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

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

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

Revision 1. Contract Cover Page, under "Agency Billing Contact Name/Address" and "Contract Manager Name/Address ("Notice Address"), the contract manager's name and phone number, is hereby amended as follows:

Ashley Miller
515-380-2973

Revision 2. Contract Cover Page, under "Agency Billing Contact Name/Address" and "Contract Manager Name/Address ("Notice Address"), the contract manager's name, phone number and email, is hereby amended as follows:

Ashley Miller
Phone: 515-380-2973
E-Mail: ashley.miller9@hhs.iowa.gov

Revision 3. Table of Contents. C.6: Provider Terminations and Incentive Payment, is hereby amended as follows:
C.6: Provider Terminations and Incentive Payment Programs

Revision 4. Table of Contents. E.8. Provider Incentive Plan, is hereby amended as follows:
E.8: Provider Incentive Payment Programs

Revision 5. Table of Contents. Exhibit G: State Directed Payments, is hereby added.
Exhibit G: State Directed Payments

Revision 6. A.07(e)(14). Program Integrity Manager and Special Investigations Unit Staffing, the term "at least," is hereby removed.

Revision 7. B.1.03. Other Discrimination Prohibited, is hereby replaced as follows:
B.1.03. *Other Discrimination Prohibited*. The Contractor shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, disability or sex which includes discrimination on the basis of sex characteristics, including intersex traits, pregnancy or related conditions; sexual orientation; and sex stereotypes. See: 42 C.F.R. § 438.3(d)(4); 42 C.F.R. § 457.1201(d); 45 C.F.R. § 92.B.1.04.

Revision 8. B.1.04. Non-Discriminatory Policies, is hereby replaced as follows:
B.1.04. *Non-Discriminatory Policies.* The Contractor shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, disability or sex which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and sex stereotypes. See: 42 C.F.R. § 438.3(d)(4); 42 C.F.R. § 457.1201(d); 45 C.F.R. § 92.

Revision 9. C.6. Provider Terminations and Incentives, is hereby replaced as follows:
C.6 Provider Terminations and Incentives Payment Programs
C.6.01. *Provider Terminations – Timeline.* The Contractor shall make a good faith effort to give written notice of termination of a contracted Provider to each Enrolled Member who received their primary care from, or was seen on a regular basis by, the terminated provider no later than thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. See: 42 C.F.R. § 438.10(f)(1); 42 C.F.R. § 457.1207. {From CMSC C.6.01}.

C.6.02. *Information Regarding Provider Incentive Payment Programs.* The Contractor shall make available, upon request, any physician incentive plans, defined as provider incentive payment programs within Section C.6, Section D.4, Section E.8, and Section G.5 in place. See: 42 C.F.R. § 438.10(f)(3); 42 C.F.R. § 438.3(i); 42 C.F.R. § 457.1207. {From CMSC C.6.02}.

C.6.03. *Provider Incentive Payment Programs.* The Contractor shall establish performance-based incentive programs for its Providers. The Contractor shall follow the requirements for developing Provider incentive payment programs within this section and subsections. These programs shall include clearly defined, objectively measurable and well-documented clinical or quality improvement standards that the provider must meet to receive the incentive plan. The Contractor shall obtain the Agency approval prior to implementing any Provider incentive payment program and before making any changes to an approved incentive. The Agency encourages creativity in designing incentive programs that encourage positive Enrolled Member engagement and health Outcomes tailored to issues prevalent among Enrolled Membership as identified by the Contractor. The Contractor shall provide information concerning its Provider incentive payment program plan, upon request, to its Enrolled Members and in any Marketing Materials in accordance with the disclosure requirements stipulated in federal regulations. See: 42 C.F.R. § 438.3(i); 42 C.F.R § 438.8(e)(2)(iii)(A)

C.6.04. *Provider Incentive Payment Program Contract Requirements*. The Contractor's Provider incentive payment program contracts with network Providers shall:

a) Have a defined performance period that can be tied to the applicable MLR reporting period(s).
b) Be signed and dated by all appropriate parties prior to the commencement of the applicable performance period.
c) Include clearly defined, objectively measurable, and well-documented clinical or quality improvement standards the provider must meet to receive the incentive payment.
d) Specify a dollar value or percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, include a date of payment.

See: 42 C.F.R. § 438.3(i)(3); 42 C.F.R. § 457.1201(h).

C.6.05. *Provider Incentive Payment Program Documentation Requirements.* The Contractor's Provider incentive payment programs shall:

a) Maintain detailed documentation to support the provider incentive payment programs and all requested data elements in accordance with the Agency instructions outlined in the Reporting Manual.
    1. Detailed documentation should include, but is not limited to:
        a. Contracts
        b. Provider incentive payment listings
        c. Payment calculations
        d. Scorecards, including detail to demonstrate metrics are met and reconcile to payment terms within the calculations
        e. Copy of paid checks
        f. Estimates or anticipated payments
        g. Reconciliations to the general ledger
b) Prohibit the use of attestations as supporting documentation for data that factors into the MLR Calculation.
c) Make Provider incentive payment program contracts and other supporting documentation as detailed in C.6.03.02(a) available, upon request and at any routine frequency in accordance with the Agency instructions outlined in the Reporting Manual.

See: 42 C.F.R. § 438.3(i)(4); 42 C.F.R. § 457.1201(h).

Revision 10. C.11.03. Costs, the below is hereby added to the end of the paragraph as follows:
Any Value-Added Services that a Contractor elects to provide shall be provided at no additional cost to the Agency. The costs of Value-added Services are not reportable as allowable medical or administrative expenses and therefore are not factored into the rate setting process. In addition, the Contractor shall not pass on the cost of the Value-Added Services to Providers. The Contractor shall specify the conditions and parameters regarding the delivery of the Value-Added Services in the Contractor's Marketing Materials and Member communication materials Reference Agency instructions outlined in the Reporting Manual for Value-Added Services treatment for MLR and Risk Corridor reporting.

Revision 11. D.1.12. Mandatory Rates, first paragraph, is hereby replaced as follows:
For the Dental Wellness Plan program, the Contractor shall reimburse in-network direct care provider types 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 the Contractor and the Provider. Capitation rates will be developed reflecting provider reimbursement of 110% of the Medicaid fee schedule in aggregate across all rating cells where an approved value-based purchasing agreement does not exist. This only applies for non-FQHC services, since FQHC services are reimbursed at the PPS rate.

Revision 12. D.4. Medical Loss Ratio (MLR), is hereby replaced as follows:
D.4 Medical Loss Ratio (MLR)
D.4.01. *Medical Loss Ratio (MLR) Applicability.* The Contractor shall calculate and report an MLR for each MLR reporting year in accordance with the MLR standards (at 42 C.F.R. § 438.8) and the Agency instructions outlined in the Reporting Manual. The following MLR standards apply to both Title XIX and Title XXI capitation payments. The Contractor shall report separate MLRs for the Title XIX and Title XXI populations and aggregate across both populations for minimum MLR application. The timeline is outlined in the Reporting Manual and record-keeping requirements are outlined in 42 C.F.R. § 438.3(u).
See: 42 C.F.R. § 438.8(a); 42 C.F.R. § 457.1203.

D.4.02. *MLR Requirement.* A minimum MLR of eighty-seven percent (87%) is required for each MLR Reporting Year of the Contractor. See: 42 C.F.R § 438.8(c).

D.4.03. *MLR Calculation.* The MLR calculation for each Contractor in a MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR § 438.8(e)) to the denominator (as defined in accordance with 42 CFR § 438.8(f)). See: 2 CFR § 438.8(d) - (f)and Section C.6 regarding Provider incentive payment programs requirements.

D.4.04. *Contractor Expenses.* Each Contractor expense type and allocation for multiple contract or population expenditures are in alignment with 42 CFR § 438.8(g)(1)(i) - (ii). -

D.4.05. *Expense Allocation.* Expense allocations, shared expenses, and reporting entity operation expenses will be in accordance with 42 CFR § 438.8(g)(2)(i) - (iii). {From CMSC I.D.4.06-.08}.

D.4.06. *Credibility Adjustment.* Credibility adjustments will align with the standards in 42 CFR § 438.8(h)(1) - (3). {From CMSC I.D.4.09-.12}.

D.4.07. *Data Aggregation.* The Contractor will aggregate data for all Medicaid eligibility groups covered under the contract with the Agency unless the state requires separate reporting and a separate MLR calculation for specific populations. See: 42 CFR § 438.8(i) {From CMSC I.D.4.13}.

D.4.08. *Remittance.* If required by the Agency outlined in the Reporting Manual, the Contractor must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR of eighty-seven percent (87%). See: 42 CFR § 438.8(j); 42 CFR § 438.8(c) {From CMSC I.D.4.14}.

D.4.09. The Contractor must submit a MLR report to the state that includes reporting components outlined in 42 CFR § 438.8(k)(1)(i) - (xiii); 42 CFR § 438.3(m); 42 CFR § 438.8(i); and 45 CFR Part 158. {From CMSC I.D.4.15-.29}.

D.4.10. *MLR Reporting Year.* The MLR Reporting Year will be considered a twelve (12) month period, consistent with the Rating Period. The MLR shall be prepared using all data available from the MLR Reporting Year. See: 42 C.F.R. § 438.8(b); 42 CFR § 438.8(k)(2); 42 CFR § 438.8(k)(1) {From CMSC I.D.4.30}.

D.4.11. *Third Party Vendors.* The Contractor must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to that Contractor within 180 days of the end of the MLR Reporting Year or within 30 days of being requested by the Contractor whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. See: 42 C.F.R. § 438.8(k)(3) {From CMSC I.D.4.31}.

D.4.12. *Newer Experience*. The Agency, in its discretion, may exclude a Contractor that is newly contracted from the requirements in this section for the first year of the Contractor's operation. Such Contractors must comply with the requirements in this section during the next MLR reporting year in which the Contractor is in business with the Agency, even if the first year was not a full 12 months. See: 42 C.F.R. § 438.8(l).

D.4.13. *Recalculation of MLR*. In any instance where the Agency makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the Agency, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the requirements in 42 C.F.R. § 438.8(k). See: 42 C.F.R. § 438.8(m). {From CMSC I.D.4.32-.33}.

D.4.14. *MLR Attestation*. The Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports. See: 42 CFR § 438.8(n); 42 CFR § 438.8(k) {From CMSC I.D.4.34}.

D.4.15. *Risk Corridor*. The Agency shall include a Risk Corridor for the rate period beginning July 1, 2025, running through June 30, 2026. The Agency reserves the right to prospectively modify the terms of the Risk Corridor though a contract amendment.

D.4.16. *Overview.* The risk corridor settlement is the calculated gain or loss determined when comparing the Risk Corridor Percentage to the risk corridor target percentages outlined in the table as reflected on the capitation rate sheets. The Risk Corridor Percentage is calculated as the total adjusted medical expenditures divided by the total capitation revenue for all populations. Items may be disallowed from the Risk Corridor Percentage at the discretion of the Agency.

D.4.17. *Total Capitation Revenue.* Revenue represents the capitation rates paid by the Agency to the Contractor for the contract period and shall exclude:

a) Taxes and fees explicitly built into the capitation rates, including premium taxes,
b) Amounts related to the Enhanced Fee Schedule for UI Dental Clinics and Broadlawns
c) Any unearned withhold amounts will not be included within the capitation revenue for purposes of the risk corridor calculation.

The capitation rates utilized in the revenue calculation have been determined to be actuarially sound by an actuary that meets the qualifications and standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board. See: 42 CFR § 438.4; 42 CFR § 438.5.

D.4.18. *Total Adjusted Medical Expenditures.* Total adjusted medical expenditures shall be determined by Agency/Agency's contracted actuaries based on Contractor submitted financial data in a format prescribed by the Agency and compared to encounter data.

Adjusted medical expenditures include services covered by the Agency and the Contractor, except the following:

a) Expenditures associated with carved-out services as reflected in Special Contract Exhibits, Exhibit A and Section 5.
b) Expenditures for services that were incurred before or after the reporting period.
c) Expenditures for services rendered to enrollees who are not eligible on the incurred date of service.
d) Administrative expenditures that are related to pharmacy services, health care quality improvement or health information technology costs, including case management or care coordination, and other administrative costs claimed in medical expenditures. These administrative expenditures will be removed for purposes of the Risk Corridor calculation.
e) Expenditures for value-added services.
f) Expenditures related to the Enhanced Fee Schedule for UI Dental Clinics and Broadlawns

The Agency reserves the right to audit Claims expenditures. For purposes of the Risk Corridor in the Dental Wellness Plan program, the Agency may limit the overall level of reimbursement to one hundred and ten percent (110%) of the Medicaid fee schedule if there is no demonstration of network adequacy for a particular provider. Reimbursement associated with Agency approved incentives and value-based purchasing arrangements as outlined in Section E.8.03 are not included in the one hundred and ten percent (110%) review noted above.

The data used by the Agency and its actuaries for the Risk Corridor settlement will be the accepted MMIS encounter data and financial data submitted by the Contractor. The Agency and the Contractor agree that to the extent there are differences between Claims expenditures as reflected in the encounter data and the financial data submitted by the Contractor, the Agency and Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement as described below.

D.4.19. *Risk Corridor Percentage.* The Risk Corridor Percentage is calculated as the total adjusted medical expenditures divided by the total capitation revenue for all populations.

Risk Corridor Minimum Percentage	**Risk Corridor Maximum Percentage**	**Contractor Share**	**State / Federal Share**
0.0%	87.0%	0%	100%
87.0%	89.0%	100%	0%
89.0%	91.0%	100%	0%
91.0%	91.0%+	0%	100%

D.4.20. *Timelines.* The Contractor shall submit the required information based on Agency instructions and timeline outlined in the Reporting Manual, shall provide Agency with a complete

and accurate report of actual medical expenditures for enrollees, by category of service, based on claims incurred for the contract period including six (6) months of claims run-out, and its best estimate of any claims incurred but not reported (IBNR) for claims run-out beyond six (6) months, and any applicable IBNR completion factors.

Prior to eighteen (18) months following contract period, Agency shall provide the Contractor with a final settlement under the risk share program for the contract period. Any balance due between Agency and the Contractor, as the case may be, will be paid within sixty (60) days of receiving the final reconciliation from Agency.

Revision 13. D.5.01. Timely Payment Obligation, is hereby replaced as follows:
D.5.01. *Timely Payment Obligation*. The Contractor shall meet the requirements of fee for service (FFS) timely payment for all Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) Providers in its network, including the paying of 90% of all Clean Claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within thirty (30) Days of the date of receipt; and paying 99% of all Claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) Days of the date of receipt. Fully adjudicate (pay or deny) 100% of all Claims within 180 Days of the date of receipt. See: 42 C.F.R. § 438.14(b)(2)(iii); ARRA § 5006(d); 42 C.F.R. § 447.45; 42 C.F.R. § 447.46; SMDL 10-001); 42 C.F.R. § 457.1209. {From CMSC D.5.01}.

Revision 14. D.6.01. Timely Payment Obligation, is hereby replaced as follows:
D.6.01. *Timely Payment Obligation*. The Contractor shall meet the requirements of FFS timely payment (see also D.6.04), including the paying of 90% of all Clean Claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within thirty (30) Days of the date of receipt; paying 95% of all Clean Claims within forty-five (45) Days of the date of receipt; and paying 99% of all Claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) Days of the date of receipt. Fully adjudicate (pay or deny) 100% of all Claims within 180 Days of the date of receipt. The obligation for timely payment shall be met at both an aggregate and provider type level (*e.g.*, hospital, home health, waiver, nursing facility, etc.). Final provider type levels will be determined by the Agency. See: 42 C.F.R. § 447.45(d)(2) - (3); 42 C.F.R. § 447.46; sections 1902(a)(37)(A) and 1932(f) of the Social Security Act). {From CMSC D.6.01}.

Revision 15. D.6.02. Claims Reprocessing and Adjustment, is hereby replaced as follows:
D.6.02. *Claims Reprocessing and Adjustment*. The Contractor shall accurately adjudicate 90% of all clean identified adjustments including Reprocessed Claims within thirty (30) business days of receipt and 99% of all identified adjustments including Reprocessed Claims within ninety (90) business days of receipt and fully adjudicate (pay or deny) 100% of all Claims within 180 Days of the date of receipt. (see also D.6.04). The Contractor shall 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 the Contractor 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 internal Contractor staff. In the event the Contractor requests clarification from the Agency regarding a Claim reprocessing project, the

time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the Claims. The Contractor shall reprocess mass adjustments of Claims upon a schedule approved by the Agency and the Contractor. *See:* Sections 1902(a)(37)(A) and 1932(f) of the Social Security Act; 42 C.F.R. § 447.45(d)(2) - (3); 42 C.F.R. § 447.46.

Revision 16. E.1.24. Capacity Assurances, is hereby replaced as follows:
E.1.24. *Capacity Assurances.* The Contractor shall give assurances and provide supporting documentation that demonstrates it has the capacity to serve the expected enrollment in its service area in accordance with the Agency's standards for Access and timeliness of care. See: 42 C.F.R. § 438.207(a); 42 C.F.R. § 438.68; 42 C.F.R. § 438.206(c)(1); 42 C.F.R. § 457.1230(b). {From CMSC E.1.06}.

Revision 17. E.1.27. Appropriate Provider Mix, all instances of the term State are replaced with Agency.

Revision 18. E.8. Physician Incentive Plan, is hereby amended, as follows:
E.8 Provider Incentive Payment Programs
For the below sections in E.8, reference additional clarifications and requirements in Section C.6.

Revision 19. E.8.01. Restriction on Reducing or Limiting Services, hereby replaced as follows:
E.8.01. *Restriction on Reducing or Limiting Services.* The Contractor may only operate a Provider incentive payment program if no specific payment can be made directly or indirectly under a Provider incentive payment program to a physician or physician group as an incentive to reduce or limit Medically Necessary Services to an Enrolled Member. See: Section 1903(m)(2)(A)(x) of the Social Security Act; 42 C.F.R. § 422.208(c)(1); 42 C.F.R. § 438.3(i); 42 C.F.R. § 457.1201(h). {From CMSC E.8.01}.

Revision 20. E.8.03. Value-Based Purchasing Arrangement, third paragraph, is hereby removed.

Revision 21. F.6.25. Early and Periodic Screening, Diagnostic Treatment (EPSDT) Services, is hereby replaced as follows:
F.6.25. *Early and Periodic Screening, Diagnostic Treatment (EPSDT) Services.* The Contractor shall provide EPSDT services to all Enrolled Members under twenty-one (21) years of age in accordance with law. EPSDT covers dental services regardless of whether these services are provided under the State Plan and regardless of any restrictions that may be imposed on coverage.

a) *Partnering with Local Agencies for Screening*.
The Contractor shall partner with Maternal Health, Screening Center, and Public Health agencies to ensure the completion of dental screens and preventive visits in accordance with the EPSDT periodicity schedule. Screening exams consist of a health history, developmental history, complete physical exam, vision screening, hearing test, appropriate laboratory tests, immunizations, nutrition screen, health education including anticipatory guidance, oral health assessment, other tests as needed and referrals for treatment. Treatment consists of any treatment necessary to correct or ameliorate a

child's physical, dental, or behavioral health condition as deemed medically necessary on a case-by-case basis. EPSDT medical necessity determinations shall consider a child's long-term needs.

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

Note that screenings need not be conducted by a Medicaid provider to trigger EPSDT coverage for follow up diagnostic services and medically necessary treatment by a qualified Medicaid provider. Additionally, screening service provided before a child enrolls in Medicaid is sufficient to trigger EPSDT coverage, after Enrollment, for follow-up diagnostic services and necessary treatment. The contractor must, as determined medically necessary, make available health care, treatment, or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services regardless of if the services if a state plan covered benefit.

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

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

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

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

The Contractor shall cover out-of-State services in the following circumstances under EPSDT: the out-of-State services are required because of an emergency; the child's health would be endangered if required to travel to Iowa/their home state; the Agency determines that the needed services are more readily available in another state.

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

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

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

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

Revision 22. G.2.13. Completion of Initial Oral Health Risk Screening, is hereby replaced as follows:
G.2.13. *Completion of Initial Oral Health Risk Screening.* The Contractor shall complete an initial oral health risk screening no later than ninety (90) Days after Member Enrollment with the Contractor. Each quarter, at least twenty percent (20%) of the Contractor's new DWP Adult Enrolled Members, who have been assigned to the Contractor for a continuous period of at least ninety (90) Days, shall complete an initial oral health risk screening within ninety (90) Days. For any DWP Adult Enrolled Member who does not obtain an initial oral health risk screening, the Contractor shall document at least three (3) attempts to conduct the screening.

Revision 23. G.5.27. Value-Based Purchasing Programs, is hereby replaced as follows:
G.5.27. *Value-Based Purchasing Programs.* The Contractor shall identify the goals the Contractor has set to address its strategy for improving the delivery of health care Benefits and services to its Enrolled Members via value-based purchasing programs. The Contractor shall identify the steps to be taken including a timeline with target dates and providing reporting on such timelines and targets consistent with the obligations in the Reporting Manual. The Contractor's VBP programs shall align with the Agency's Quadruple Aim Strategy, including specific detail for the value-based purchasing requirements described in Section E.8 and C.6.

Revision 24. G.5.29. Value-Based Purchasing – PCPs, is hereby replaced as follows:
G.5.29. *Value-Based Purchasing – PCPs*. The specific PCP designation is required for those Enrolled Members under a value-based purchasing arrangement described in Section E.8 and C.6. If using a PCP model, Contractor shall describe the types of physicians eligible to serve as a PCP, any panel size limits or requirements, and proposed policies and procedures to link Enrolled Members to PCPs in its PPM.

Revision 25. G.6.01. Cultural Competence Obligation, is hereby replaced as follows:
G.6.01. *Cultural Competence Obligation*. The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Enrolled Members, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex which includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and sex stereotypes. See: 42 C.F.R. § 438.206(c)(2); 42 C.F.R. § 457.1230(a); 45 C.F.R. § 92.

Revision 26. I.1.01. Excluded Providers, is hereby replaced as follows:
I.1.01. *Excluded Providers*. The Contractor shall not employ or contract with Providers excluded from participation in Federal and State health care programs. See: 42 C.F.R. § 438.214(d)(1)]. {From CMSC I.1.01}.

Revision 27. I.5.02. Reporting, is hereby replaced as follows:
I.5.02. *Reporting.* The Contractor shall fulfill the reporting requirements in this section, as well as I.5.03, I.5.04, I.5.05, and I.5.06, which include, but are not limited to prompt reporting of all Overpayments identified or recovered within thirty (30) days to the Agency, specifying the Overpayments due to Fraud. The Contractor must submit all reporting in accordance with Agency instructions outlined in the Reporting Manual. The Contractor shall certify all reports in accordance with the requirements of Section I.2.11. See: 42 C.F.R. § 438.608(a)(2); 42 C.F.R. § 457.1285.{From CMSC I.5.08}.

Revision 28. I.5.03. Annual Reports, the CFR references are hereby replaced as follows:
See: 42 C.F.R. § 438.604(a)(7); 42 C.F.R. § 438.606; 42 C.F.R. § 438.608(d)(3); 42 C.F.R. § 457.1285. {From CMSC I.6.05}.

Revision 29. I.8.02. Recovery of Improper Payments, is hereby replaced as follows:
I.8.02. *Recovery of Improper Payments.* The Contractor shall initiate administrative action and recover improper payments or overpayments related to claims paid by the Contractor within twenty-four (24) months from the date the claim was paid or from the date of any applicable reconciliation, whichever is later. Except for Overpayments identified under a Credible Allegation of Fraud, the Contractor shall confer with the Agency before pursuing Overpayment recoveries for Claims where more than twenty-four (24) months have passed since the claims were paid or adjudicated. The Contractor shall not subject these claims to repayment or offset against future claim reimbursements without prior consent from the Agency.

a) Payment Disputes- Request for Agency Review:
Should a provider ask the Agency to review the Contractor's post-payment activity once the provider has exhausted the Contractor's dispute or grievance process, the Contractor shall cooperate with the Agency by providing information that supports the recovery activity. If the Agency, in the review of information from the Provider and the Contractor, finds evidence of erroneous findings by the Contractor, the Agency will instruct the Contractor to amend or overturn the provider's dispute and reimburse the provider any funds that have been recovered.

The Contractor shall collaborate with the Agency in the creation of Standard Operating Procedures for this process. If the Contractor's decision is amended or overturned, the

Agency may require the Contractor to waive timely filing requirements and allow the Provider to reprocess claims for payment.

Revision 30. Revision 30. I.9.08 Contact Before Proceeding, is hereby amended as follows:
I.9.08 *Agency-Identified Overpayments*

Revision 31. I.9.08. Agency-Identified Overpayments, is hereby replaced as follows:
I.9.08 *Agency-Identified Overpayments.* If the Agency discovers and identifies an improper payment or overpayment after twenty-four (24) months from the date the claim was paid, the Agency will recover the identified Overpayment from the Contractor, unless the improper payment or overpayment was the result of an Agency error. The Contractor shall not recover Overpayments for which it did not discover or issue an overpayment finding to the Provider. The Contractor may dispute the Agency's notice of findings in accordance with the Payment Integrity Audit process.

Revision 32. J.2.01. e) The Americans with Disabilities Act., is hereby replaced as follows:
e) The Americans with Disabilities Act

1. The Agency requires the Contractor to comply with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. This requirement for compliance includes Contractor compliance with an Interim Memorandum of Understanding (MOU) between Iowa HHS and the National Federation for the Blind, which clarifies expectations for the Contractor to provide accessible documents and information to Blind and seeing-impaired individuals.
2. Specifically, it is the Agency's expectation that the Contractor will comply with Sections VII(a), VII(d), and IX(h) of the MOU.
3. Section VII(a) of the MOU requires HHS and its Contractor to provide documents in accessible formats when requested by Blind or seeing-impaired individuals. Further, the MOU requires that documents translated into Braille or other accessible formats are mailed within seven (7) business days or emailed within two (2) business days of a request being made. Section VII(d) requires that Iowa HHS ensure contractor compliance with Section VII(a).
4. Section IX(h) requires Iowa HHS to notify its Contractor of its expectation that all public-facing websites shall be and remain in compliance with the ADA and Section 504.

Revision 33. J.4.09. COBA Obligations, is hereby replaced as follows:
J.4.09. *COBA Obligations.* The Contractor shall enter into a Coordination of Benefits Agreement (COBA) with Medicare for the purpose of coordinating crossover payment if applicable. If the Agency elects to use a methodology other than requiring the PAHP to enter into a COBA with Medicare, that methodology must ensure that the submitting provider is promptly informed on the Agency's remittance advice that the Agency has not denied payment and that the claim has been sent to the PAHP for payment consideration. The Contractor shall have the responsibility for coordination of benefits for individuals dually eligible for Medicaid and Medicare. The Contractor shall send eligibility information to CMS and receive Medicare Claims data for processing supplemental insurance benefits from CMS' national crossover contractor, the Benefits Coordination & Recovery Center (BCRC). Therefore, Contractor shall enter into a COBA with Medicare and participate in the automated Claims crossover process. See: 42 C.F.R. § 438.3(t). {From CMSC J.4.02}.

Revision 34. Exhibit A. Section 3: Payment for Performance Chart, for SFY2025, is hereby replaced as follows:

Table A: SFY 2026 PAY FOR PERFORMANCE MEASURES
The Agency will provide a document with the full description of the guidelines and data definitions for the SFY 2026 Pay for Performance Measures.

Performance Standard 1	**Amount of Performance Withhold at Risk**
Initial Oral Health Risk Screening	10%
Required Contractual Standard	
The Contractor shall report the percent of unique new Enrolled Members in the Dental Wellness Plan Adult (DWP-A) population, who have been assigned to the Contractor for a continuous period of at least ninety (90) Days during the measurement State fiscal year per reporting manual definitions, who complete an Initial Oral Health Risk Screening using the Oral Health Equity Self-Assessment Tool. This percentage shall exceed twenty percent (20%).	
Standard Required to Receive Incentive Payment	
This percentage shall not include those members excluded due to 3 or more unsuccessful contact attempts. Percentage Calculation: Numerator: Measure Order #123 in current A1 Care Coordination template Denominator: Measure Order # 122 Withholds may be earned based on the following tiers determined by the percentage calculation above reported for each quarter in the A-1 Care Coordination template (without rounding): 20.1-25.0% - 2.5% of withhold 25.1-30.0% - 5.0% of withhold 30.1-35.0% - 7.5% of withhold 35.1% or more – 10% of withhold	
Performance Standard 2	**Amount of Performance Withhold at Risk**
Verification of Attempts to Contact for Initial Oral Health Risk Screening	5%
Required Contractual Standard	
The Contractor shall report detailed information regarding all unsuccessful attempts to contact members for their Initial Oral Health Risk Screening as listed on the Ad Hoc Verification of Attempts to Contact template. This Ad Hoc template shall be completed in full and submitted quarterly with all other regular quarterly reporting. All information shall be completed for all three unsuccessful attempts for each member listed.	
Standard Required to Receive Incentive Payment	
The number of members reported on the Ad Hoc template each quarter should equal the number of members reported as Measure Order #143 on the A1 Care Coordination template for the corresponding quarter. Each unsuccessful attempt to contact each member must consist of a different method per	

attempt.
The three unsuccessful attempts to contact each member shall consist of the following:

Acceptable Contact Methods:
Phone
Email
Mailing
Text

If any of the above methods are not available (no email address, mailing address or phone) that must be documented on the report and another method must be used. Documenting that a member does not have an e-mail address, phone number or mailing address will not count as an unsuccessful attempt. Every avenue should be attempted to locate member information including contacting the member's MCO, IMPA, etc.

All available methods of communication must be used to reach the member as part of the three attempts. There should not be more than one unsuccessful attempt for each method, unless there are only one or two methods available.

Withholds may be earned based on reporting the information above for each eligible quarter:

Q2 SFY26 – 1% withhold earned
Q3 SFY26 – 2% withhold earned
Q4 SFY26 – 2% withhold earned

Performance Standard 3	**Amount of Performance Withhold at Risk**
Preventive Care Utilization	25%
Required Contractual Standard	
The percentage of Enrolled Members who accessed preventive dental care services within the measurement state fiscal year. Rates are reported for: 1) the Dental Wellness Plan Adult (DWP-A) population, 2) the Dental Wellness Plan Kids (DWP-K) population age 1 through age 5. No Rounding.	
Standard Required to Receive Incentive Payment	

1. Dental Wellness Plan Adult (DWP-A) population who accessed preventive dental care within the measurement state fiscal year (12.5%)
    a. The universe is any Dental Wellness Plan Adult (DWP-A),19 and older member that turned 19 during the reporting period. (The age used for the report; is the age of the member is at the end of the SFY)
    b. CDT Codes to be used: D0120, D0145, D0150, D0180, D0190, D1110, D1206, D1208, D1351, D1353, D1354, D4910
    c. HHS will validate the data.
    d. 25% Benchmark - 12.5% of withhold

2. Dental Wellness Plan Kid (DWP-K) population age 1 through age 5 who accessed preventive dental care within the measurement state fiscal year (12.5%)
    a. The universe is any child that turned 1 any time during the month to the month prior to turning 6.
    b. Did the member have at least 1 preventive service with a lookback to 6 months

of age.
c. CDT Codes to be used: D0120, D0145, D0150, D0180, D0190, D1120, D1206, D1208, D1351, D1353, D1354
d. HHS will validate the data.
e. 52% Benchmark - 12.5% of withhold

Performance Standard 4	Amount of Performance Withhold at Risk
Sealant Receipt on Permanent Molars	20%

Required Contractual Standard

The percentage of Enrolled Members who received Sealants within the measurement State fiscal year. Rates are reported for all Enrolled Members in the universe below:

Standard Required to Receive Incentive Payment

Sealant Receipt on Permanent First Molars (SFM-CH): Percentage of enrolled children who have ever received sealants on permanent first molar teeth: (1) at least one sealant and (2) all four molars sealed by the 10th birthdate must meet benchmarks below to receive all or portion of withhold. No rounding.

- Universe is beneficiaries who turn age 10 during the measurement year State Fiscal Year (SFY) and continuously enrolled for 12 months prior to the 10th birthday
- CDT code to be used: D1351
- HHS will validate the data.

CMS Core Set Measure SFM-CH (FY23)
- National Average: (1) 48.3% (2) 35.4%
- Iowa Average (1) 30.4%) (2) 23.3%

1. Beneficiaries aged 10, who have at least one sealant treatment on permanent first molars.
   a. 40%-48.2% Benchmark (05%)
   b. 48.3% Benchmark (10%)
2. Beneficiaries aged 10, who have a sealant treatment on all four permanent first molars by their 10th birthday.
   a. 30%-35.3% Benchmark (05%)
   b. 35.4% Benchmark (10%)

Performance Standard 5	Amount of Performance Withhold at Risk
Encounter Data Reconciliation	20%

Required Contractual Standard

Encounter data shall be submitted by the twentieth (20th) of the month subsequent to the month for which data is reflected. All corrections to the monthly encounter data submission shall be finalized within forty-five (45) Days from the date the initial error report for the month was sent to the Contractor or fifty-nine (59) Days from the date the initial encounter data was due. The error rate for the encounter data shall not exceed one percent (1%). For every service provided, providers must submit corresponding Claim or encounter data with Claim detail identical to that required for fee-for-service Claims submissions.

Standard Required to Receive Incentive Payment

Within ninety (90) days of the end of each quarter, the Contractor's accepted encounter data shall match the Contractor's submitted financial information within ninety-eight percent (98%) using reporting criteria set forth in the financial reporting template.

Performance Standard 6	Amount of Performance Withhold at Risk

Timely Claims Processing	20%
Required Contractual Standard	
The Contractor shall pay Providers for covered medically necessary services rendered to the Contractor's Enrolled Members in accordance with the Contract. The Contractor shall pay or deny ninety percent (90%) of all Clean Claims within fourteen (14) calendar days of receipt, ninety-five percent (95%) of all Clean Claims within twenty-one (21) calendar days of receipt, and ninety-nine percent (99%) of all claims within ninety (90) calendar days of receipt. A "Clean Claim" is one in which all information required for processing is present. If a Claim is denied because more information was required to process the Claim, the Claim denial notice shall 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), the Contractor may, by mutual agreement, establish an alternative payment schedule with in-Network Providers. The alternative payment schedule shall be outlined in the Provider contract. In accordance with 42 C.F.R. § 447.45(d), the date of receipt of a Claim is the date the Contractor 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.	
Standard Required to Receive Incentive Payment	
The Contractor will achieve a measure of ninety-six percent (96%) of all Clean Claims paid or denied within twenty-one (21) calendar days of receipt to receive fifty percent (50%) of the total withhold for this measure. The Contractor will achieve a measure of ninety-seven percent (97%) of all Clean Claims paid or denied within twenty-one (21) calendar days of receipt to receive seventy-five percent (75%) of the total withhold for this measure. The Contractor will achieve a measure of ninety-eight percent (98%) of all Clean Claims paid or denied within twenty-one (21) calendar days of receipt to receive one hundred (100%) of the total withhold for this measure.	

Revision 35. Exhibit B. Glossary of Terms/Definitions, Case Management definition, is hereby replaced as follows:
Provides service coordination and monitoring. Available as a 1915 (i) Habilitation service when the individual is not enrolled in an Integrated Health Home and does not otherwise qualify for targeted case management.

Revision 36. Exhibit B. Glossary of Terms/Definitions, Chronic Condition Health Home ("CCHH") is hereby removed:

Revision 37. Exhibit B. Glossary of Terms/Definitions, Clean Claim definition, is hereby replaced as follows:
Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the Contractor's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. See: 42 CFR § 447.45(b)

Revision 38. Exhibit B. Glossary of Terms/Definitions, Iowa Medicaid Portal Access, is hereby added as follows:

IMPA: Iowa Medicaid Portal Access

Revision 39. Exhibit B. Glossary of Terms/Definitions, Reporting Manual definition, is hereby replaced as follows:
The document to be distributed by the Agency detailing the reporting requirements for the Program. Reference the State of Iowa Department of Health and Human Services, Iowa Medicaid Pre-Paid Ambulatory Health Plan (PAHP) Reporting Manual.

Revision 40. Exhibit B. Glossary of Terms/Definitions, Readily Accessible, the below two paragraphs are hereby added to the definition language as follows:
The Agency requires the Contractor to comply with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. This requirement for compliance includes Contractor compliance with an Interim Memorandum of Understanding (MOU) between Iowa HHS and the National Federation for the Blind, which clarifies expectations for the Contractor to provide accessible documents and information to Blind and seeing-impaired individuals.

Specifically, it is the Agency's expectation that the Contractor will comply with Sections VII(a), VII(d), and IX(h) of the MOU.

Section VII(a) of the MOU requires HHS and its Contractor to provide documents in accessible formats when requested by Blind or seeing-impaired individuals. Further, the MOU requires that documents translated into Braille or other accessible formats are mailed within seven (7) business days or emailed within two (2) business days of a request being made. Section VII(d) requires that Iowa HHS ensure contractor compliance with Section VII(a).

Section IX(h) requires Iowa HHS to notify its Contractors of its expectation that all public-facing websites shall be and remain in compliance with the ADA and Section 504.

Revision 41. Exhibit D. Table D.01: Eligible Enrollees, Pregnant Women, is hereby amended as follows:

POPULATION	DESCRIPTION
Pregnant Women	Individuals eligible in accordance with 42 C.F.R. § 435.116. A woman who is pregnant with income at or below 215% FPL or at or below 300% FPL for Hawki.

Revision 42. Exhibit G. Hospital Directed Payments, is hereby added as follows:
G.1 UIHC Dental Enhanced Fee Schedule- Description of Arrangement
State Plan Amendment 23-0019 was first effective July 1, 2023 and allows for supplemental payments to the University of Iowa for professional dental services. Federal regulations under 42 CFR 447 allow state Medicaid programs to pay for certain professional services practitioners at rates up the "upper limit", which is typically the "average commercial rate" for these services. The supplemental payments related to these qualified practitioner services are equal to the difference between the average commercial rate and the amounts otherwise paid pursuant to the fee schedules, which is approximately 265.55% of Medicaid for SFY26.

G.2 Broadlawns Dental Enhanced Fee Schedule- Description of Arrangement

State Plan Amendment 23-0021 was first effective October 1, 2023 and allows for supplemental payments to the Broadlawns Dental Clinics for professional dental services. Federal regulations under 42 CFR 447 allow state Medicaid programs to pay for certain professional services practitioners at rates up the "upper limit", which is typically the "average commercial rate" for these services. The supplemental payments related to these qualified practitioner services are equal to the difference between the average commercial rate and the amounts otherwise paid pursuant to the fee schedules, which is approximately 207.37% of Medicaid for SFY26.

Revision 42. Effective July 1, 2025, the state is updating the rates for SFY26. Updated Special Contract Amendment below.

Revision 43. Federal Funds. The following federal funds information is provided

<table>
<tr><td>Contractor a Business Associate? Yes</td><td>Contractor a Qualified Service Organization? Yes</td></tr>
<tr><td>Contractor subject to Iowa Code Chapter 8F? No</td><td>Contract Includes Software (modification, design, development, installation, or operation of software on behalf of the Agency)? Yes</td></tr>
<tr><td colspan="2">Contract Payments include Federal Funds? Yes
The Contractor for federal reporting purposes under this Contract is a: Vendor
Federal Funds Include Food and Nutrition Service (FNS) funds? No
UEI #: G8HWKM9ADJ74
The Name of the Pass-Through Entity: Iowa Department of Health and Human Services</td></tr>
<tr><td>ALN #: 93.778
Grant Name: Medical Assistance Program</td><td>Federal Awarding Agency Name: Department of Health and Human Services/Centers for Medicare & Medicaid Services</td></tr>
</table>

Section 2: Ratification & Authorization
Except as expressly amended and supplemented herein, the Contract shall remain in full force and effect, and the parties hereby ratify and confirm the terms and conditions thereof. Each party to this Amendment represents and warrants to the other that it has the right, power, and authority to enter into and perform its obligations under this Amendment, and it has taken all requisite actions (corporate, statutory, or otherwise) to approve execution, delivery and performance of this Amendment, and that this Amendment constitutes a legal, valid, and binding obligation.

Section 3: Execution
IN WITNESS WHEREOF, in consideration of the mutual covenants set forth above and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into the above Amendment and have caused their duly authorized representatives to execute this Amendment.

Contractor, MCNA Insurance Company		**Agency, Iowa Department of Health and Human Services**	
Signature of Authorized Representative:	Date: 6-19-25	Signature of Authorized Representative:	Date: 06/20/2025
Printed Name: Shannon LePage		Printed Name: Kelly Garcia	
Title: Chief Executive Officer		Title: Director	

Special Contract Amendment – SFY2026 Rates
MCNA – DWP
Rates Effective July 1, 2025 – June 30, 2026

MCNA - DWP	Withhold Summary			
Rate Cell	SFY26 Rate	Withhold %	Withhold PMPM	SFY26 Rate Net Withhold
Children 0-1	$ 4.82	2.0%	$ 0.10	$ 4.72
Children 2-5	$ 19.14	2.0%	$ 0.38	$ 18.76
Children 6-18	$ 22.23	2.0%	$ 0.44	$ 21.79
Community and LTSS Disabled	$ 17.41	2.0%	$ 0.35	$ 17.06
Community and LTSS Elderly	$ 6.25	2.0%	$ 0.13	$ 6.12
Community Duals <65	$ 13.97	2.0%	$ 0.28	$ 13.69
Pregnant Women	$ 8.57	2.0%	$ 0.17	$ 8.40
TANF 19-34 F	$ 15.88	2.0%	$ 0.32	$ 15.56
TANF 19-34 M	$ 10.62	2.0%	$ 0.21	$ 10.41
TANF 35-49 F	$ 15.60	2.0%	$ 0.31	$ 15.29
TANF 35-49 M	$ 12.35	2.0%	$ 0.25	$ 12.10
TANF 50+	$ 19.20	2.0%	$ 0.38	$ 18.82
Wellness Plan 19-34 F	$ 13.56	2.0%	$ 0.27	$ 13.29
Wellness Plan 19-34 M	$ 8.57	2.0%	$ 0.17	$ 8.40
Wellness Plan 35-49 F	$ 15.09	2.0%	$ 0.30	$ 14.79
Wellness Plan 35-49 M	$ 10.79	2.0%	$ 0.22	$ 10.57
Wellness Plan 50+	$ 14.02	2.0%	$ 0.28	$ 13.74