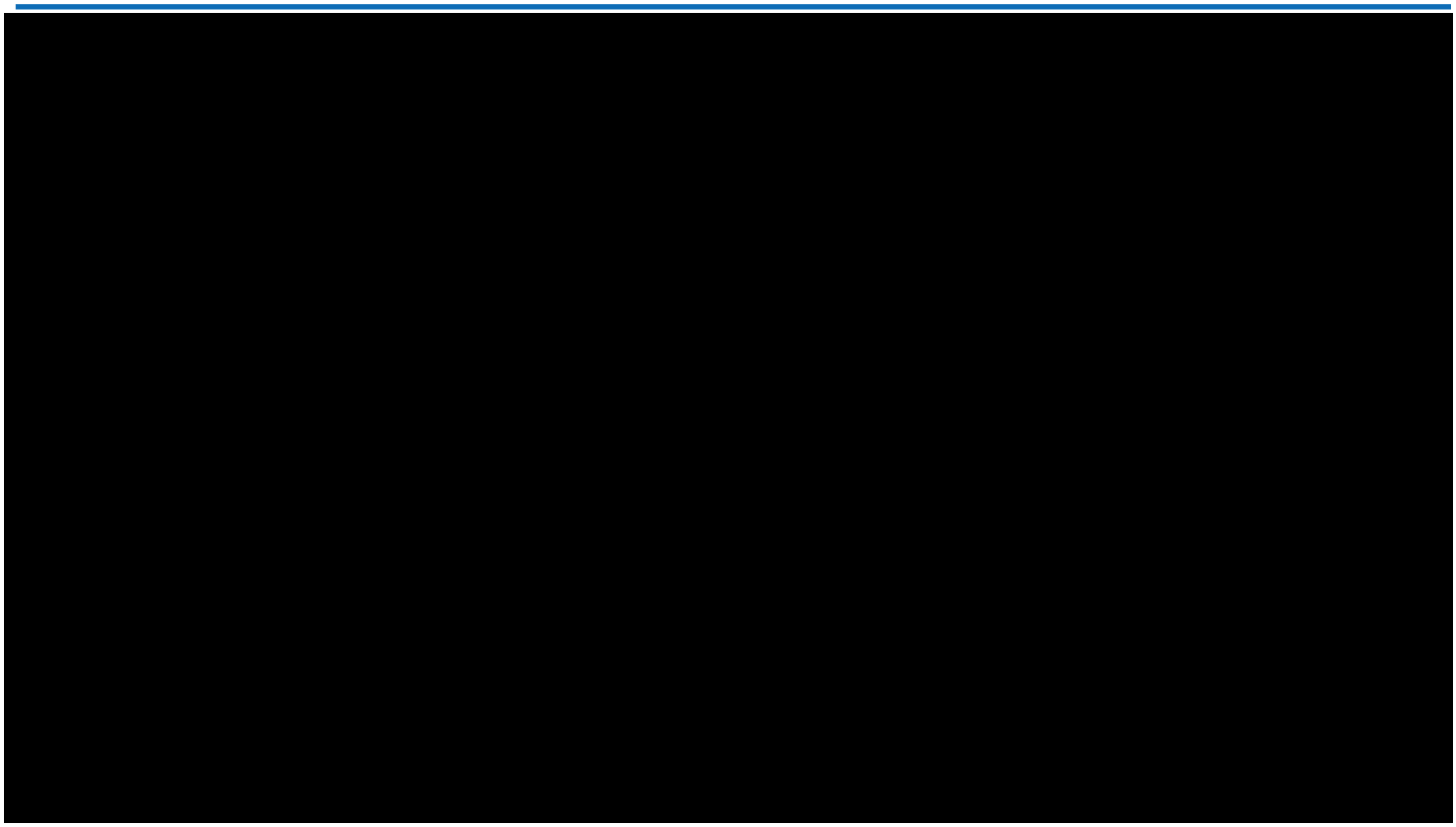

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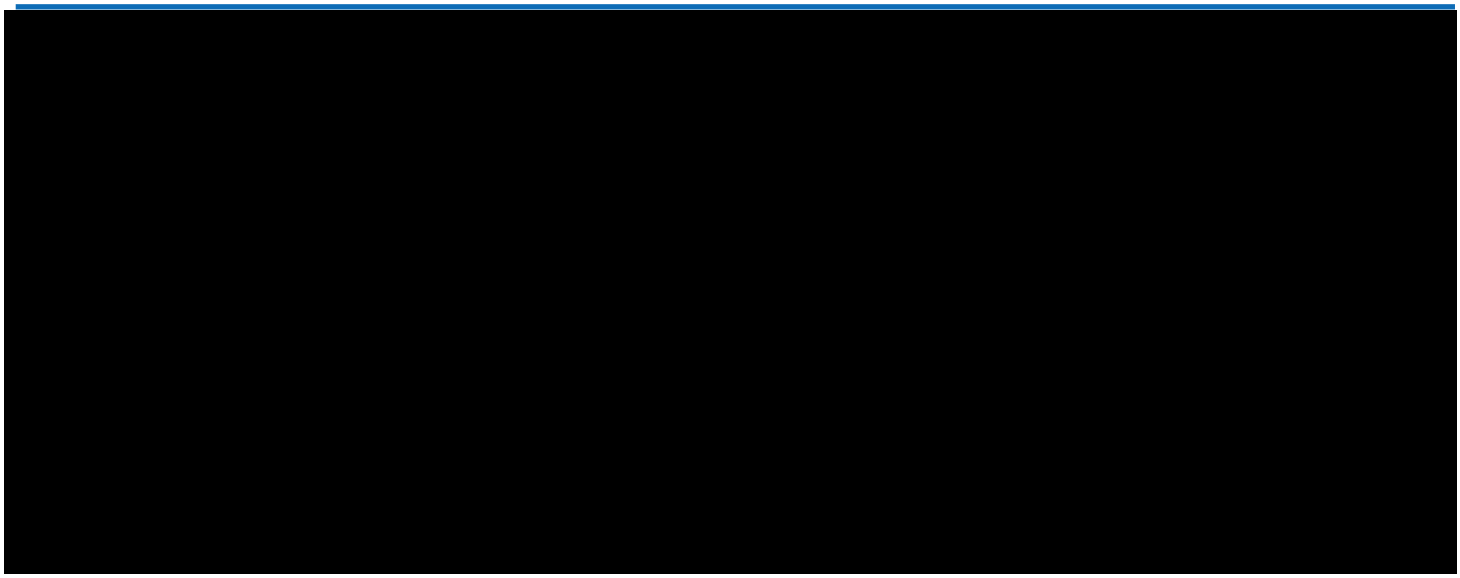

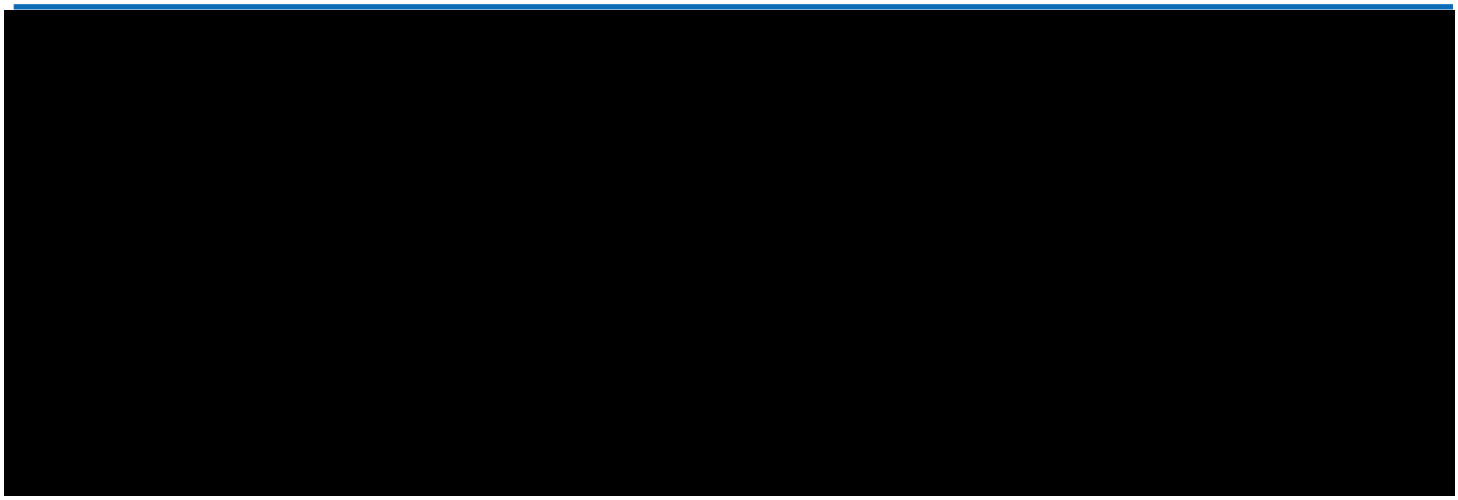

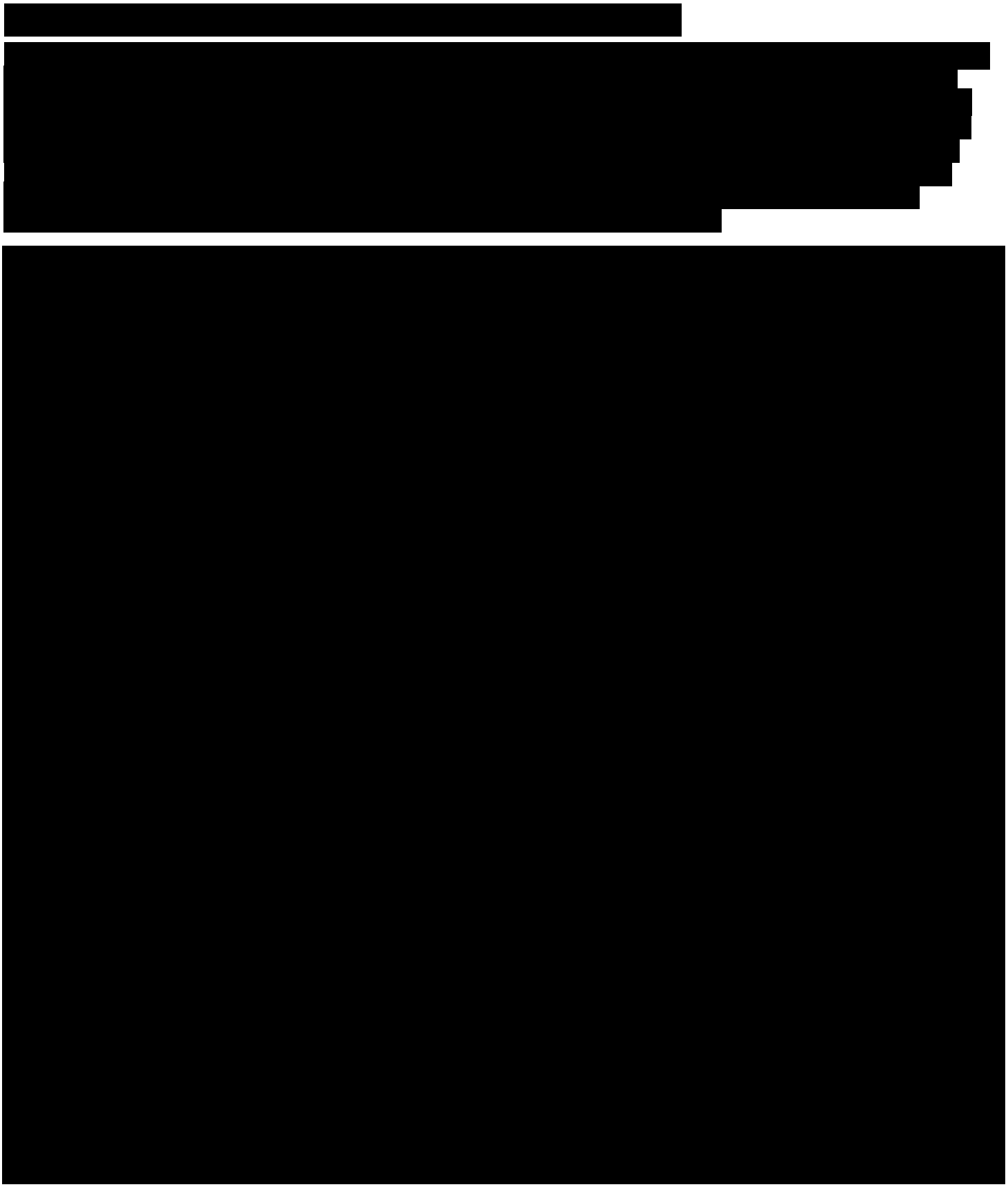

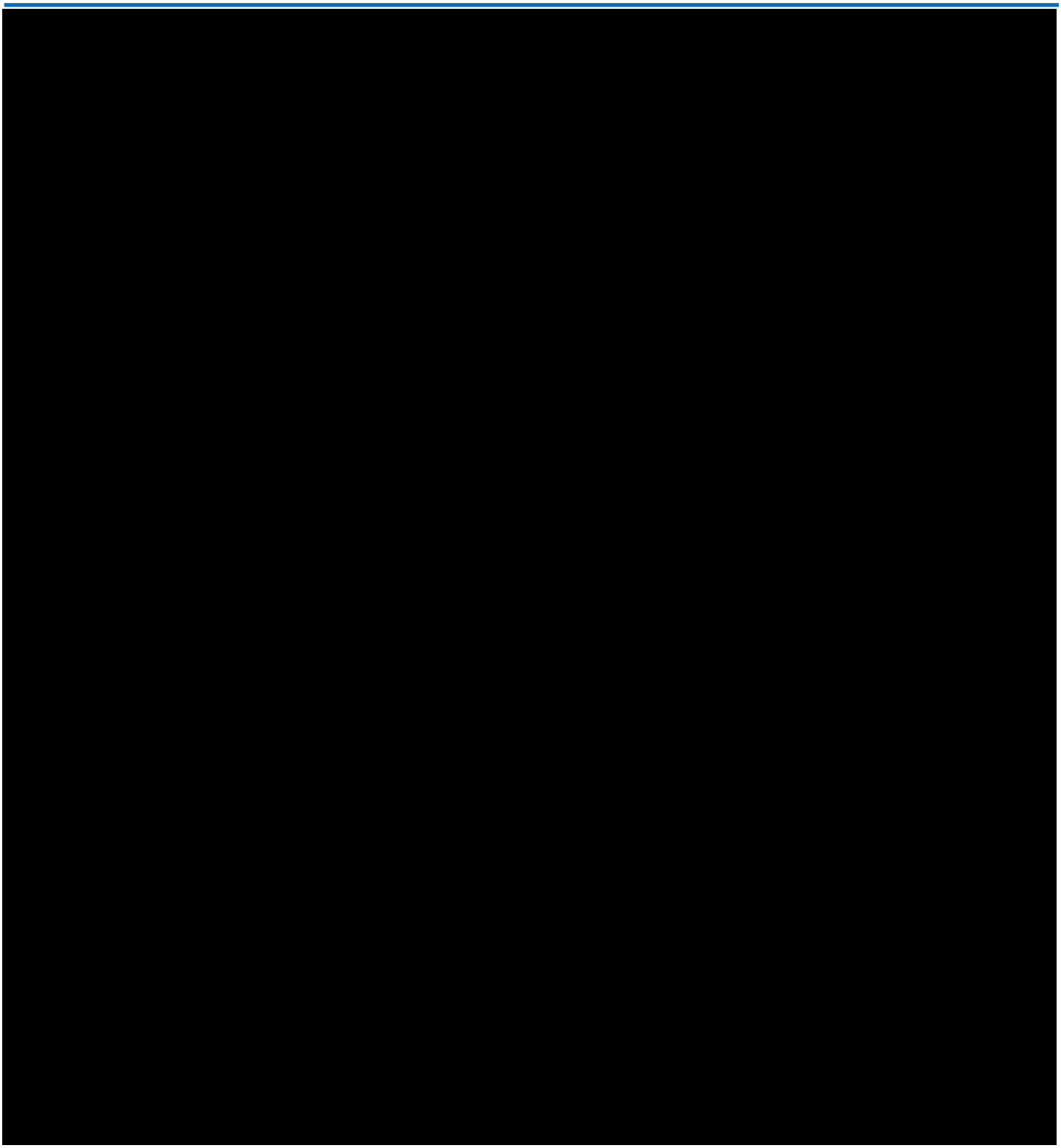

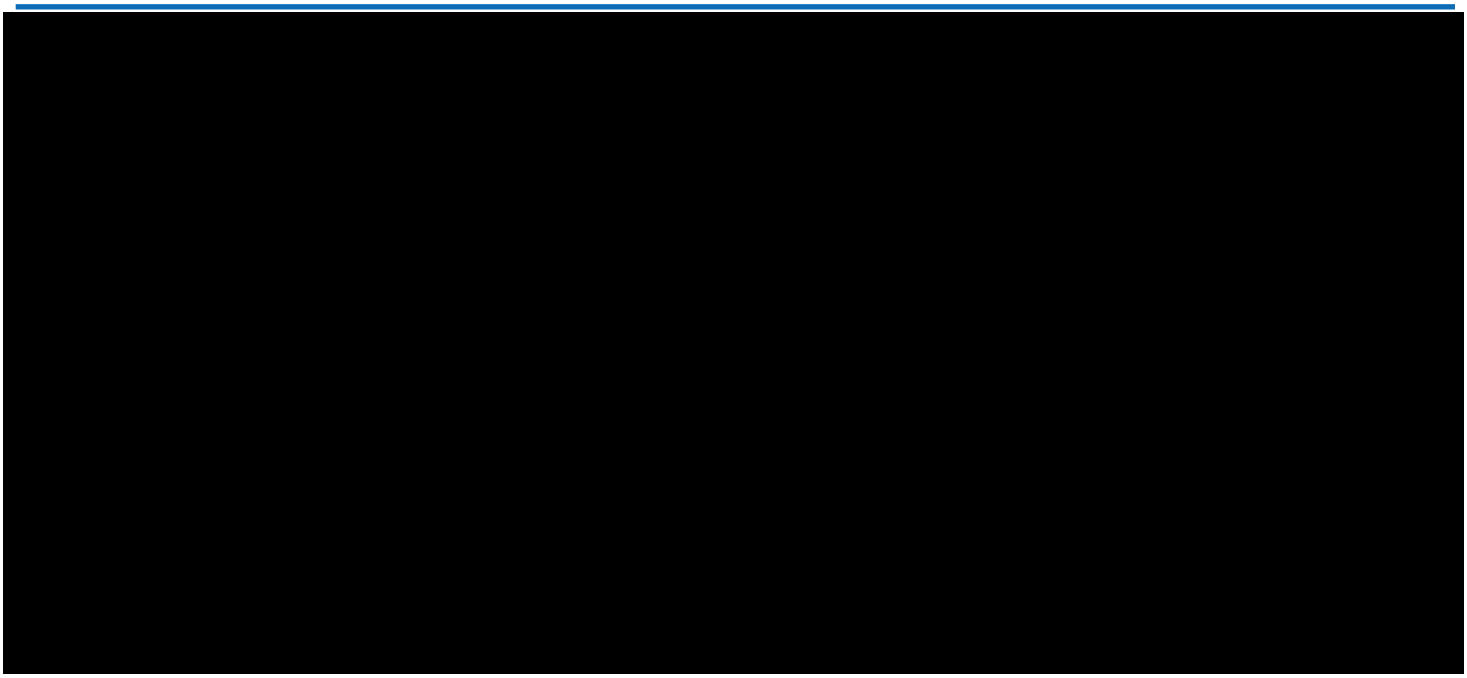

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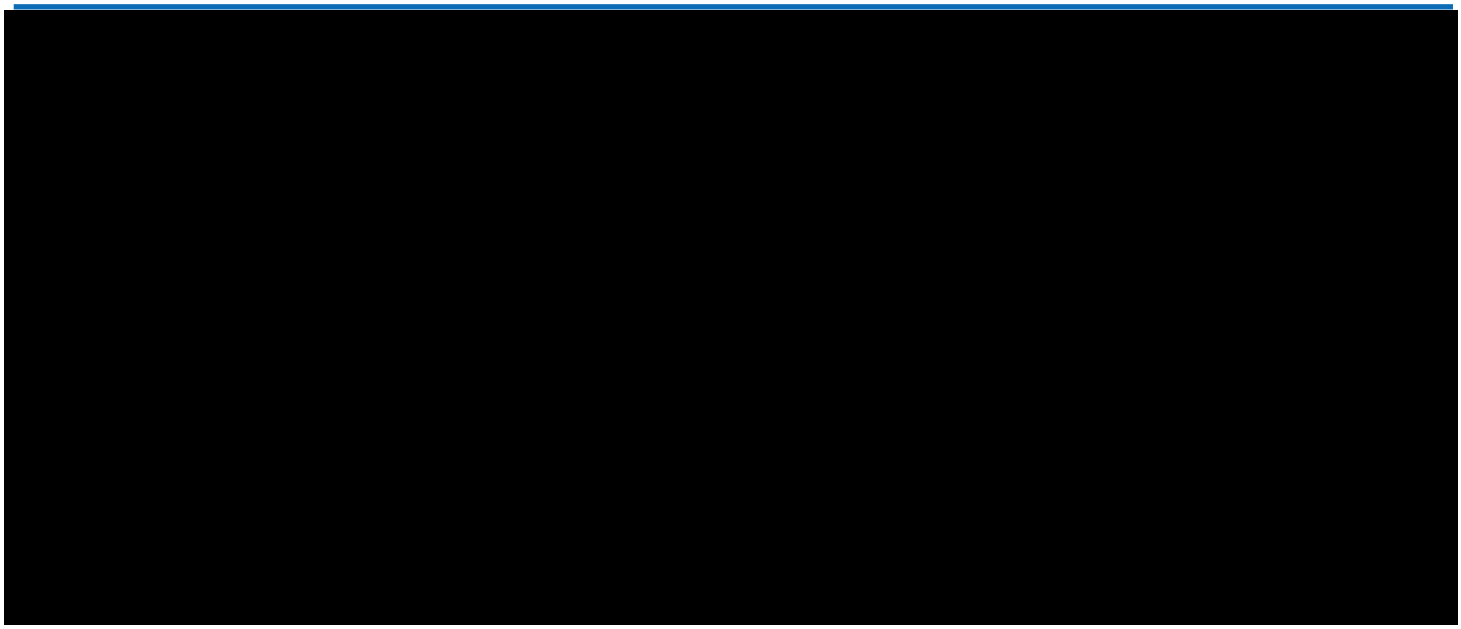

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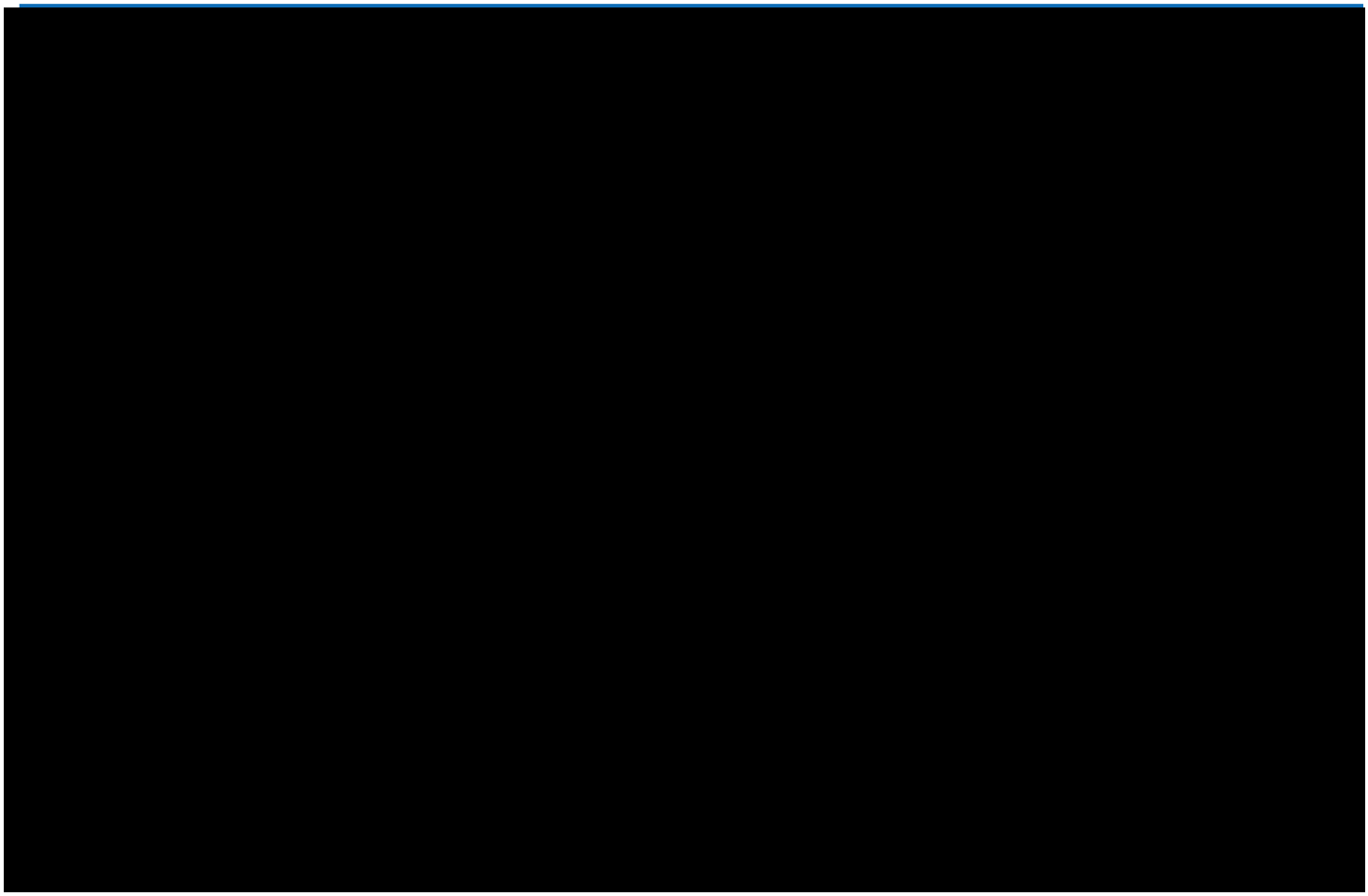

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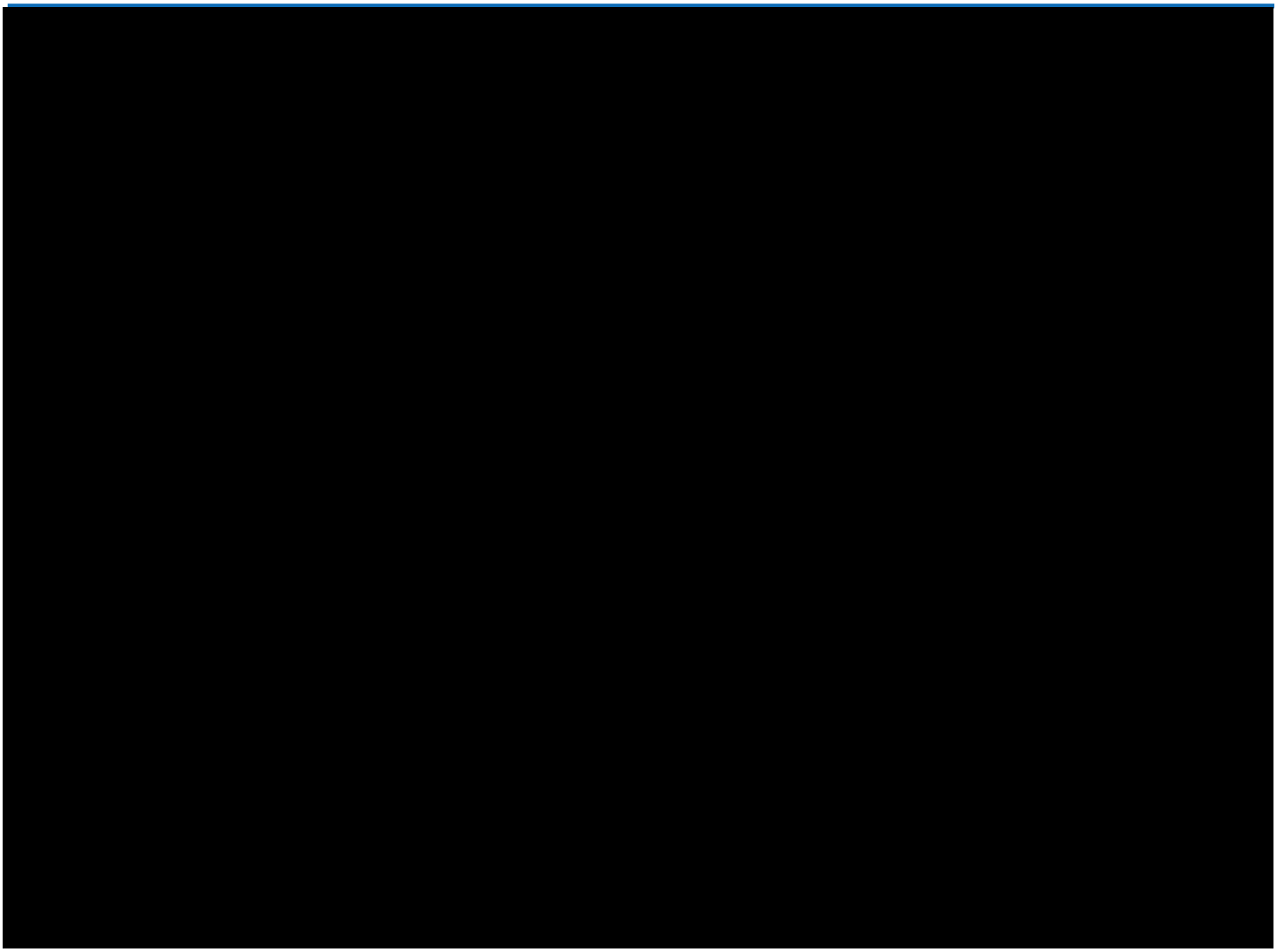

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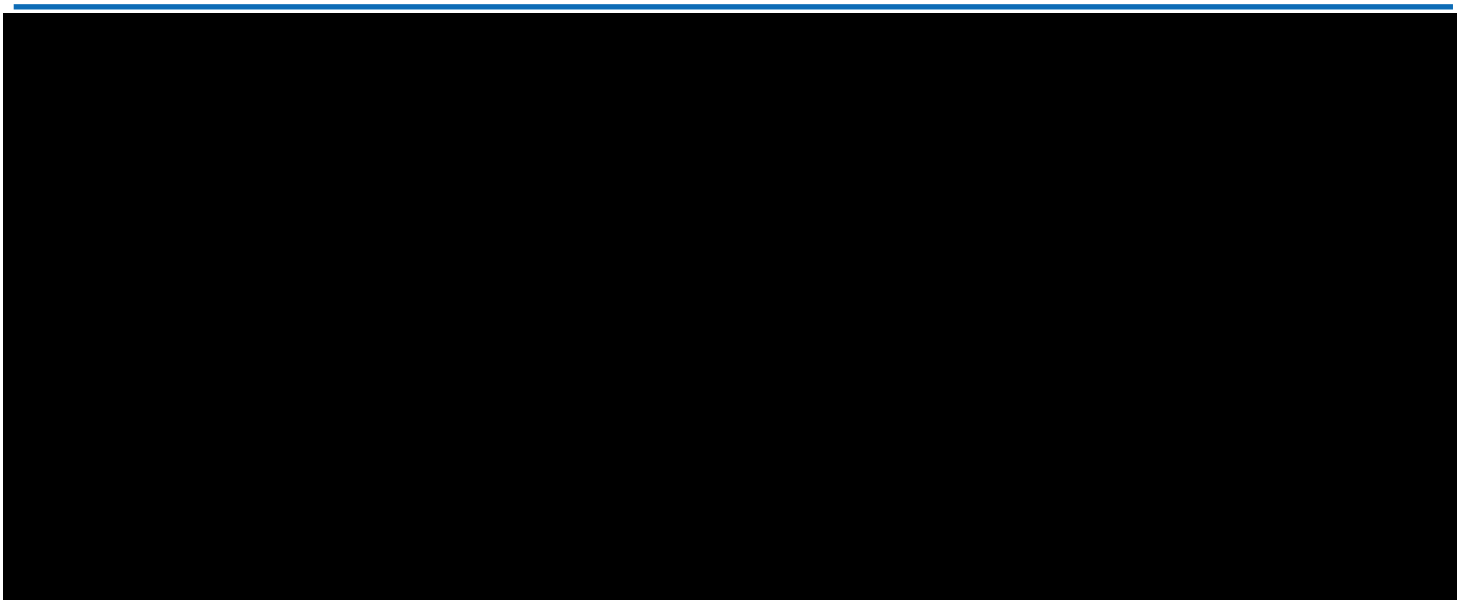

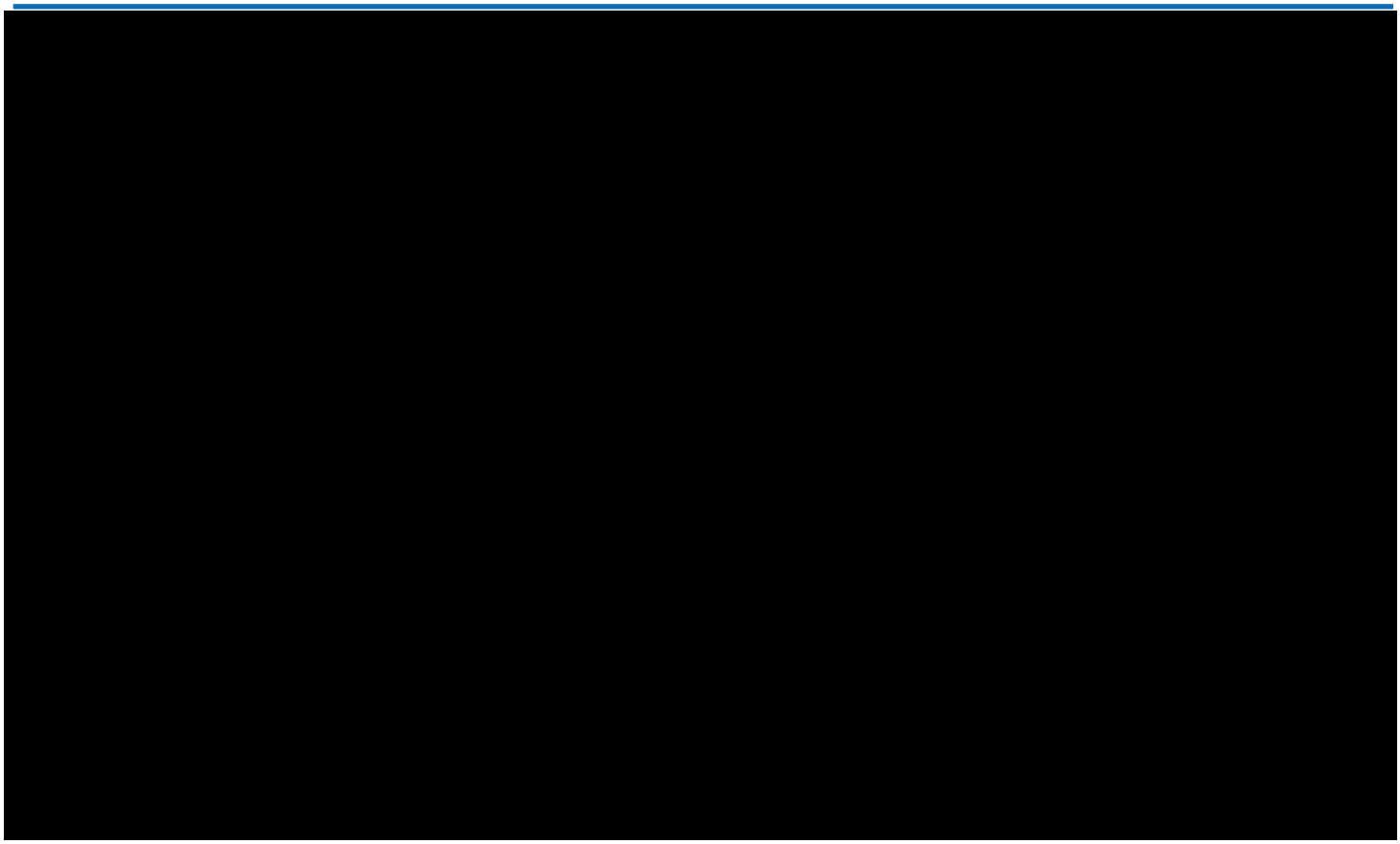

Tab 6: RFP Forms

Attachment A: Release of Information

RFP# MED-24-004
Iowa Dental Wellness Plan and Hawki Dental PAHP

Attachment A: Release of Information
(Return this completed form behind Tab 6 of the Bid Proposal.)

MCNA Insurance Company (name of Bidder) hereby authorizes any person or entity, public or private, having any information concerning the Bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Agency.

The Bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The Bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Agency or may otherwise hurt its reputation or operations. The Bidder is willing to take that risk. The Bidder agrees to release all persons, entities, the Agency, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

MCNA Insurance Company
Printed Name of Bidder Organization

Shannon LePage
Signature of Authorized Representative

July 10, 2023
Date

Shannon LePage, Chief Executive Officer
Printed Name

Page **25** of **201**
Form Date 6/24/20

Attachment B: Primary Bidder Detail & Certification Form

Attachment B: Primary Bidder Detail & Certification Form

(Return this completed form behind Tab 6 of the Proposal. If a section does not apply, label it "not applicable".)

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	**Shannon LePage**
Address:	**PO Box 740370, Atlanta, GA 30374-0370**
Tel:	**830-431-5051**
Fax:	**210-853-4946**
E-mail:	**slepage@mcna.net**

Primary Bidder Detail	
Business Legal Name ("Bidder"):	MCNA Insurance Company
"Doing Business As" names, assumed names, or other operating names:	MCNA Dental
NAIC Number:	14063
Parent Corporation Name and Address of Headquarters, if any:	MCNA Health Care Holdings, LLC PO Box 740370, Atlanta, GA 30374-0370
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	Corporation
State of Incorporation/organization:	Texas
Primary Address:	Mailing: PO Box 740370, Atlanta, GA 30374-0370 Physical: 6200 Northwest Parkway, San Antonio, TX 78249
Tel:	800-494-6262
Local Address (if any):	Site being selected and will be operational by March 1, 2024.
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	3100 SW 145th Avenue, Suite #200, Miramar, FL 33027 6200 Northwest Parkway, San Antonio, TX 78249 2021 Transformation Drive, Suite #1400, Lincoln, NE 68508 1401 West Capitol Avenue, Suite #170, Little Rock, AR 72201 3850 North Causeway Boulevard, Suite #1510, Metairie, LA 70002
Number of Employees:	Approximately 400, with approximately 600 across the MCNA family of companies.
Number of Years in Business:	32
Primary Focus of Business:	Medicaid and CHIP Dental Benefits Administration
Federal Tax ID:	52-2459969
UEI #:	G8HWKM9ADJ74
Bidder's Accounting Firm:	MCNA performs all accounting functions internally. Our third-party accounting audit firm for 2023 is Baker Tilly US, LLP.
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	MCNA was licensed in Iowa on 7/22/2015.
Do you plan on using subcontractors if awarded this Contract? {If "YES," submit a Subcontractor Disclosure Form for each proposed subcontractor.}	Yes, we will be using our affiliate, Managed Care of North America, Inc., to provide third-party administrative services.
	(YES/NO)

Request for Confidential Treatment (See Section 3.1)		
Check Appropriate Box: ☐ **Bidder Does Not Request Confidential Treatment of Bid Proposal** ☒ **Bidder Requests Confidential Treatment of Bid Proposal**		
Location in Bid Proposal (Tab/Page)	**Specific Grounds in Iowa Code Chapter 22 or Other Applicable Law Which Supports Treatment of the Information as Confidential**	**Justification of Why Information Should Be Kept in Confidence and Explanation of Why Disclosure Would Not Be in The Best Interest of the Public**
Tab 3, Pages 14-19	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public staffing plan is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Page 22	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This strategic partnership information is not public information and is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 24-27	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public implementation plan is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 29-30	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This risk management and education methodology is a competitive differentiator and is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Page 32	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public call center technology and performance information is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 33-34	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This approach to outreach and education is a competitive differentiator and is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Page 35	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This proprietary technology and methodology for addressing healthcare gaps and disparities is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Page 38	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public process flowchart is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Page 39	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public technology and enrollment methodology is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 41-42	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public member assignment and contact methodology is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 46-60, 64, 67-72, 75-76	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public staffing, beneficiary notification and education, and call center methodology, as well as proposed value-added services, are a competitive differentiator and are considered a Trade Secret as defined

		by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Page 84	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public payment result is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 86-105, 107-118	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public approach and methodology for strategic dental partnerships, communications, provider recruitment, onboarding, dental record review, and education are a competitive differentiator and are considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 119, 121-122, 124-127	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public approach, technology, and methodology for value-added services, strategic partnerships, dental staffing, UM program, development of clinical practice guidelines, and provider support are a competitive differentiator and are considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 137-148, 150-192	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public approach, technology, and methodology for execution of our quality strategy, quality outcomes, community engagement, care coordination, UM program and processes, staffing and training, VBP and APM, and cultural competency are a competitive differentiator and are considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 193-197, 200, 203-204, 207-208	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public approach, technology, and methodology for processing complaints, grievances, and appeals are a competitive differentiator and are considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 209, 211-217, 221-228, 230-242	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public approach, technology, and methodology for program integrity, encounters, system edits, compliance oversight, reporting, auditing and internal controls, and training are a competitive differentiator and are considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 244-269	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public program integrity plan is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 271-274, 275-277	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public approach, technology, and methodology for cultural competency, subcontracting, and TPL are a competitive differentiator and are considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 279, 281-282	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public financial information, and our approach, technology, and methodology for implementations and disaster recovery/business continuity are a competitive differentiator and are considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.

Tab 3, Pages 284-299, 301-343	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This detail of our non-public and proprietary technology solutions, including security information and schematics, and our process for completing deliverables and audits utilizing this proprietary technology are a competitive differentiator and are considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 346-354	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public transition plan is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 3, Pages 355-362	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This non-public approach, technology, and methodology for reporting, data maintenance, auditing, and agency communications are a competitive differentiator and are considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 4, Pages 364-366	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This overview of technical experience is a competitive differentiator, contains results and methodology for completing deliverables, and is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 4, Pages 371-387	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This plan listing contains confidential financial, contract, agency contact, and performance information and is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 4, Page 398	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This subcontractor oversight detail and methodology is not public information and is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.
Tab 5, Pages 402-447	Trade secrets pursuant to IA Code §22.7 and IA Code §550.2.	This detailed organization structure, personnel listing, resource allocation, and personal resumes for staff is not public information and is considered a Trade Secret as defined by IA Code § 550.2 and exempt from disclosure pursuant to IA Code § 22.7.

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language:**	**Cost Savings to the Agency if the Proposed Replacement Language is Accepted**
N/A	**N/A**	**N/A**	**N/A**

PRIMARY BIDDER CERTIFICATIONS

1. BID PROPOSAL CERTIFICATIONS. By signing below, Bidder certifies that:

1.1 Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change except as otherwise expressly stated in the Primary Bidder Detail & Certification Form. Objections or responses shall not materially alter the RFP. All changes to proposed contract language, including deletions, additions, and substitutions of language, must be addressed in the Bid Proposal. The Bidder accepts and shall comply with all Contract Terms and Conditions contained in the Sample Contract without change except as set forth in the contract;

1.2 Bidder has reviewed the Additional Certifications, which are incorporated herein by reference, and by signing

below represents that Bidder agrees to be bound by the obligations included therein;

1.3 Bidder has received any amendments to this RFP issued by the Agency;

1.4 *Reserved*;

1.5 If Bidder requests confidential treatment of any information submitted in its Proposal, the Bidder expressly acknowledges and agrees that the Agency's evaluation document(s) may reference information of which the Bidder requested confidential treatment in the Bid Proposal. These Agency evaluation documents may then be in the public domain and be open to inspection by interested parties upon the Agency's issuance of a Notice of Intent to Award. The Agency will not redact information or references to information in evaluation documents even in instances which a Bidder requested confidential treatment in the Bid Proposal; and,

1.6 The person signing this Bid Proposal certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make decisions regarding the prices quoted and, Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one (1) year from the issuance of this RFP, whichever is earlier.

2. SERVICE AND REGISTRATION CERTIFICATIONS. By signing below, Bidder certifies that:

2.1 Bidder certifies that the Bidder's organization has sufficient personnel and resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Agency to substitute staff;

2.2 Bidder certifies that if the Bidder is awarded the contract and plans to utilize subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Agency in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Agency and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract;

2.3 Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a contract pursuant to this RFP;

2.4 Bidder certifies it is either: 1) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or 2) not a "retailer" of a "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Agency may declare the Bid Proposal void if the above certification is false. Bidders may register with the Department of Revenue online at: http://www.state.ia.us/tax/business/business.html; and

2.5 Bidder certifies it will comply with Davis-Bacon requirements if applicable to the resulting contract.

3. ADDITIONAL CERTIFICATIONS. By signing below, Bidder certifies that:

3.1 Bidder will furnish the services required by Enrolled Members as promptly as is appropriate and that the services provided will meet the Agency's quality standards;

3.2 The capitation rates will cover included covered services and meet the Medical Loss Ratio requirements as listed in Section 3: Special Contract Exhibits, Exhibit A. Per RFP Section 1.3.3.1 Pricing, the Agency will exclude from the capitation rates the select services and treatments as set forth in Special Contract Exhibit A;

3.3 The liquidated damages, as described in Section 3: Special Contract Exhibits, Exhibit A, may be imposed for failure to perform as set forth in this RFP; and

3.4 The contract will be performance-based and incentives may apply to the Contractor's performance as set forth in this RFP.

4. EXECUTION.

By signing below, I certify that I have the authority to bind the Bidder to the specific terms, conditions, and technical specifications required in the Agency's RFP and offered in the Bidder's Proposal. I understand that by submitting this Bid Proposal, the Bidder agrees to provide services described herein which meet or exceed the

specifications of the Agency's RFP. The Bidder has not participated, and will not participate, in any action contrary to the anti-competitive obligations outlined in the Additional Certifications. I certify that the contents of the Bid Proposal are true and accurate and that the Bidder has not made any knowingly false statements in the Bid Proposal.

Signature:	Shannon LePage
Printed Name/Title:	Shannon LePage, Chief Executive Officer
Date:	July 10, 2023

Attachment C: Subcontractor Disclosure Form

Attachment C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it "not applicable." If the Bidder does not intend to use subcontractor(s), this form does not need to be returned.)*

Primary Bidder ("Primary Bidder"):	**MCNA Insurance Company**
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	**Shannon LePage**
Address:	**PO Box 740370, Atlanta, GA 30374-0370**
Tel:	**830-431-5051**
Fax:	**210-853-4946**
E-mail:	**slepage@mcna.net**

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	**Managed Care of North America, Inc.**
"Doing Business As" names, assumed names, or other operating names:	MCNA Dental Plans
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Corporation
State of Incorporation/organization:	Florida
Primary Address:	Mailing: PO Box 740370, Atlanta, GA 30374-0370 Physical: 3100 SW 145th Avenue, Suite #200, Miramar, FL 33027
Tel:	800-494-6262
Fax:	210-853-4946
Local Address (if any):	Site being selected and will be operational by March 1, 2024.
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	3100 SW 145th Avenue, Suite #200, Miramar, FL 33027 6200 Northwest Parkway, San Antonio, TX 78249 2021 Transformation Drive, Suite #1400, Lincoln, NE 68508 1401 West Capitol Avenue, Suite #170, Little Rock, AR 72201 3850 North Causeway Boulevard, Suite #1510, Metairie, LA 70002
Number of Employees:	Approximately 200, with approximately 600 across the MCNA family of companies.
Number of Years in Business:	32
Primary Focus of Business:	Medicaid and CHIP Dental Benefits Administration
Federal Tax ID:	65-0303864
Subcontractor's Accounting Firm:	MCNA performs all accounting functions internally. Our third-party accounting audit firm for 2023 is Baker Tilly US, LLP.
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	N/A
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	40%

General Scope of Work to be performed by this Subcontractor
MCNA Insurance Company contracts with our affiliate, Managed Care of North America, Inc., to provide third party administrative services, including: claims processing and payment credentialing, quality improvement, utilization management, network development, accounting and financial reporting, disaster recovery and overflow call center services, and information technology.
Detail the Subcontractor's qualifications for performing this scope of work
Managed Care of North America, Inc., has provided this scope of work to MCNA Insurance Company since 2011. Since 2016, Managed Care of North America, Inc., has been a subcontractor to MCNA Insurance Company for our Iowa DWP contract. Managed Care of North America, Inc., performs substantially similar services to those outlined in this RFP as a subcontractor to MCNA Insurance Company in the following markets: Iowa, Arkansas, Idaho, Louisiana, Nebraska, Texas, and Utah.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning Bidder in this procurement;
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications;
3. Subcontractor recognizes and agrees that if the Primary Bidder enters into a contract with the Agency as a result of this RFP, all restrictions, obligations, and responsibilities of the contractor under the contract shall also apply to the subcontractor;
4. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law; and,
5. Subcontractor certifies that it will comply with Davis-Bacon requirements if applicable to the resulting contract.

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and the Subcontractor has not participated, and will not participate, in any action contrary to the anti-competitive obligations outlined in the Additional Certifications.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	Shannon LePage
Printed Name/Title:	Shannon LePage, Chief Executive Officer
Date:	July 10, 2023

Attachment E: Certification and Disclosure Regarding Lobbying

Attachment E: Certification and Disclosure Regarding Lobbying
(Return this executed form behind Tab 6 of the Bid Proposal.)

Instructions:
Title 45 of the Code of Federal Regulations, Part 93 requires the bidder to include a certification form, and a disclosure form, if required, as part of the bidder's proposal. Award of the federally funded contract from this RFP is a Covered Federal action.

1) The bidder shall file with the Agency this certification form, as set forth in Appendix A of 45 CFR Part 93, certifying the bidder, including any subcontractor(s) at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) have not made, and will not make, any payment prohibited under 45 CFR § 93.100.
2) The bidder shall file with the Agency a disclosure form, set forth in Appendix B of 45 CFR Part 93, in the event the bidder or subcontractor(s) at any tier (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) has made or has agreed to make any payment using non-appropriated funds, including profits from any covered Federal action, which would be prohibited under 45 CFR § 93.100 if paid for with appropriated funds. All disclosure forms shall be forwarded from tier to tier until received by the bidder and shall be treated as a material representation of fact upon which all receiving tiers shall rely.

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an 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, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure Form to Report Lobbying,'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure Form to Report Lobbying,'' in accordance with its instructions.

Submission of this statement is a pre-requisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 for each such failure.

I certify that the contents of this certification are true and accurate and that the bidder has not made any knowingly false statements in the Bid Proposal. I am checking the appropriate box below regarding disclosures required in Title 45 of the Code of Federal Regulations, Part 93.

✓ The bidder is NOT including a disclosure form as referenced in this form's instructions because the bidder is NOT required by law to do so.

☐ The bidder IS filing a disclosure form with the Agency as referenced in this form's instructions because the bidder IS required by law to do so. If the bidder is filing a disclosure form, place the form immediately behind this in the Proposal.

Signature:	Shannon LePage
Printed Name/Title:	Shannon LePage, Chief Executive Officer
Date:	July 10, 2023