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

This Amendment to Contract Number MED-25-011 is effective as of January 1, 2026, 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. Page 1. Agency of the State (hereafter "Agency"), is hereby amended as follows:

Agency of the State (hereafter "Agency")	
Name/Principal Address of Agency: Iowa Department of Health and Human Services Lucas State Office Building 321 East 12th Street Des Moines, IA 50319-1002	**Agency Billing Contact Name / Address:** Ashley Miller Lucas State Office Building 321 East 12th Street Des Moines, IA 50319-1002 **Phone:** 515-380-2973
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Ashley Miller Lucas State Office Building 321 East 12th Street Des Moines, IA 50319-1002 **Phone:** 515-380-2973 **E-Mail:** ashley.miller9@hhs.iowa.gov	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Lee Grossman Lucas State Office Building 321 East 12th Street Des Moines, IA 50319-1002 **E-Mail:** lee.grossman@hhs.iowa.gov

Revision 2. Table of Contents. Section 2. General Terms for Services Contracts, has been added to the Table of Contents.

Revision 3. Table of Contents. Section 3. Contingent Terms for Service Contracts, has been added to the Table of Contents.

Revision 4. Table of Contents. Section 2, Program Specific Statements, has been amended in the Table of Contents as follows:
Section 4: Program Specific Statements

Revision 5. Table of Contents. Section 3, Special Contract Exhibits, has been amended in the Table of Contents as follows:
Section 5: Special Contract Exhibits

Revision 6. Table of Contents. Section 5, Special Contract Exhibits, Exhibit A, has been amended in the Table of Contents as follows:
Exhibit A: Capitation Rate Information, MLR, Pay for Performance, and Liquidated Damages

Revision 7. Section 1.1 Special Terms Definitions, is hereby amended as follows:
Special Terms Definitions are stated in Section 5 Special Contract Exhibits, Exhibit B: Glossary of Terms/Definitions.

Revision 8. Section 1.2. Contract Purpose & Interpretative Intent, is hereby amended as follows:
The Iowa Department of Health and Human Services ("Agency") intends to contract for the delivery of high-quality dental health care services for the Iowa Dental Wellness Plan and Healthy and Well Kids in Iowa (Hawki) programs.

The Agency seeks to improve the quality of care and health outcomes for Medicaid and Children's Health Insurance Program (CHIP) populations while leveraging the strength and success of current initiatives. This Contract is designed to align with Iowa Medicaid's commitment to ensure all members have equitable access to high quality services in all areas of healthcare, including dental care. This process will build stability for Iowa Medicaid members and providers by providing covered benefits in a highly coordinated manner, integrate care and improve quality outcomes and efficiencies across the healthcare delivery system, and decrease costs through the reduction of unnecessary, inappropriate, and duplicative services. Specifically, the Agency aims to accomplish the following key goals, identified as drivers for improved dental health equity, access, and outcomes:

1. Improve Network Adequacy and availability of services.
2. Increase recall and prevention services.
3. Improve oral health equity among Medicaid members.
4. Improve coordination and continuity of care between managed care plans and enhance medical/dental integration.

This Section 1 addresses core contractual obligations of the parties. Section 2 incorporates by reference the General Terms for Service Contracts required by State law. Section 3 incorporates by reference the Agency's Contingent Terms for Services Contracts. Section 4 sets forth the Program-specific requirements of this Contract. The sections set forth in Section 4 largely mirror the content and structure of the current federal Medicaid Managed Care Contract Review and Approval guidance (at the time of this writing, available at: https://www.medicaid.gov/medicaid/managed-care/guidance/contract-review/index.html). Clauses from the CMS checklist are designated at the end of each statement by a reference to the corresponding CMS checklist statement, designated by the acronym "CMSC." All such CMS checklist clauses are to be interpreted in accordance with federal law, including but not limited to the statutory, regulatory, and guidance listed at the end of each clause.

It is the intent of the parties to this Contract that the Contract be interpreted in a manner consistent with all Applicable Law, as well as the obligations imposed on the State, the Agency, and/or the PAHP under the Iowa State Plan under Title XIX of the Social Security Act Medical Assistance Program ("State Plan"), CMS approved waivers under the State Plan, and federal guidance, as well as any and all future amendments, changes, and additions to the State Plan, approved waivers, or federal guidance as of the effective date of such change.

Revision 9. Section 1.3.3.1. Pricing, is hereby amended as follows:
In accordance with the payment terms outlined in this section and the Contractor's completion of the Scope of Work as set forth in this Contract, the Agency will make Capitation Payments to the Contractor on a monthly basis (as outlined in Section 1.3.3.2 below). The Capitation Payments include per member per month capitation rates as further defined in this section. The Capitation Payments shall be payment in full for goods and services provided pursuant to this Contract. Retroactive adjustments to the capitation rates to reflect the actual cost of goods and

services provided pursuant to the Contract are prohibited. For more information on retroactive adjustments please see Sections 1.3.3.4, 1.3.3.6, and Special Contract Exhibit A.

The parties anticipate Contractor to begin providing managed care services to its assigned Medicaid population on July 1, 2024. However, if the implementation date is delayed for any reason, Contractor shall not be entitled to payments pursuant to this Contract until Contractor begins providing services for its patient population consistent with the Scope of Work as set forth in this Contract. The Agency has sole discretion to determine the implementation date.

For each capitated rate period as defined on the rate sheet, the parties will agree on a rate sheet specifying the payment for each Enrolled Member by the categories determined by the Agency to be appropriate. These categories will be determined by the Agency. Nothing in this Contract shall limit the ability of the Agency to require the determination of a state-wide average even if the Contractor is not providing services for members in all counties in the State. The rate-setting methodology will be in compliance with federal requirements.

The Agency's actuarial contractor will analyze data to determine actuarially sound rates to be offered to Contractor. The Agency and Contractor may discuss proposed capitation rates, but the Agency's actuarial contractor will ultimately be responsible for establishing the actuarially-sound rates to be offered and attesting to the capitation rates to be presented to CMS. After the first rate period, subsequent capitated rates will be added to the Contract in sequentially numbered Special Contract Exhibits (i.e., Exhibit A-01, Exhibit A-02, etc.). Contractor and the Agency must mutually agree to the capitation rates and signify this agreement by executing the Contract amendment. Capitation rates within any rate period are subject to amendment, which shall only occur through formal Contract amendment. The parties agree to work diligently and in good faith to establish and agree to capitation rates before the expiration of any rate period. If the parties are unable to establish new annual capitation rates for a subsequent rate period due to delays or disagreements, the Agency or Contractor may terminate the Contract upon ninety (90) days written notice. Effective date of the termination shall be no sooner than ninety (90) days from expiration of the current rate period and contract amendment term or, if notice is given after the expiration of the current rate period, ninety (90) days written notice from the date of the notice.

> **Examples**:
> Example 1: Current agreed rates expire June 30, 2025. The PAHP determines that it does not want to agree to continue with the managed care contract and provides notice of termination on January 1, 2025. Because the parties are currently performing under agreed rates that run through June 30, 2025, the first day of the ninety (90) day notice period is July 1, 2025 – the first day of the new rate period. The effective date of contract termination is September 30, 2025 – the last day of the month that is ninety (90) days from the first day of the notice period.
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> Example 2: Rates expired on June 30, 2026. The Agency and PAHP are unable thereafter to come to terms on new rates after expiration of the current rates. The MCP provides notice of termination on August 1, 2026. The first day of the ninety (90) day notice period is August 1, 2026. The last day of the notice period is October 31, 2026 – the last day of the month that is ninety (90) days from the beginning of the notice period.

Upon agreement to the capitation rates, the Agency will perform a reconciliation between the capitation rates paid and the newly agreed upon rates for the rate period. Any discrepancy will be reconciled through the capitation rate payment process.

By agreeing to the rates offered to Contractor through the Contract amendment process, Contractor irrevocably and unconditionally releases, acquits, and forever discharges the State of Iowa, the Agency, and all of the Agency's officers, directors, employees, agents, and attorneys, from any and all liability whatsoever from any and all claims, demands and causes of action of every nature whatsoever that Contractor may have or may ever claim to have now existing or hereafter arising that relate to or arise out of any assertion regarding the actuarial soundness of the agreed rates.

The Agency will make Capitation Payments to the Contractor based on the Contractor's Medicaid-member enrollment as reflected on the monthly HIPAA 834 file (full positive file). Contractor shall reconcile Contractor's HIPAA 820 capitation file with the monthly HIPAA 834 file (full positive file) on a monthly basis. Any discrepancies found between these two (2) files shall be reported to the Agency within ninety (90) Days from the date the Contractor receives the HIPAA 820 capitation file. No adjustments to the Capitation Payment may be claimed by Contractor for any discrepancies reported after the ninety (90) Day period. The Capitation Payments will be subject to retroactive changes to the Medicaid-member eligibility criteria. This may include, but is not limited to, Medicaid-members moving from Medicaid-only eligibility to Medicare and Medicaid eligibility. The Agency will adjust payments to Contractor to reflect the Member enrollment changes.

The capitation rates will be subject to a withhold amount as shown in the capitation rate sheet. The withhold will be retained by the Agency until the period for determination of return of the withhold to the Contractor. The determination of the return of the withhold is outlined in Special Contract Exhibits, Exhibit A.

The Agency will exclude from the capitation rates the services and treatments as set forth in Special Contract Exhibits, Exhibit A. Contractor shall continue to provide coverage for these services and treatments, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for Special Contract Exhibits, Exhibit A services and treatments paid. Contractor may only invoice for the lower of (1) actual cost to the Contractor or (2) the actual cost paid. All such invoices must be submitted by Contractor within twelve (12) months of the date of service, with the exception of coordination of benefits situations, in which Contractor shall invoice for these treatments within six (6) months from the Contractor's receipt date of the claim and explanation of benefits from a primary carrier. The Agency will pay Contractor the lesser of the amount that would be paid under the fee-for-service system for the treatment, or the amount the Contractor actually paid for the treatment. Contractor must include with the invoice details as required by the Agency to document that the claim was appropriately paid, as well as verification regarding oversight to ensure appropriate utilization. At minimum, Contractor's invoice must include claim level detail sufficient to support the invoices. The selected services and treatments included in Special Contract Exhibits, Exhibit A are intended to be those which are new, emerging, high cost, and/or not accounted for in capitation rate development. Special Contract Exhibits, Exhibit A is subject to change upon State approval, and State may remove any previously included service or treatment from Special Contract Exhibits, Exhibit A when its financial impact has been quantified and incorporated into the capitation rates.

Revision 10. Section 1.3.2 Monitoring, Review, and Problem Reporting, is hereby amended as follows:

The provisions of this Section 1.3.2 are in addition to any Agency activity, reporting, or procedures specifically allowed or required in the Section 4. If there is a conflict between the

provisions of this Section and the provisions of Section 4, Section 4supersedes the provisions of this Section.

Revision 11. Section 1.3.3.2. Payment Methodology, is hereby amended as follows:
The Agency will pay the Contractor on a monthly basis using the capitation payment methodology for enrollees assigned to Contractor. Payment will be issued within the early part of each month. The Agency will pay all other approved invoices in conformance with Contract Section 1.3.3.6.

Revision 12. Section 2. General Terms for Service Contracts, is hereby added as follows:
SECTION 2: GENERAL TERMS FOR SERVICE CONTRACTS
The version of the General Terms for Services Contracts Section posted to the Agency's website at https://hhs.iowa.gov/contract-terms that is in effect as of the date of last signature in the Contract Declarations and Execution section, or a more current version if agreed to by amendment, is incorporated into the Contract by reference.

Revision 13. Section 3: Contingent Tearms for Service Contracts, is hereby added as follows:
SECTION 3: CONTINGENT TERMS FOR SERVICE CONTRACTS
The version of the Contingent Terms for Services Contracts posted to the Agency's website at https://hhs.iowa.gov/contract-terms that is in effect as of the date of last signature in the Contract Declarations and Execution section, or a more current version if agreed to by amendment, is incorporated into the Contract by reference.

Revision 14. Section 2. Program-Specific Statements, has been amended as follows:
SECTION 4: PROGRAM SPECIFIC STATEMENTS

Revision 15. Section 3. Contingent Terms for Services Contracts, has been amended as follows:
SECTION 5: SPECIAL CONTRACT EXHIBITS

Revision 16. A.31. Enrolled Member Engagement, is hereby amended as follows:
The Contractor shall ensure the provision of Enrolled Member engagement by utilizing partners to work with providers and Enrolled Members to promote successful compliance with treatment plans and use of preventive care. This will include educating Enrolled Members about good oral hygiene, prevention, and maintenance of teeth and gums. The Contractor will work with key community service organizations, including the Wellness and Preventive Health(WPH) Subdivision and its I-Smile contractors to assist in education and awareness activities at the local level and support Enrolled Member education and compliance, including linking Enrolled Members with participating dental providers. The Contractor shall develop member education activities that increase beneficiary awareness and access to services.

The Contractor shall establish a process for ongoing care facilitation and coordination with the Enrolled Member's physical health care to ensure patient-centeredness.

Revision 17. B.04. Estate Recovery Information, is hereby amended as follows:
The Contactor shall send Form 470-5727, a State-approved form, to Members over the age of fifty-five (55) once a year. When the Agency requests it, the Contractor shall produce documentation providing details of the information sent to the Enrolled Member. Information may include but not limited to mailing date, address, and recipient information.

Revision 18. D.1.12. Mandatory Rates, is hereby amended 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.

Revision 19. D.3.02. General, is hereby amended as follows:
For all Withhold Arrangements authorized by this Contract:

a. The arrangement is for a fixed period of time.
b. The withhold amount shall be two percent (2%) of capitation payments. The withhold amount is based on the capitation rates.
c. That performance is measured during the Rating Period under the Contract in which the Withhold Arrangement is applied.
d. The arrangement is not to be renewed automatically.
e. The arrangement is made available to both public and private contractors under the same terms of performance.
f. The arrangement does not condition Contractor participation in the Withhold Arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.
g. The arrangement is necessary for the specified activities, targets, Performance Measures, or Quality-based Outcomes that support Program initiatives as specified in the Iowa HHS Medicaid Quality Strategy.

See: 42 C.F.R. § 438.6(b)(3)(i) - (v); 42 C.F.R. § 438.340. {From CMSC D.3.01 - D.3.06}.

Revision 20. D.4.17. Total Capitation Revenue, is hereby amended as follows:
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.
b. 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.

Revision 21. D.4.18. Total Adjusted Medical Expenditures, is hereby amended as follows:
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.

The Agency reserves the right to audit Claims expenditures. 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.

Revision 22. E.1.01. Network Adequacy Obligations, is hereby amended as follows:
Contractor shall:

a. Provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for Emergency Medical Conditions.
b. Make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under the Contract can be furnished promptly and without compromising the Quality of care.
c. The Contractor shall maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.

See: 42 C.F.R. § 438.3(q)(1); 42 C.F.R. § 438.3(q)(3); 42 C.F.R. § 457.1201(m). {From CMSC E.1.01 - E.1.02}. ~~-~~ 42 C.F.R. § 438..206(b)(1)

Revision 23. E.8.04. Value-Based Purchasing Compliance, is hereby amended as follows:
Contractor shall ensure compliance with the obligations set forth in 42 C.F.R. § 438.6(c) by showing that the VBP arrangement with Providers:

a. Is based on utilization and delivery of services;
b. Directs expenditures equally, and using the same terms of performance, for a class of Providers providing the service under the Contract;
c. Expects to advance at least one (1) of the goals and objectives in the Iowa HHS Medicaid Quality Strategy in 42 C.F.R. § 438.340;
d. Has an evaluation plan that measures the degree to which the arrangement advances at least one (1) of the goals and objectives in the Iowa HHS Medicaid Quality Strategy in 42 C.F.R. § 438.340;
e. Does not condition Network Provider participation in contract arrangements under 42 C.F.R. § 438.6(c)(1)(i) through (iii) on the Network Provider entering into or adhering to intergovernmental transfer agreements; and
f. May not be renewed automatically.

Revision 24. F.6.10. Prior Authorizations, is hereby amended as follows:
At any point that the Agency redistributes membership within the Iowa Dental Wellness Plan and Hawki Dental program or following open Enrollment, the Contractor shall honor existing authorizations for covered Benefits for a minimum of ninety (90) Days, without regard to whether such services are being provided by contract or non-contract Providers, when an Enrolled Member transitions to the Contractor from another source of coverage. The Contractor shall honor existing Waiver of Administrative Rule granted by the Director for the scope and duration

designated. At all other times outside of Agency member redistribution and following open Enrollment, the Contractor shall honor existing authorizations for a minimum of thirty (30) Days when an Enrolled Member transitions to the Contractor from another source of coverage, without regard to whether services are being provided by contract or non-contract Providers. The Contractor shall obtain Agency approval for policies and procedures to identify existing Prior Authorizations at the time of Enrollment. The Contractor shall implement and adhere to the Agency-approved policies and procedures. Additionally, when an Enrolled Member transitions to another Program Contractor, the Contractor shall 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.

Revision 25. F.6.25. Early and Periodic Screening, Diagnostic Treatment (EPSDT) Services., first paragraph is hereby amended as follows:
The Contractor shall provide EPSDT services to all DWP 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.

Revision 26. F.16.09. Exceptions to Policy, is hereby retitled as follows:
Waiver of Administrative Rule

Revision 27. F.16.09. Waiver of Administrative Rule, is hereby amended as follows:
Under the Waiver of Administrative Rule (formerly known as the “exceptions to policy”) process, an Enrolled Member can request an item or service not otherwise covered by the Agency or the Contractor. Waiver of Administrative Rule may be granted to Contractor policies, but they cannot be granted to federal or State law or regulations. The Contractor may forward requests for waivers to Agency policy to the Agency for consideration. A Waiver of Administrative Rule is a last resort request and is not appealable to the extent the request is for services outside of State Plan or waiver Benefits.

A Waiver of Administrative Rule may be granted in individual cases upon the HHS Director’s own initiative or upon request. A Waiver of Administrative Rule is only specifically granted by the HHS Director with the recommendation of the Medicaid Director. The Department issues written decisions for all requests for a Waiver of Administrative Rule. .

The Contractor is not responsible for decisions regarding a Waiver of Administrative Rule under state rule and should not present themselves as such and shall not use the term “Waiver of Administrative Rule” to describe their own internal medical necessity review decisions when communicating with Enrolled Member.

The Contractor on their own and by their own determination, may make an exception to their own policies, but shall not refer to these actions as a Waiver of Administrative Rule . Any scenario in which the Contractor determines to provide coverage for items or services outside of their own policies must not be referred to as a Waiver of Administrative Rule.

The Contractor on their own may determine that a Waiver of Administrative Rule 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 an Enrolled Member’s assessed needs may initiate a Waiver of Administrative Rules request following the process outlined in 441 IAC 6.1.

Any scenarios in which the Contractor determines to approve, deny, reduce, or terminate an Enrolled 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.

Revision 28. G.2.36. Prior Authorization, is hereby amended as follows:
During the first two (2) years of the Contract, the Contractor shall honor all existing authorizations for covered Benefits for a minimum of ninety (90) Days, without regard to whether such services are being provided by contract or non-contract Providers, when an Enrolled Member transitions to the Contractor from another source of coverage. The Contractor shall honor existing Waiver of Administrative Rule granted by the Director for the scope and duration designated. At all other times, the Contractor shall honor all existing authorizations for a minimum of thirty (30) Days when an Enrolled Member transitions to the Contractor from another source of coverage, without regard to whether services are being provided by contract or non-contract Providers. The Contractor shall obtain Agency approval for policies and procedures to identify existing Prior Authorizations at the time of Enrollment. The Contractor shall implement and adhere to the Agency approved policies and procedures. Additionally, when an Enrolled Member transitions to another Program Contractor, the Contractor shall 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.

Revision 29. G.3.17. Notice - Timeframe, is hereby amended as follows:
For standard authorization decisions, Contractor shall provide Notice as expeditiously as the Enrolled Member's condition requires and within State-established timeframes that may not exceed seven (7) Days after receipt of request for service, with a possible extension of up to fourteen (14) Days if the Enrolled Member requests an extension or the Contractor justifies the need for additional information and how the extension is in the Enrolled Member's interest. See: 42 C.F.R. § 438.210(d)(1); § 438.210(d)(2)(ii) 42 C.F.R. § 457.1230(d). {From CMSC G.3.07}.

Revision 30. G.3.19. PA Performance Metric, is hereby amended as follows:
Ninety-nine percent (99%) of standard authorization decisions shall be rendered within seven (7) Days of the request for service, or seventy-two (72) hours for expedited authorization decisions. For outpatient prescription drug PA, one hundred percent (100%) of authorization decisions shall be rendered within twenty-four (24) hours of the request. Requests for extensions approved in accordance with previous sections of the Contract shall be removed from this timeliness measure.

Revision 31. G.5.10. Special Health Care Needs Obligation, is hereby amended as follows:
Contractor's comprehensive QAPI program shall include mechanisms to assess the Quality and appropriateness of care furnished to Enrolled Members with special health care needs, as defined by the Iowa HHS Medicaid Quality Strategy. See: 42 C.F.R. § 438.330(b)(4); 42 C.F.R. § 438.340; 42 C.F.R. § 457.1240(b). {From CMSC G.5.05}.

Revision 32. G.5.27. Value-Based Purchasing Programs, is hereby amended as follows:
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 Iowa HHS Medicaid Quality Strategy, including specific detail for the value-based purchasing requirements described in Section E.8 and C.6.

Revision 33. G.5.28 Dental Quality Strategy, is hereby retitled as:
Iowa HHS Medicaid Quality Strategy

Revision 34. G.5.28. Iowa HHS Medicaid Quality Strategy, is hereby amended as follows:
The Contractor shall obtain Agency approval of an approach to support Iowa's goal of delivery system transformation consistent with the Agency's Iowa HHS Medicaid Quality Strategy plan. The Iowa HHS Medicaid Quality Strategy consists of five (5) strategic goals to promote policy and action to effectively improve the Medicaid Program. The goals are: 1) enhance access to care; 2) promote whole person coordinated care; 3) create health equity; 4) improve program administration; and 5) promote the voice of the customer. The Contractor shall implement and adhere to the Agency-approved strategies. Changes to these strategies shall receive the Agency's prior approval.

Revision 35. H.1.03. Eligibility, Effective Date of Coverage, Premiums, Copayments, and Exceptions to Policy is hereby retitled as:
Eligibility, Effective Date of Coverage, Premiums, Copayments, and Waiver of Administrative Rule.

Revision 36. H.1.03. Eligibility, Effective Date of Coverage, Premiums, Copayments, and Waiver of Administrative Rule, is hereby amended as follows:
Contractor shall direct the following types of Appeal or Grievance requests to the Agency:

a. Enrolled Member eligibility including termination of eligibility;
b. Effective dates of coverage;
c. Determinations of premium and copayment responsibilities; and
d. Waiver of Administrative Rule regarding services outside of State Plan Benefits.

Revision 37. H.3.05. *Fourteen* (*14) Day Notice Deadline,* is hereby retitled as follows:
Seven* (*7) Day Notice Deadline

Revision 38. H.3.05. *Seven* (*7) Day Notice Deadline,* is hereby amended as follows:
Contractor shall give Notice of an Adverse Benefit Determination as expeditiously as the Enrolled Member's condition requires within Agency-established timeframes that may not exceed seven (7) Days following receipt of the request for service, for standard authorization decisions that deny or limit services. See: 42 C.F.R. § 438.210(d)(1); 42 C.F.R. § 438.404(c)(3); 42 C.F.R. § 457.1230(d). {From CMSC H.3.05}.

Revision 39. H.3.06. *Extensions of Fourteen (14) Day Deadline,* is hereby retitled as follows:
Extensions of Seven (7) Day Deadline.

Revision 40. H.3.06. Extensions of Seven (7) Day Deadline, is hereby amended as follows:
Contractor may extend the seven (7) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional Days if the Enrolled Member or the Provider requests extension. See: 42 C.F.R. § 438.404(c)(4); 42 C.F.R. § 438.210(d)(1)(i); 42 C.F.R. § 457.1230(d). {From CMSC H.3.06}.

Revision 41. H.3.07. Extensions of Standard Authorizations, is hereby amended as follows:
Contractor may extend the seven (7 calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional Days if the Contractor justifies a need (to the Agency, upon request) for additional information and shows how the extension is in the Enrolled Member's best interest. See: 42 C.F.R. § 438.210(d)(1)(ii); 42 C.F.R. § 438.404(c)(4); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.07}.

Revision 42. H.3.08. Written Notice Obligation, is hereby amended as follows:
If Contractor extends the seven (7) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services, Contractor shall give the Enrolled Member written Notice of the reason for the extension and inform the Enrolled Member of the right to file a Grievance if the Enrolled Member disagrees with the decision. See: 42 C.F.R. § 438.210(d)(1)(ii); 42 C.F.R. § 438.404(c)(4)(i); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.08}.

Revision 43. H.3.09. Duty to Make the Determination Expeditiously, is hereby amended as follows:
If Contractor extends the seven (7) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services, Contractor shall issue and carry out its determination as expeditiously as the Enrolled Member's health condition requires and no later than the date the extension expires. See: 42 C.F.R. § 438.210(d)(1)(ii); 42 C.F.R. § 438.404(c)(4)(ii); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.09}.

Revision 44. I.3.01. Ownership or Control Disclosures, is hereby amended as follows:
Contractor and Subcontractors shall disclose to the Agency any persons or corporations with an ownership or control interest in the Contractor that:

a. Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity;
b. Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets;
c. Is an officer or director of an MCP organized as a corporation; or
d. Is a partner in an MCP organized as a partnership.

See: Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Act; 42 C.F.R. § 438.608(c)(2); 42 C.F.R. § 455.100 - .104. {From CMSC I.3.01}.

Revision 45. I.5.03. Annual Reports, is hereby amended as follows:
Annually, on the date identified by the Agency, the Contractor shall submit the reports included in the Program Integrity Reporting Companion Guide. 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 46. I.5.04. Quarterly Reports, is hereby amended as follows:
Quarterly, on the date identified by the Agency, the Contractor shall submit the reports included in the Program Integrity Reporting Companion Guide.

Revision 47. I.5.05. Monthly Reports, is hereby amended as follows:
Monthly, on the date identified by the Agency, the Contractor shall submit the reports included in the Program Integrity Reporting Companion Guide.

Revision 48. J.4.10. Coordination with Medicare, is hereby amended as follows:
Contractor shall provide medically necessary covered services to Enrolled Members who are also eligible for Medicare if the service is not covered by Medicare, if applicable reference J.4.09. The Contractor shall ensure that services covered and provided under the Contract are delivered without charge to Enrolled Members who are dually eligible for Medicare and Medicaid. The Contractor shall coordinate with Medicare payers, Medicare Advantage Plans, and Medicare Providers as appropriate to coordinate the care and Benefits of Enrolled Members who are also enrolled with Medicare. Contractor shall develop a plan to coordinate care for duals and document such in its PPM.

Revision 49. K.41. a) Claims Processing Capability, is hereby amended as follows:
The Contractor shall process and pay Provider Claims for services rendered to the Contractor's Enrolled Members. The Contractor shall have a Claims processing system for both in- and Out-of-Network Providers capable of processing all Claims types. The Contractor shall accept Claims submitted via standard EDI transactions directly from Providers, or through their intermediary, and must have the capacity to process paper Claims. The Contractor shall electronically accept and adjudicate Claims and accurately support payment of Claims for Enrolled Members' periods of eligibility. The Contractor shall also provide electronic remittance advice and to transfer Claims payment electronically. The Contractor shall process as many Claims as possible electronically. The Contractor shall track electronic versus paper Claim submissions over time to measure success in increasing electronic submissions. The Contractor shall accurately price specific procedures or encounters (according to the agreement between the Provider(s) and the Contractor) and to maintain detailed records of remittances to Providers. The Contractor shall update Provider reimbursement rates in its Claims processing system and adjudicate Claims using the new rates no later than thirty (30) Days from notification by the Agency, or as otherwise directed by the Agency. Except as otherwise specified in law, or as otherwise directed by the Agency, rate updates shall be implemented prospectively. The Contractor shall develop, implement, and adhere to policies and procedures, subject to Agency review and approval, to monitor Claims adjudication accuracy and shall submit its policies and procedures to the Agency for review and approval within fifteen (15) Days of Contract execution. The Out-of-Network Provider filing limit for submission of Claims to the Contractor is twelve (12) months from the date of service. This conforms with the filing limit under the Medicaid State Plan (42 C.F.R. § 447.45(d)(4)). The in-Network Provider filing limit is established in the Contractor's Provider agreements as described in Section E.1 and shall be no more than one hundred and eighty (180) Days from the date of service.

Revision 50. L.4.01. Identifying Persons with Special Health Care Needs, is hereby amended as follows:
The Agency, the Enrollment Broker, or the Contractor will identify persons with special health care needs as defined by the Agency. The 834 file and any other mechanisms identified by the Agency will convey the identity of those persons with special health care needs. See: 42 C.F.R. § 438.208(c)(1); 42 C.F.R. § 457.1230(c). {From CMSC L.4.01}.

Revision 51. Section 5: Special Contract Exhibits. Exhibit A, Capitation Rate Information, MLR, Pay for Performance, Liquidated Damages, and Carved-Out Services, 2. MLR Information and 5. Carved-Out Services is hereby retitled as follows:
Exhibit A, Capitation Rate Information, Pay for Performance, and Liquidated Damages

Revision 52. Section 3: Special Contract Exhibits. Exhibit A, Capitation Rate Information, MLR, Pay for Performance, Liquidated Damages, and Carved-Out Services, 2. MLR Information and 5. Carved-Out Services is hereby amended as follows:

Exhibit A: Capitation Rate Information, MLR, Pay for Performance, and Liquidated Damages

1. Capitation Rate Information
2. Payment for Performance Chart
3. Liquidated Damages

Revision 53. Section 5. Special Contract Exhibits. Exhibit A, Section 5. Carved-Out Services, is hereby removed and reserved as follows:
Section 5: Reserved.

Revision 54. Exhibit A. Section 2: MLR for Rate Period, is hereby removed and reserved as follows:
Section 2: Reserved.

Revision 55. Section 3: SFY 2025 Payment for Performance Chart, is hereby amended as follows:
SFY 2026 Payment for Performance Chart

Revision 56. Exhibit B. Glossary of Terms/Definitions, is hereby added as follows:
Adult Day Care: Adult day care services provide an organized program of supportive care in a group or individual environment to persons who need a degree of supervision and assistance on regular or intermittent basis in a day care center or in the home due to the absence of the primary caregiver. Supports provided during day care would be protective oversight, supervision, ADLs and IADLs. Included are personal cares (i.e.: ambulation, toileting, feeding, medications), behavioral support, or intermittent health-related cares, not otherwise paid under other waiver or state plan programs.

Revision 57. Exhibit B. Glossary of Terms/Definitions, is hereby amended as follows:
Case management: Provides service coordination and monitoring. Available as a 1915 (i) Habilitation service when the individual does not otherwise qualify for targeted case management.

Revision 58. Exhibit B. Glossary of Terms/Definitions, is hereby removed as follows:

Revision 59. Exhibit B. Glossary of Terms/Definitions, is hereby added as follows:
Certified Community Behavioral Health Clinic (CCBHC): a specially designated clinic that provides a comprehensive range of mental health and substance use services. CCBHCs are designed to ensure access to coordinated care for anyone who requests it, regardless of their ability to pay, place of residence, or age.

Revision 60. Exhibit B. Glossary of Terms/Definitions, is hereby removed as follows:

Revision 61. Exhibit E. Section I: Dental Wellness Plan, is hereby amended as follows:
Section I: Dental Wellness Plan
Dental Wellness Plan – Covered Dental Services: Available at this link or its successor.

Dental Wellness Plan – ABM Excluded Services: Available at this link or its successor.

Dental Wellness Plan – Additional Orthodontia Detail: Contractor shall follow the Agency's Orthodontic Administrative Guide, or its successor, for adjudication of orthodontia services.

Revision 62. Exhibit F. Program-Specific Cost Sharing and Annual Benefit Maximum (ABM) Requirements, is hereby amended as follows:

Section I: Annual Benefit Maximum (ABM) - Overview

DWP Enrolled Members aged twenty-one (21) years and over are limited to an Annual Benefit Maximum (ABM) of $1,000 per State fiscal year (July 1 - June 30). ABM is determined using the Medicaid FFS rates, regardless of reimbursement rate to providers.

Section II: Annual Benefit Maximum (ABM) – Dental Wellness Plan

The DWP ABM does not apply to preventive, diagnostic, emergency, anesthesia in conjunction with oral surgery approved codes, and fabrication of removable denture services. A list of excluded ABM services can be found Exhibit E. If a member reaches the $1,000 ABM and receives additional services that are not excluded services from the ABM, the DWP member is responsible for payment of services. If the member's ABM is met, services that meet medically necessity can still be received through a Waiver of Administrative Rule.

DWP Enrolled Members under aged twenty-one (21) years do not have an ABM as part of their dental package and are limited to cost-sharing requirements established by federal EPSDT guidance.

Section III: Reserved.

Revision 63. Effective July 1, 2025, the state is updating the rates for SFY26. Updated Special Contract Amendment below.

Revision 64. 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: Shannon LePage	Date: 12-23-25	Signature of Authorized Representative: Lee Grossman	Date: 12/26/2025
Printed Name: Shannon LePage		Printed Name: Lee Grossman	
Title: Chief Executive Officer		Title: Medicaid Director	

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

MCNA - DWP	DWP Rate Comparison			
Rate Cell	SFY24 MMs	SFY26 Original Rate	SFY26 Revised Rate	% Difference
Children 0-1	187,140	$ 4.82	$ 5.42	12.5%
Children 2-5	285,846	$ 19.14	$ 21.16	10.5%
Children 6-18	797,698	$ 22.23	$ 24.04	8.1%
Community and LTSS Disabled	137,048	$ 17.41	$ 18.85	8.3%
Community and LTSS Elderly	126,193	$ 6.25	$ 6.74	7.9%
Community Duals <65	94,096	$ 13.97	$ 15.25	9.2%
Pregnant Women	58,140	$ 8.57	$ 9.33	8.8%
TANF 19-34 F	150,858	$ 15.88	$ 17.06	7.4%
TANF 19-34 M	45,347	$ 10.62	$ 11.28	6.2%
TANF 35-49 F	84,220	$ 15.60	$ 17.04	9.3%
TANF 35-49 M	35,565	$ 12.35	$ 13.20	6.9%
TANF 50+	16,069	$ 19.20	$ 20.84	8.5%
Wellness Plan 19-34 F	219,871	$ 13.56	$ 14.60	7.6%
Wellness Plan 19-34 M	204,791	$ 8.57	$ 9.09	6.1%
Wellness Plan 35-49 F	124,674	$ 15.09	$ 16.60	10.0%
Wellness Plan 35-49 M	135,955	$ 10.79	$ 11.69	8.3%
Wellness Plan 50+	189,617	$ 14.02	$ 15.50	10.6%