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SoonerSelect Program Annual External Quality Review Technical Report

2025-2026 Reporting Cycle

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SoonerSelect Program Annual External Quality Review Technical Report of Aetna Better Health of Oklahoma; Humana Healthy Horizons; Oklahoma Complete Health, Inc. (Medical and CSP); DentaQuest; and LIBERTY Dental Plan
2025-2026 Reporting Cycle
Submission Date: April 16, 2026

Introduction

Background and Objectives

In May 2022, the Ensuring Access to Medicaid Act, 56 O.S. § 4002.3a, directed the Oklahoma Health Care Authority (OHCA, the State) to enter public-private partnerships with contracted entities (CEs), through risk-based capitated contracts, to provide integrated medical services to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries in Oklahoma. KFMC Health Improvement Partners (KFMC), under contract with OHCA, serves as the External Quality Review Organization (EQRO) for SoonerSelect (Oklahoma's Medicaid and CHIP managed care programs). OHCA's aims for the SoonerSelect program are to: improve the health of Oklahoma Medicaid members and the health of Oklahoma communities and the State as a whole; improve care delivery through a provider-led model with emphasis on access to high-quality, person-centered, and coordinated care; improve member experience; improve provider experience; and improve financial sustainability of the Oklahoma Medicaid Program.[1]

Tale I.1. describes the CEs that were awarded contracts for the SoonerSelect program.

Table I.1. SoonerSelect CEs			
CE Name	**PlanType**	**Start Date**	**Population Served**
Dental Plans			
DentaQuest (DQ)	Dental Plan; Prepaid Ambulatory Health Plan (PAHP)	February 1, 2024	Children and Adults
LIBERTY Dental (LIBERTY; LD)			
Medical Plans			
Aetna Better Health of Oklahoma (Aetna; ABH)	Managed Care Organization (MCO)	April 1, 2024	Children and Adults
Humana Healthy Horizons in Oklahoma (Humana; HHH)			
Oklahoma Complete Health (OCH)			
Children's Specialty Plan (CSP)			
OCH	MCO	April 1, 2024	Children within Special Populations

[1] SoonerSelect Quality Strategy https://oklahoma.gov/content/dam/ok/en/okhca/docs/about/soonerselect/_20230906-OHCA%20SoonerSelect%20QS%20Final.pdf. Accessed March 24, 2025.

External Quality Review Activities

As the EQRO, KFMC evaluated the CEs in their provision of services to SoonerSelect enrollees, basing evaluations on the External Quality Review (EQR) protocols developed by the Centers for Medicare & Medicaid Services (CMS), updated February 2023.[2] This report includes summaries of reports (submitted to the State May 2025 through March 2026) evaluating the following activities for each CE during the 2025-2026 reporting cycle. No SoonerSelect CE was exempt from external quality review.

- Performance Measure Validation (PMV)
- Performance Improvement Project (PIP) Validation
- Review of Compliance with Medicaid and CHIP Managed Care Regulations (Compliance Review)
- Network Adequacy Validation
- Quality Assessment and Performance Improvement (QAPI) Review
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Evaluation

For this reporting cycle, the Encounter Data Validation activity could not be completed due to data access limitations. KFMC will continue to work with the State in 2026 to obtain the encounter data needed to conduct this activity.

KFMC used the following CMS *EQR Protocol* worksheets and narratives in the completion of these activities:

- EQR Protocol 1: Validation of Performance Improvement Projects
- EQR Protocol 2: Validation of Performance Measures
- EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations
- EQR Protocol 4: Validation of Network Adequacy

Nonduplication of Mandatory EQR Activities

CMS allows the use of comparable Medicare or private accreditation review findings to replace information that would otherwise need to be produced through mandatory EQR activities. This nonduplication option may be used when certain conditions are met, including when the accreditation standards align with the requirements in the EQR protocols, and when the State can provide the EQRO with all applicable accreditation findings supporting that determination. Additionally, the EQRO would be required to conduct a validation process to ensure the accreditation review findings adequately support the completion of the mandatory EQR activities.

The SoonerSelect dental and medical CEs were not required to be accredited until September and October 2025, respectively. Therefore, no accreditation findings were available to support nonduplication of mandatory EQR-related activities for this reporting cycle. Accreditation review results will be available for this use in future years.

EQR Reports Produced in the 2025-2026 Cycle

KFMC completed individual reports for each activity throughout the 2025-2026 reporting cycle to provide the State and CEs timely feedback on program progress. These individual reports contain more

[2] Centers for Medicare & Medicaid Services, *CMS External Quality Review (EQR) Protocols*, February 2023, OMB Control No. 0938-0786.

detail, and additional feedback beyond what is required, then what is presented in the following activity summaries. This additional feedback includes suggestions for improvement that have no effect on compliance scores. See Appendix A for a list of the full reports (which are available upon request) for the activities conducted in accordance with the Code of Federal Regulations (CFR) § 438.358.

Report Content and Structure

In this Annual External Quality Review Technical Report, the summaries provided include, as appropriate, objectives; technical methods of data collection; descriptions of data obtained; strengths and opportunities for improvement regarding quality, timeliness, and access to health care services; an assessment of the degree to which the previous year's EQRO recommendations have been addressed; and recommendations for quality improvement. The full reports and appendices of each report provide extensive details by CE, program, and metrics. Recommendations and conclusions in the summaries that follow primarily focus on those related directly to improving health care quality, access, and timeliness; additional technical, methodological, and general recommendations to the CEs may be included in the individual reports submitted to the State and CEs. The Quality Strategy (QS) section contains suggestions, based on the EQR findings, for how the State can target goals and objectives in the SoonerSelect QS.

Overview of CE-Level Strengths and Opportunities for Improvement

Most EQR-related activities require that findings be tied to access, quality, and timeliness of care. Table I.1 and I.2 present an overview of CE-level strengths and opportunities for improvement identified via the external quality review activities conducted during the 2025-2026 reporting cycle.

The tables are organized into Strengths and Opportunities so that information can be compared across CEs. Separate tables are presented for the Dental CEs (Table I.1) and for the Medical and CSP CEs (Table I.2) because the two groups operate under different contract requirements. Presenting them separately allows for clearer, like-to-like comparisons. The "Domain" column indicates whether the strengths and opportunities are related to access, quality, or timeliness. Please see the individual activity sections for more detail regarding strengths and opportunities for improvement common among the CEs.

The PIP section below explains that two PIP validations were conducted during this cycle, one for LIBERTY and one for Humana. Strengths and opportunities for these validations are not included in Tables I.1 or I.2, as comparative findings from the other CEs will not be available until the next reporting cycle. In addition, as findings for the Network Adequacy Validation were compiled at the SoonerSelect level and not at the individual CE level, these findings are not incorporated into these tables. Please refer to the individual PIP Validation and Network Adequacy Validation sections for details on these activities.

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<table>
<tr><th colspan="4">Table I.2. CE-Level Strengths and Opportunities for Improvement: SoonerSelect Dental</th></tr>
<tr><th></th><th>DentaQuest</th><th>LIBERTY</th><th>Domain</th></tr>
<tr><td colspan="4">Performance Measure Validation</td></tr>
<tr><td>S</td><td>No strengths were identified</td><td>LIBERTY was receptive to feedback and when issues were identified by KFMC, corrections were made by LIBERTY, and a corrected DEN-1614 report was returned to KFMC.</td><td rowspan="2">Access, Quality, Timeliness</td></tr>
<tr><td>O</td><td>It is unclear if member ZIP codes are associated with the last known physical address of a member no longer eligible for SoonerSelect or with an active member’s mailing address, rather than a physical address.
There are no State-defined data cutoff dates; defining cutoff dates would ensure all CEs are reporting data as of a shared point in time.
The original report submitted for validation contained errors, particularly on the Demographics tab, that were attributed to lack of clarity regarding the template as well as an attempt to perform the stratifications manually.
In its calculations of the Topical Fluoride for Children measure, DQ reported providers without a taxonomy code.
Insufficient evidence was provided to support validation of the recalculated rates within the time frame for the validation project.
Sampling methodologies differed slightly between the Dental CAHPS and Health Plan CAHPS survey methodologies.
The size of the adult and child sample frames (i.e., files of eligible members prior to any deduplication) were not included in the CAHPS reports or other documentation provided for validation of sampling methodology.</td><td>It is unclear if member zip codes are associated with the last known physical address of a member no longer eligible or with an active member’s mailing address, rather than physical address.
There are no State-defined data cutoff dates; defining cutoff dates would ensure all CEs are reporting data as of a shared point in time.
Demographic data for the members is not included in the raw data extracts that are archived for the measure; should the measures need to be rerun and include demographics data, results may differ.
The original report submitted for validation contained errors that included missing entries or transposed values on the Demographics tab which were a result of the different order of the stratifications between the report and LD’s pivot tables.
Sampling methodologies differed slightly between the Dental CAHPS and Health Plan CAHPS survey methodologies.
The following data were not included in the CAHPS reports or other documentation provided for validation of sampling methodology:
Size of the adult and child sample frames (i.e., files of eligible members prior to any deduplication)
Denominators for questions and composites to determine margins of error and adequacy of sample sizes
Threshold for the table footnote “*Caution – small sample size”</td></tr>
<tr><td colspan="4">* S = Strength: High performance or notable mentions/O = Opportunity: Low performance</td></tr>
</table>

Table I.2. CE-Level Strengths and Opportunities for Improvement: SoonerSelect Dental (Continued)			
	DentaQuest	**LIBERTY**	**Domain**
Review of Compliance with Medicaid and CHIP Managed Care Regulations			
S	Of the 12 regulatory areas reviewed, 4 had compliance scores of 100%: • § 438.208 Coordination and continuity of care • § 438.414 Information about grievance and appeal system to providers and subcontractors and related provision § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs [Prepaid Inpatient Health Plan], PAHPs, and PCCM [Primary Care Case Management] entities: Enrollee handbook • § 438.424 Effectuation of reversed appeal resolutions • § 438.242 Health information systems	Of the 12 regulatory areas reviewed, 4 had compliance scores of 100%: • § 438.208 Coordination and continuity of care • § 438.414 Information about grievance and appeal system to providers and subcontractors and related provision § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook • § 438.424 Effectuation of reversed appeal resolutions • § 438.242 Health information systems	Access, Quality, Timeliness
O	DentaQuest had the greatest opportunity for improvement within Subpart D related to regulatory areas § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System): § 438.406 Handling of grievances and appeals; § 438.408 Resolution and notification: Grievances and appeals; § 438.410 Expedited resolution of appeals; § 438.416 Recordkeeping requirements; and § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP, appeal and State fair hearing are pending.	LIBERTY had the greatest opportunity for improvement within Subpart D related to regulatory areas § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System): § 438.404 Timely and Adequate Notice of Adverse Benefit Determination; § 438.408 Resolution and notification: Grievances and appeals; § 438.410 Expedited resolution of appeals; and § 438.416 Recordkeeping requirements.	
Early and Periodic Screening, Diagnostic, and Treatment			
S	Care coordinators or case managers are involved in EPSDT engagement.	LIBERTY partners with community and school-based organizations to identify children's oral health needs early.	Access, Quality, Timeliness
O	• DentaQuest had the greatest opportunities regarding the EPSDT benefit details in their Member Handbook, Office Reference Manual, and website. • Documentation submitted did not include evidence of member outreach regarding EPSDT benefits within 60 days of enrollment. • Prior authorizations did not include sufficient documentation to demonstrate the reviews were done by appropriately licensed professionals.	• LIBERTY had the greatest opportunities regarding the EPSDT benefit details in their Member Handbook and website. • Documentation submitted did not include evidence of member outreach regarding EPSDT benefits within 60 days of enrollment. • Prior authorizations did not include sufficient documentation to demonstrate the reviews were done by appropriately licensed professionals and all medical record documentation was considered.	

∗ S = Strength: High performance or notable mentions/O = Opportunity: Low performance

Table I.2. CE-Level Strengths and Opportunities for Improvement: SoonerSelect Dental (Continued)			
	DentaQuest	**LIBERTY**	**Domain**
Quality Assessment and Performance Improvement Review			
S	Strengths were not identified during this cycle.	Strengths were not identified during this cycle.	
O	• DentaQuest's Program Description and Work Plan did not include documented baselines, benchmarks, or performance rates making it challenging to identify gaps in member experience or to assess the effectiveness of efforts to close those gaps. • The Local Oklahoma Provider Organization representatives serving on the quality improvement committee (QIC) were not identified making local representation on the committee unclear.	• LIBERTY's limited explanation of responsibilities, reporting structures, monitoring processes, quality activities and initiatives, and evaluation methods makes it difficult to assess whether it has consistent mechanisms in place to track access, quality, and timeliness or to ensure that quality improvement activities are implemented and sustained. • LIBERTY's Program Description and Work Plan did not include documented baselines, benchmarks, or performance rates making it challenging to identify gaps in member experience or to assess the effectiveness of efforts to close those gaps. • LIBERTY's methodology for selecting the participa ting providers to profile was not documented in a manner that was transparent and reproducible.	Access, Quality, Timeliness

∗ S = Strength: High performance or notable mentions/O = Opportunity: Low performance

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Table I.3. CE-Level Strengths and Opportunities for Improvement: SoonerSelect Medical and CSP				
	Aetna	**Humana**	**OCH and OCH-CSP**	**Domain**
Performance Measure Validation				
S	• Aetna was receptive to feedback, and when issues were identified by KFMC, corrections were made by Aetna and a corrected SEL-1614 report was returned to KFMC. • Aetna was well-prepared for the virtual meetings and submitted requested documentation in a timely manner.	• Humana was receptive to feedback, and when issues were identified by KFMC, corrections were made by Humana and a corrected SEL-1614 report was returned to KFMC. • Humana was well-prepared for the virtual meetings and submitted requested documentation in a timely manner.	No strengths were identified.	Access, Quality, Timeliness
O	• It is unclear if member ZIP codes are associated with the last known physical address of a member no longer eligible or with an active member's mailing address, rather than physical address. Stratification of out-of-state members was inconsistent between the CEs. • There are no State-defined data cutoff dates; defining cutoff dates would ensure all CEs are reporting data as of a shared point in time and remove ambiguities in the technical specifications for withhold measures. • The original SEL-1614 report submitted for validation contained errors related to demographic stratifications. • Denominators for certain questions in the CAHPS surveys were fewer than 100.	• It is unclear if member ZIP codes are associated with the last known physical address of a member no longer eligible or with an active member's mailing address, rather than physical address. Stratification of out-of-state members was inconsistent between the CEs. • There are no State-defined data cutoff dates; defining cutoff dates would ensure all CEs are reporting data as of a shared point in time and remove ambiguities in the technical specifications for withhold measures. • The original SEL-1614 report submitted for validation contained errors related to demographic stratifications and reported hybrid, rather than administrative, Prenatal and Postpartum Care rates. KFMC had been instructed to validate administrative rates. • The CAHPS Survey sample frame size appeared to be too small. • Denominators for certain questions in the CAHPS surveys were fewer than 100.	• It is unclear if member ZIP codes are associated with the last known physical address of a member no longer eligible or with an active member's mailing address, rather than physical address. Geographic stratification of members was inconsistent between the CEs. • There are no State-defined data cutoff dates; defining cutoff dates would ensure all CEs are reporting data as of a shared point in time and remove ambiguities in the technical specifications for withhold measures. • Inconsistent information was provided during the kickoff meeting, the virtual meeting, and written responses. • There were delays in providing requested data, and documentation provided was incomplete. • No documentation supporting the adequacy of the CAHPS sample frames was provided. • The child CAHPS reports did not indicate the membership surveyed (i.e., CHIP or non-CHIP). • The original report submitted for validation contained errors that included missing measures and counts not supported by the member-level detail data. • CSP Only: Too few adult surveys were completed to report composite ratings	

* S = Strength: High performance or notable mentions/O = Opportunity: Low performance

Table I.3. CE-Level Strengths and Opportunities for Improvement: SoonerSelect Medical and CSP (Continued)				
	Aetna	**Humana**	**OCH and OCH-CSP**	**Domain**
Review of Compliance with Medicaid and CHIP Managed Care Regulations				
S	Of the 12 regulatory areas reviewed, 2 had compliance scores of 100%: • § 438.414 Information about grievance and appeal system to providers and subcontractors and related provision § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook • § 438.424 Effectuation of reversed appeal resolutions	Of the 12 regulatory areas reviewed, 2 had compliance scores of 100%: • § 438.414 Information about grievance and appeal system to providers and subcontractors and related provision § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook • § 438.242 Health information systems	Of the 12 regulatory areas reviewed, 3 had compliance scores of 100%: • § 438.414 Information about grievance and appeal system to providers and subcontractors and related provision § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook • § 438.424 Effectuation of reversed appeal resolutions • § 438.242 Health information systems	Access, Quality, Timeliness
O	Aetna had the greatest opportunity for improvement within Subpart D related to regulatory areas § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System); and within Subpart F for elements within § 438.408 Resolution and Notification: Grievances and appeals; § 438.416 Recordkeeping requirements; and § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP, appeal and State fair hearing are pending.	Humana had the greatest opportunity for improvement within Subpart D for elements within § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System), and within Subpart F for elements within: § 438.408 Resolution and Notification: Grievances and appeals, § 438.416 Recordkeeping requirements, § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP, appeal and State fair hearing are pending, and § 438.424 Effectuation of reversed appeal resolution.	OCH had the greatest opportunity for improvement within Subpart D related to regulatory areas § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System); and within Subpart F for elements within § 438.408 Resolution and Notification: Grievances and appeals; § 438.416 Recordkeeping requirements; and § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP, appeal and State fair hearing are pending.	
* S = Strength: High performance or notable mentions/O = Opportunity: Low performance				

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Table I.3. CE-Level Strengths and Opportunities for Improvement: SoonerSelect Medical and CSP (Continued)

	Aetna	Humana	OCH and OCH-CSP	Domain
Early and Periodic Screening, Diagnostic, and Treatment				
S	• EPSDT quality goals are included in Aetna's Annual QAPI Documentation Plan. • At the end of each member service call, the Member Service Representative checks for gaps in care and offers enrollee assistance in finding a provider, scheduling an appointment, arranging transportation, and accessing additional resources.	• EPSDT quality goals are integrated into Humana's Annual QAPI Documentation Plan. • Humana maintains an active social media presence, posting multiple times per month. While content is not always EPSDT specific, these posts effectively guide members to the website, where EPSDT resources are easily located.	SMS Health, in collaboration with OCH, sends cobranded text messages to assigned members with EPSDT screening gaps, providing a direct link to the provider's website to support convenient appointment scheduling.	Access, Quality, Timeliness
O	• Aetna's greatest opportunity is in prior authorization and appeal review and determination of EPSDT services. • Documentation submitted did not include evidence of member outreach regarding EPSDT benefits within 60 days of enrollment.	Humana's greatest opportunity is in authorization review and determination of EPSDT services	• OCH's greatest opportunity is in prior authorization and appeal review and determination of EPSDT services. • EPSDT information on the CE website was not easily accessible or understandable.	
Quality Assessment and Performance Improvement Review				
S	Strengths were not identified during this cycle.	Strengths were not identified during this cycle.	Strengths were not identified during this cycle.	
O	• Aetna's Program Description did not document how assessment and monitoring of members with special health care needs is conducted to ensure members receive timely access to specialized services. • Aetna's methodology for selecting the participating providers to profile was not documented in a manner that was transparent and reproducible.	No opportunities were identified.	• OCH and OCH-CSP did not provide measurable data making it a challenge to reliably identify performance gaps, track trends over time, compare results to benchmarks, or demonstrate improvement. • The methodology OCH and OCH-CSP documented for selecting the participating providers to profile was not documented in a manner that was transparent and reproducible.	Access, Quality, Timeliness

* S = Strength: High performance or notable mentions/O = Opportunity: Low performance

Summary of Individual EQR Components

1. Performance Measure Validation

Background/Objectives

The SoonerSelect CEs were required to undergo a Performance Measure Validation for a set of Centers for Medicare & Medicaid Services 2025 Adult and Child Core Set measures, for measurement year (MY) 2024, in 2025. KFMC also reviewed sampling methodology for the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys administered by the contracted entities.[3] Selected performance measures reported by each CE were validated in accordance with EQR Protocol 2, Validation of Performance Measures, narratives and worksheets provided by CMS. Reporting Healthcare Effectiveness Data and Information Set (HEDIS®) measures to the National Committee for Quality Assurance (NCQA) and undergoing an NCQA HEDIS® Compliance Audit™ are optional for health plans in their first year of providing services in a market (MY 2024).[4,5] Consistent with nonduplication of efforts allowed by the protocol, validation of measures reported to NCQA were outside the scope of KFMC's audit. OCH and Humana elected to report HEDIS measures to NCQA in 2025.

The PMV process had four main objectives:

- Evaluate the policies, procedures, documentation, and methods the CE used to calculate the measures.
- Determine the extent to which the CE's sampling methodology for CAHPS was reliable, free of bias, and in accordance with standards for data collection and analysis.
- Verify measure specifications are consistent with the State's requirements.
- Determine the extent to which reported rates are accurate, reliable, free of bias, and in accordance with standards for data collection and analysis.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

OHCA required the CEs to report administrative rates for selected measures. KFMC met with OHCA to verify the scope of its validation activities. The CMS EQR protocol identified key types of data that should be reviewed as part of the validation process. In September 2025, KFMC corresponded with the CEs to provide the project timeline, to request documentation and member-level tables for measures in scope for the audit, and to request documentation related to the CEs' CAHPS sampling methodology. In October 2025, KFMC met with the CEs to discuss the measures in scope, documentation requests, project timeline, systems and processes used to generate the rates, any changes to the systems and processes described in the 2024 ISCA, and challenges with rate generation. KFMC reviewed a variety of documentation, including:

- 2024 ISCA data collection tool, supporting documentation, and report
- HEDIS MY 2024 Compliance Audit Final Report prepared by the CE's auditor, if one was performed
- Member-level detail tables including members in the denominator, numerator, and member-months for the measures in scope
- SEL-1614: *Medical Quality Measures Report*/DEN-1614: *Dental Quality Measures Report* of MY 2024 performance measures

[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[4] HEDIS® is a registered trademark of NCQA.
[5] HEDIS® Compliance Audit™ is a trademark of NCQA.

- Provider type/specialties mapping from source system to the system used to calculate any measures required to be performed by specified types/specialties
- Member race/ethnicity mapping from source system to the system used to calculate any measures stratified by race and ethnicity
- Sampling methodology and vendor reports for CAHPS member surveys.

Virtual meetings were held with the CEs as follows:
- Aetna – December 10, 2025
- DentaQuest – December 18, 2025
- Humana – December 17, 2025
- LIBERTY – December 9, 2025
- OCH and OCH-CSP – December 19, 2025

Follow-up questions and requests for additional data were made following the virtual meetings. The CEs provided responses and supplemental documentation for further review.

Table 1.1 displays the performance measures KFMC validated for this activity.

Table 1.1. Performance Measures Validated in 2025

Measure	Measure Name	CE Name					
		DQ	LD	ABH	HHH	OCH	OCH-CSP
OEV-CH	Oral Evaluation, Dental Services, Ages less than or equal to 20	X	X				
PEV-AD	Periodontal Evaluation for Adults with Periodontitis, Ages 30 and older	X	X				
TFL-CH	Topical Fluoride for Children, Ages 1 through 20	X	X				
CCP-AD -CH	Contraceptive Care – Postpartum Women, Ages 15 to 20 (CH) and Ages 21 to 44 (AD)			X	X	X	X
CDF-AD -CH*	Screening for Depression and Follow-up Plan, Ages 12 to 17 (CH) and Ages 18 and older (AD)			X	X	X	X
FUA-AD -CH	Follow-up After Emergency Department Visit for Substance Use, Ages 13 to 17 (CH) and Ages 18 and older (AD)			X			
FUH-AD -CH*	Follow-up After Hospitalization for Mental Illness, Ages 6 to 17 (CH) and Ages 18 and older (AD)			X			
FUM-AD* -CH	Follow-up After Emergency Department Visit for Mental Illness, Ages 6 to 17 (CH) and Ages 18 and older (AD)			X			
HVL-AD	HIV Viral Load Suppression, Ages 18 and older			X	X	X	X
PPC2-AD* -CH*	Prenatal and Postpartum Care, Ages less than 21 (CH) and Ages 21 and older (AD)			X	X	X	X
PQI01-AD	Diabetes Short-term Complications Admissions Rate, Ages 18 and older			X	X	X	X
PQI05-AD	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate, Ages 40 and older			X	X	X	
PQI08-AD	Heart Failure Admission Rate, Ages 18 and older			X	X	X	X
PQI15-AD	Asthma in Younger Adults Admission Rate, Ages 18 to 39			X	X	X	X
W30-CH*	Well-Child Visits in the First 30 Months of Life, Ages up to 30 Months			X			

*Quality Withold Measure

Conclusions Drawn from the Data

Common Among the CEs

The CEs are subsidiaries of national organizations. Consequently, the Oklahoma plans and local staff have access to the information systems and staff of their parent organizations to support their SoonerSelect lines of business. The CEs' parent organizations have undergone audits in previous years for other markets based on the requirements of NCQA for HEDIS Compliance Audits that included review of their information systems; no issues regarding the systems used to generate performance measures were noted.

The CEs' system infrastructure allows for collection, analysis, and reporting of data to support quality assessment and improvement activities. Systems are capable of tracking enrollees that change eligibility for the benefit programs, are able to restrict reports to SoonerSelect data, and stratify by product line. Data required for calculation of performance measures are accessible within the system infrastructure. The systems and processes in place are capable of maintaining up-to-date and accurate member, provider, and claims data. Systems utilize unique member and provider identifiers that allow data to be linked in a manner that supports accurate calculation of performance measures.

Data and Processes Impacting Rates

In this section, items that had an impact on the completeness of the population data included in the calculations of performance measures and on KFMC's ability to validate the results provided to it by the CEs are discussed.

OHCA noted that American Indian tribal members have the option of seeking services from the CEs' provider network or from tribal clinics. Requirements for the tribal claims filed with the State for reimbursement differ from requirements for claims submitted by the CEs' providers. Procedure codes are not required on tribal claims, which would prohibit the inclusion of these claims in measure calculations that are dependent on procedure codes.

KFMC did not have access to CE or State claims and encounters data, which was a limitation on its ability to do its own rate calculations to verify the accuracy of the populations included in denominators and numerators. KFMC's access to claims and encounters data is expected to be resolved in 2026.

Geographic stratifications of the measures on the Demographics tab of the SEL-1614/DEN-1614 reports had limitations. The Demographics tab on the reports submitted to KFMC differed between the CEs. Some reports included a column labeled Other which was used for members with out-of-state addresses. Other CEs counted the record in the urban or rural categorization of the member regardless of the address (in-state or out-of-state). Not all CEs provided geographic stratifications for all reported measures. The urban and rural designations are determined based on member ZIP codes. Beginning with MY 2025, CMS will require certain measures reported to its Quality Measure Reporting System to include urban/rural stratification *as of time of service*.

Race and ethnicity stratifications of the measures on the Demographics tab of the SEL-1614/DEN-1614 reports provide an incomplete profile of measure populations. The CEs report receipt of one code on the State's eligibility/membership files to indicate race and ethnicity; possible values include Caucasian, Black, Hispanic, Asian or Pacific Islander, and Not Provided. Consequently, the value represents either race or ethnicity. Some CEs supplement data provided by the State on 834 files with other sources. The

Demographics tab on the reports submitted to KFMC differed between the CEs. Some reports included a column for Multiple Races for Race and some included the columns Unknown or Declined to Answer for Ethnicity.

DentaQuest

DentaQuest's information system for member, provider, and claims processing, as well as analytics and reporting, is Windward, a proprietary platform. Data from Windward are replicated to a mirrored Windward database and to a reporting environment. The quality of the historical data provided to DentaQuest from the State was incomplete which reduced its usefulness for rate calculations, although historical data were used for calculation of the adult measure. Programming was handled by DentaQuest's parent organization. Rates were recalculated near the end of the review process due to errors DentaQuest discovered in its continuous enrollment calculations. The recalculated rates had substantial differences in numerators and denominators which DentaQuest attributed to continuous enrollment and retroactive enrollment changes.

DentaQuest contracted with Qualtrics, an NCQA-certified vendor, to conduct its annual CAHPS Dental Plan survey. KFMC reviewed SQL code provided by DentaQuest that it used to create the sample frame and sample, although the Qualtrics report stated that it performed the random sampling. Although DentaQuest reported that the data were deduplicated, the sample did include more than one member per household. The deduplication method (by Subscriber ID) could introduce a slight bias toward newer members. The criteria for the dental plan survey differed from HEDIS specifications for the CAHPS Health Plan surveys, as noted in the DentaQuest Performance Measure Validation for MY 2024 report, and also differed from the methodology followed by LIBERTY's Dental Plan survey vendor.

LIBERTY

LIBERTY's information system for members, providers, and claims processing, data analysis, and reporting is Conduent's Health Solutions Plus (HSP) platform. Data warehouses, replicas of HSP databases, are refreshed nightly from production data and are used to generate performance and quality reports. Corporate staff performed the programming required for calculation of the performance measures and did not deviate from the CMS Child Core Set Technical Specifications and Dental Quality Alliance (DQA) Measure Specifications. KFMC reviewed the code used to calculate the measures and it appeared to be consistent with specifications.

LIBERTY contracted with Press Ganey, an NCQA-certified vendor, to conduct its annual adult and child CAHPS Dental plan surveys, modified versions of Agency for Healthcare Research and Quality's Dental CAHPS survey. No code was provided to KFMC for review of methodology used to create the sample frame that was provided to the vendor. The vendor drew a simple random sample of adult members and of child members. The methodology provided to KFMC did not include size of the sample frames, denominators for questions and composites, the threshold for determination of small sample size, which impacted its ability to determine the sufficiency of the Dental Plan survey samples.

Aetna

Aetna's primary system for member and provider management and claims processing is Cognizant's QNXT platform. Vendor, provider, and clinical data files are housed in Aetna's Plan Audit database. QNXT data are extracted to the Plan Report replicated database. Data from these systems are extracted and normalized and loaded to Aetna's HEDIS Data Mart. Data are deduplicated, mapped as necessary, and extracted for loading to Inovalon's NCQA-certified Converged Analytics platform. Aetna's data

extracts included three years of historical clinical, medical, vision, and pharmacy data received from the State which were used for calculation of measures where permitted. Inovalon programmed its platform to calculate the non-HEDIS rates included in the PMV according to the CMS Adult and Child Core Set Technical Specifications with no deviations. Although Aetna did not report rates to NCQA for MY 2024, it did submit documentation to Advent Advisory Group LLC, its NCQA-certified HEDIS auditor. The auditor found no issues with Aetna's information systems or performance measure reporting processes. Additionally, Inovalon completed an auditor measure walkthrough with several auditors, including Advent, which consisted of a review of measures in scope for this audit including the PQI measures, to ensure measures were calculated according to specifications. There were no concerns with how the PQI measures were calculated by Inovalon.

Aetna contracted with Press Ganey, an NCQA-certified vendor, to conduct its annual adult and child CAHPS Health Plan 5.1H surveys using Adult (Medicaid) and Child (With Children with Chronic Conditions [CCC] Measure) questionnaires. The sample of CHIP members did not meet the minimum size. For NCQA-reportable results, question denominators need to be at least 100. Denominators were less than 100 for adults related to Rating of Health Care, Getting Needed Care, and Getting Care Quickly. Results were not reportable for both child surveys for Getting Needed Care, Getting Care Quickly, and Coordination of Care. Oversampling would be a way to increase the number of returned surveys so that these items would be reportable.

Humana

Humana's primary system for claims processing is its Claims Adjudication System (CAS). Data from CAS and other systems are extracted several times a day to Humana's Enterprise Data Warehouse which is used for reporting and analytics. Humana provided data extracts for loading to Cotiviti's NCQA-certified Quality Intelligence platform for performance measure analysis and reporting. Humana's data extracts included two years of historical medical, dental, vision, and pharmacy data received from the State which were used for calculation of measures where permitted. Cotiviti programmed its platform to calculate the non-HEDIS rates included in the PMV according to the CMS Adult and Child Core Set Technical Specifications with no deviations. Humana contracted with DTS Group for an NCQA-certified HEDIS audit and, as part of that audit process, reported FUA, FUH, FUM, and hybrid PPC2 performance measure rates directly to NCQA.

Humana contracted with Press Ganey, an NCQA-certified vendor, to conduct its annual adult and child CAHPS Health Plan 5.1H surveys using Adult (Medicaid) and Child (With CCC Measure) questionnaires. The sample frame, drawn from the Cotiviti platform, was validated by DTS Group who determined that the sample frame supported reporting to NCQA. Based on total enrollment, KFMC questioned whether the sample frame may have been too small. Based on the information provided, KFMC could not determine whether results identified as CCC included both CHIP and non-CHIP members, nor could KFMC determine whether the samples for the child surveys included the supplemental samples of children with a prescreen status code based on claims history. For NCQA-reportable results, question denominators need to be at least 100. Denominators were less than 100 for many measures for both child surveys (e.g., Rating of Health Care, Getting Needed Care, Getting Needed Care Quickly). Oversampling would be a way to increase the number of returned surveys so that these items would be reportable.

OCH and OCH-CSP

Centene's (OCH parent organization) primary system for processing member data is its Unified Member View. Member and provider data are fed to the claims adjudication platform, SS&C Technologies' AMISYS Advance. Amisys data are continuously staged to Centene's Enterprise Data Warehouse (EDW), a cloud-based analytics platform. Claims, member, provider, and vendor data are extracted from the EDW and supplemental data sources and loaded to a landing zone to ensure data comply with Inovalon requirements. Data are then loaded to Inovalon's NCQA-certified Converged Analytics platform for calculation of performance measures. Results are pushed to a data lake and accessed using Quality Data Hub, a plan-facing application that allows OCH to review rates and query the support data. OCH reported that historical data received from the State were not used to calculate performance measures; however, an historical claim file was used for determination of the HVL measure denominator. Inovalon programmed its platform to calculate the non-HEDIS rates included in the PMV according to the CMS Adult and Child Core Set Technical Specifications with no deviations. OCH contracted with Attest Health Care Advisors for an NCQA-certified HEDIS audit and, as part of that audit process, reported FUA, FUH, and FUM performance measure rates directly to NCQA. Rates are reported separately for OCH and for OCH-CSP. As noted above for Aetna, Inovalon met with NCQA auditors in multiple markets to review its programming of the non-HEDIS measures for the Converted Analytics platform and no concerns were reported.

OCH contracted with Press Ganey, an NCQA-certified vendor, to conduct its annual adult and child CAHPS Health Plan 5.1H surveys using Adult (Medicaid) and Child (With CCC Measure) questionnaires for the OCH and the OCH-CSP plans. The HEDIS audit final report from Attest Heath Care Advisors validated CAHPS sample frames, but it was not clear in its report if the OCH and OCH-CSP sample frames were included in the validation. Documentation provided by OCH, including the vendor reports for the OCH and OCH-CSP surveys, did not provide sufficient detail of sampling methodology, including the size of the sample frames. Only one OCH and one OCH-CSP child report included responses indicating CCC; the reports described a supplemental sample but no evidence was provided that the survey with CCC-categorized responses included the supplemental samples of children with a prescreen status code based on claims history. Vendor reports for the child surveys for both OCH and OCH-CSP did not indicate which survey included CHIP members and which included non-CHIP members, or if one of the child surveys included both. For NCQA-reportable results, question denominators need to be at least 100. Denominators were less than 100 for Getting Needed Care and Coordination of Care for both OCH child surveys although response totals were close to the minimum needed. For the OCH-CSP surveys, denominators were below the minimum on the child surveys for Access to Specialized Services and Coordination of Care. Denominators were below the minimum for the OCH-CSP Adult survey for Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Getting Needed Care, and Getting Care Quickly.

Issues found during the performance measure validation activities are described below in the Opportunities for Improving Quality, Timeliness, and Access to Health Care Services, both those common to the CEs as well as those specific to each CE.

Reported Rates

For MY 2024, the SoonerSelect CEs submitted performance measure results based on a partial year of operations following program implementation. Therefore, KFMC's activities were primarily limited to a review of documentation and processes to determine the validity of the reported rates. In subsequent

years, the PMV process will include an evaluation of the reported rates. For this partial year, though, KFMC observed the following.

- Across both dental and medical plans, reported rates were consistent with the shortened measurement period and showed similar patterns within each measure set. For example:
  - Dental results for Oral Evaluation and Topical Fluoride measures were comparable across DentaQuest and LIBERTY, with nearly identical totals and parallel age-band distributions.
  - Medical and CSP plans also reported results within a narrow range across CEs, including uniformly low rates for Depression Screening and Follow-Up and comparable Prevention Quality Indicator rates.

Appendix B contains tables detailing the rates reported by DentaQuest, LIBERTY, Aetna, Humana, OCH, and OCH-CSP.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

LIBERTY

- LIBERTY was receptive to feedback, and when issues were identified by KFMC, corrections were made by LIBERTY, and a corrected DEN-1614 report was returned to KFMC.

Aetna

- Aetna was receptive to feedback, and when issues were identified by KFMC, corrections were made by Aetna and a corrected SEL-1614 report was returned to KFMC.
- Aetna was well-prepared for the virtual meetings and submitted requested documentation in a timely manner.

Humana

- Humana was receptive to feedback, and when issues were identified by KFMC, corrections were made by Humana and a corrected SEL-1614 report was returned to KFMC.
- Humana was well-prepared for the virtual meetings and submitted requested documentation in a timely manner.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

Common Among the CEs

- It is unclear if member ZIP codes are associated with the last known physical address of a member no longer eligible or with an active member's mailing address, rather than physical address. Stratification of out-of-state members was inconsistent between the CEs.
- There are no State-defined data cutoff dates; defining cutoff dates would ensure all CEs are reporting data as of a shared point in time and remove ambiguities in the technical specifications for withhold measures.
- The original SEL-1614/DEN-1614 reports submitted for validation contained errors, primarily related to demographic stratifications.

DentaQuest

- In its calculations of the Topical Fluoride for Children measure, DentaQuest reported providers without a taxonomy code.
- Insufficient evidence was provided to support validation of the recalculated performance measure rates within the time frame for the validation project.

- Sampling methodologies differed slightly between the Dental CAHPS and Health Plan CAHPS survey methodologies.
- The size of the adult and child sample frames (i.e., files of eligible members prior to any deduplication) were not included in the CAHPS reports or other documentation provided for validation of sampling methodology.

LIBERTY

- Demographic data for the members is not included in the raw data extracts that are archived for the measure; should the measures need to be rerun and include demographics data, results may differ.
- Sampling methodologies differed slightly between the Dental CAHPS and Health Plan CAHPS survey methodologies.
- Insufficient data were included in the CAHPS reports or other documentation provided for validation of sampling methodology.

Aetna

- Denominators for certain questions in the CAHPS surveys were fewer than 100.

Humana

- The CAHPS sample frame size appeared to be too small.
- Denominators for certain questions in the CAHPS surveys were fewer than 100.

OCH

- Inconsistent information was provided during the kickoff meeting, the virtual meeting, and written responses.
- There were delays in providing requested data, and documentation provided was incomplete.
- No documentation supporting the adequacy of the CAHPS sample frames was provided.
- The child CAHPS reports did not indicate the membership surveyed (i.e., CHIP or non-CHIP).
- The original report submitted for validation contained errors that included missing measures and counts not supported by the member-level detail data.

OCH-CSP

- Inconsistent information was provided during the kickoff meeting, the virtual meeting, and written responses.
- There were delays in providing requested data, and documentation provided was incomplete.
- No documentation supporting the adequacy of the CAHPS sample frames was provided.
- The child CAHPS reports did not indicate the membership surveyed (i.e., CHIP or non-CHIP).
- Too few adult surveys were completed to report composite ratings.
- The original SEL-1614 submitted for validation contained errors that included missing measures and counts not supported by the member-level detail data.

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Because implementation dates for SoonerSelect contracts were February 1, 2024 (Dental) and April 1, 2024 (Medical and CSP), there are no prior recommendations due to this being the first year for PMV.

Recommendations for Quality Improvement

Common Among the CEs

1. Closely review the SEL-1614/DEN-1614 report, especially the Demographics tab, prior to report submission to ensure all information is included and is accurate.
2. Consider working with the OHCA and the other CEs to establish common data cutoff dates for the measures.
3. Seek additional guidance from OHCA regarding the preferred geographic stratification for out-of-state addresses.

DentaQuest

1. Archive the datasets and code used to generate the measures so that it is possible to recreate the reports from the population as it existed as of any data cutoff date.
2. Seek additional guidance from OHCA regarding the preferred handling of race and ethnicity stratifications when a member may have only one value for race/ethnicity that describes either race or ethnicity.
3. Seek additional guidance from OHCA or CMS regarding the handling of provider records that do not have a taxonomy code when calculating the Topical Fluoride for Children measures.
4. Consider working with the OHCA to establish a common methodology for the CAHPS Dental Surveys.
5. Include the sizes of the adult and child sample frames in the CAHPS reports, or other documentation, submitted to KFMC for validation.

LIBERTY

1. Include the reported demographic stratifications in archived data so that it is possible to recreate the reports from the population as it existed as of any data cutoff date.
2. Consider working with the OHCA to establish a common methodology for the CAHPS Dental Surveys.
3. Include the sizes of the adult and child sample frames, the denominators for questions and composites, and the threshold for designating small sample sizes in the CAHPS report, or other documentation, submitted to KFMC for validation.

Aetna

1. Implement methods to increase the number of surveys returned through oversampling or increasing response rates.

Humana

1. Verify CAHPS sample frames are calculated according to HEDIS technical specifications.
2. Implement methods to increase the number of CAHPS surveys returned through oversampling or increasing response rates.

OCH

1. Verify that all requested information, including data elements in the member-level detail files, are provided to support validation.
2. Verify sample frames are calculated according to HEDIS technical specifications.
3. Clarify the membership included in the child CAHPS surveys (i.e., CHIP or non-CHIP members).

Recommendations for Quality Improvement (Continued)

OCH-CSP

1. Verify that all requested information, including data elements in the member-level detail files, are provided to support validation.
2. Verify sample frames are calculated according to HEDIS technical specifications.
3. Increase the sample size for the Adult CAHPS survey.
4. Clarify the membership included in the child CAHPS surveys (i.e., CHIP or non-CHIP members).

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2. Performance Improvement Project Validation

Background/Objectives

The purpose of a PIP is to assess and improve care processes and, ultimately, health outcomes. As outlined in the SoonerSelect CE Dental Contract, both DentaQuest and LIBERTY are required to conduct at least two PIPs annually. The Medical and CSP SoonerSelect contracts require Aetna, Humana, Oklahoma Complete Health, and Oklahoma Complete Health – Children's Specialty Program to each conduct at least three PIPs annually. PIPs may be active for up to 3 years. An active PIP in continuation from the previous year will be counted towards satisfying the number of ongoing PIPs each year.

During the first year of the CE contracts (2024), the focus was on identifying appropriate PIP topics and refining proposed methodologies. KFMC's review of PIP methodologies in 2025 continued this work by evaluating the proposed PIPs and providing technical assistance to support methodologically sound project design. The intent is for each CE to develop PIPs capable of achieving and sustaining meaningful improvement in the identified clinical or process concern, ultimately leading to better health outcomes.

KFMC also validated two PIP annual reports during the reporting cycle: LIBERTY's Preventive Services for Children and Humana's Social Needs Screening (SNS) and Intervention. The objectives of KFMC's review were to determine if the PIP design was methodologically sound, validate the annual PIP results, evaluate the overall validity and reliability of the methods and findings, and assess the evidence of improvement.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

PIP Methodology Reviews

During this review cycle, regular interagency meetings occurred that included focused PIP discussions among staff from OHCA, KFMC, and each of the CEs. KFMC provided feedback on PIP methodologies, including PIP aim and goals, interventions, measure technical specifications, and data analytic plans.

Each CE utilized the designated *PIP Reporting Template* and *PIP Instructional Guide* to develop methodologies and write annual PIP reports. These documents outline essential steps for designing and conducting PIPs, along with key points to consider for each step.

During the PIP methodology approval process, each methodology went through multiple review cycles in which the CE submitted a draft for KFMC and OHCA review. Feedback was provided through written comments within the document, followed by collaborative feedback meetings involving KFMC, OHCA, and the CE. These meetings helped clarify outstanding issues and refine proposed revisions. The CE then incorporated the recommended changes and resubmitted the methodology for additional review. Table 2.1 summarizes these activities over the past year, organized by CE and PIP topic.

Table 2.1. CEs' PIP Topics and Methodology Review			
PIP Topic	**Initial Submission**	**# of Review Rounds**	**Final Approval**
DentaQuest			
Increase the Percentage of DentaQuest SoonerSelect Children Receiving a Dental Visit by their First Birthday	February 21, 2025	9	July 9, 2025
Enhancing Oral Health Literacy Among American Indian/Alaska Native Adults: A Culturally Tailored Approach to Improve Oral Health Outcomes and Address Diabetes-Related Disparities	March 6, 2025	3	June 2, 2025
LIBERTY			
Improving Access to Care through Transportation Appointment Scheduling and Transportation Assistance	February 27, 2025	6	October 22, 2025
Increasing Preventive Services for Children	Methodology review occurred during previous reporting cycle		February 27, 2025
Aetna			
Improve Rate of Follow-Up Care for Children Prescribed ADHD [Attention-Deficit/Hyperactivity Disorder] *Medication, Initiation and Continuation Sub Measures*	February 18, 2025	7	July 14, 2025
Improving Social Determinants of Health (SDOH) Assessment and Referral in Plan Members	February 28, 2025	5	July 23, 2025
Childhood Immunization Status Combo 3	Methodology review occurred during previous reporting cycle		January 30, 2025
Humana			
Follow-up After Hospitalizations for Mental Illness	March 7, 2025	3	June 1, 2025
Social Needs Screening and Intervention	March 19, 2025	5	July 9, 2025
Comprehensive Diabetes Care (Hemoglobin HbA1c Control for Patients with Diabetes)	Methodology review occurred during previous reporting cycle		February 26, 2025
OCH			
Improve Performance of the Follow-Up After Hospitalization for Mental Illness (FUH)-7 Days HEDIS Measure	March 12, 2025	3	June 11, 2025
Increase Submissions of Notification of Pregnancy (NOP) Form	April 11, 2025	6	N/A*
Improve Performance of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents HEDIS Measure	Methodology review occurred during previous reporting cycle		February 26, 2025
OCH-CSP			
Improve Performance of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents HEDIS Measure and Annual Wellness Visits	Methodology review occurred during previous reporting cycle		February 26, 2026
Improve Performance of the Follow-Up After Hospitalization for Mental Illness (FUH)-7 Days HEDIS Measure	March 12, 2025	3	June 11, 2025
Foster Care	March 20, 2025	4	November 4, 2025
*Final approval is anticipated in 2026			

Key Opportunities for PIP Methodologies

During the methodology review and approval process, several opportunities for improvement regarding revisions emerged that were common to all CEs. These common reasons for revisions included the following:

- Enhancing clarity and adding more detail throughout the methodology,
- Strengthening the interventions by increasing the number and/or robustness,
- Clearly defining both process and outcome measures,

- Using the *PIP Instructional Guide* and lessons learned from prior feedback meetings when writing methodologies, and
- Ensuring the overall PIP is focused on improving health outcomes.

PIP Validations

KFMC conducted PIP validations in accordance with CMS EQR Protocol 1, Validating Performance Improvement Projects. The protocol outlines nine steps for the validation and provides multiple questions for consideration for each step. The CEs' annual progress reports and approved PIP methodologies were the main source documents for the PIP evaluations.

Please see below for the CE-specific findings regarding the PIPS validated during this reporting cycle. The following two PIPs were evaluated.

- LIBERTY's *Increasing Preventive Services for Children* PIP
- Humana's *Social Needs Screening and Intervention* PIP

Overall Validity and Reliability of PIP Results

The first rating is determined based on KFMC's level of confidence (High Confidence: 95% to 100%, Confidence: 90% to <95%, Low Confidence: 80% to <90%, Little Confidence: below 80%) that the CEs adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis, assessed for statistical significance of any differences, and provided an interpretation of the PIP results.

The second rating determines whether the PIP produced significant evidence of improvement and has, or is on track to, reach the PIP's goal. As an assessment guide, KFMC uses a 12-point system. The CE rating is based on KFMC's determination of progress made toward the PIP outcome goal, evidence that improvements are attributable to the PIP interventions, and evidence that improvements are sustainable. The net result is the *evaluation score*, which determines the level of overall confidence: High Confidence, 10 to 12 points; Confidence, 7 to 9 points; Low Confidence, 4 to 6 points; and Little Confidence, 3 points or fewer.

The two level of confidence ratings for each of the PIPs evaluated are included in Table 2.1 below.

Table 2.2. CE PIP Topics and Validation Ratings

PIP Topic	Validation Status	Validation Rating	Evidence of Improvement
LIBERTY			
Increasing Preventive Services for Children	Yes	85.5% – Low Confidence	High Confidence
Humana			
Social Needs Screening and Intervention	Yes	88.3% – Low Confidence	Not Rated*

*No data for the PIP Outcome Measures were reported due to HEDIS dashboard limitations.

Recommendations for Quality Improvement

Common among the CEs

KFMC identified the following commonalities among the recommendations for the two PIPs validated in this reporting cycle.

- Strengthen alignment between the data presented and the conclusions drawn, ensuring interpretations accurately reflect the results.
- Include numerator and denominator counts for all applicable measures, applying CMS cell suppression requirements when needed.
- Improve clarity and consistency of tables by using descriptive titles and properly labeled columns and rows.
- Ensure staff qualifications and responsibilities are clearly documented as required.
- Conduct thorough review of all report materials to identify and correct errors, inconsistencies, or unclear language prior to submission.
- Maintain consistency between narrative descriptions, technical specifications, and measure definitions throughout the report.
- Provide sufficient detail when interventions deviate from the planned methodology, including explanations for delays, changes, or missing data in the annual report.

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Please see Appendix D for detailed information regarding CE progress on the three recommendations from 2024. All recommendations made in 2024 were fully addressed.

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LIBERTY Dental

Increasing Preventive Services for Children PIP

Background/Objectives

LIBERTY's stated aim for this PIP is to "use targeted interventions to increase utilization of dental benefits, measured by an increase in the percentage of eligible enrollees 0 to 20 years of age that had at least one OEV-CH (CDT codes D0150, D0120, D0145), SFM-CH (D1351), or TFL-CH (D1206, D1208) service completed during each re-measurement year. The overall utilization increase should meet or exceed an 8 percentage points increase in overall utilization during a four-year period (7/1/2024-6/30/2028)." The activity period for this PIP was July 1, 2024, to June 30, 2025. This PIP included the four interventions listed in Table 2.2.

Table 2.3. LIBERTY's Increasing Preventive Services for Children PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: Text Message/Mail Outreach Campaigns *(Implemented 2024 Q3)*	• Unable to verify measure results, as numerators and denominators were not provided.
Intervention 2: Telephonic Outreach Campaigns *(Implemented 2024 Q3)*	• Unable to verify measure results, as numerators and denominators were not provided.
Intervention 3: Regional Disparities Analysis *(Implemented 2024 Q3)*	• LIBERTY identified 114 cities with a total of 52,680 members and a below average utilization rate.
Intervention 4: Provider Incentive Intervention *(Methodology approval date 02/27/25; Not yet implemented)*	• This intervention is pending final approval from LIBERTY leadership.

Conclusions Drawn from the Data

LIBERTY set out with a goal to increase the percentage of members aged 0 to 20 using preventive dental services by a total of 8 percentage points over a four-year period (July 1, 2024, to June 30, 2028), with an annual goal of increasing utilization by 2 percentage points from the prior year. For the PIP Activity Period from July 1, 2024, to June 30, 2025, LIBERTY reported that 42.6% of members aged 0 to 20 received at least one applicable dental service. This is an increase of about 18.5 percentage points from the initial baseline that LIBERTY calculated using historical claims data (24.1%). This increase should be interpreted with caution, as the initial baseline was calculated using data from prior to the implementation of managed care in Oklahoma. Nevertheless, the annual goal for the PIP was met.

Data for Interventions 1 and 2 were not included in this evaluation report due to an apparent discrepancy between the number of members identified for these interventions and the number of members reported in the denominator of the PIP Outcome Measure. The denominators were expected to be similar. Data for the PIP Outcome Measure were included since the specifications are based on nationally standardized HEDIS measures and CMS Core Set measures.

LIBERTY implemented the text message and telephonic outreach campaigns, as planned for Interventions 1 and 2. The plan made appropriate changes to various measures to better assess the impact of these interventions. However, the changes to the measures still appear to include some

limitations as evidenced by the substantially higher utilization rate reported for members who did not receive outreach compared to those that did. Intervention 1 also included a mailer campaign, but LIBERTY stated the "mailer outreach has been placed on hold pending efficacy reports to assess its measurable impact." LIBERTY did not describe implementation efforts prior to the mailer campaign being placed on hold, nor did they provide initial efficacy data or a more detailed rationale for the change. OHCA was not notified prior to this change in plans.

For Intervention 3, LIBERTY analyzed a full year of claims data to identify priority cities and guide next steps, including barrier identification and development of community partnerships to address oral health disparities. Through this analysis, LIBERTY narrowed their focus to 114 priority cities (from 547 cities), while increasing the number of members to be impacted from 10,566 to 52,580. The identified cities each have 100 or more members and a below average utilization rate (less than 40%). Concerns were noted for this intervention due to the apparent lack of progress towards the identification of barriers for members in cities classified as disparate and the development of community partnerships to address oral health disparities.

Intervention 4 was delayed due to a lack of approval from LIBERTY leadership to move forward with implementing provider incentives. LIBERTY indicated the baseline period focused on identifying providers eligible for incentives while awaiting executive approval. However, no provider performance data was reported, and LIBERTY did not inform OHCA of the implementation delay.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- LIBERTY improved the clarity of technical specifications for Intervention 1 by refining the denominator description for text messages.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Unsupported Interpretations
  - The data did not support the statements regarding the effectiveness of Interventions 1 and 2.
- Information Gaps
  - Gaps in describing implementation, barriers, and delays were not provided for some of the interventions.
  - Tables were not labeled, making it difficult to refer to a specific table when necessary.
- Data Variances
  - The denominators reported for multiple PIP Outcome Measures differed substantially from the population reported for the text message and telephonic outreach campaigns.
- Reporting Discrepancies
  - Several reported values (number of cities, rate for one PIP Outcome Measure, age ranges, measure labels) were inaccurate or inconsistent across activities.

Recommendations for Quality Improvement

See Appendix C for details on the 18 recommendations made regarding opportunities for improvement in 2025.

Humana Healthy Horizons

Social Needs Screening and Intervention PIP

Background/Objectives

Humana's stated aim for this PIP is "Through Enrollee HRS [Health Risk Screening], referral, and engagement, we aim to increase the rate of HHH [Humana] in Oklahoma Enrollees of all ages who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, as well as increase the rate of Enrollees who received a corresponding intervention within 30 days of screening positive, over the next 3 years beginning in 2025." The activity period for this PIP was April 1, 2024, to December 31, 2025. This PIP included the two interventions listed in Table 2.3.

Table 2.4. Humana's Social Needs Screening PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: Health Related Social Needs Screening *(Implemented 2024 Q2)*	• Unable to verify most measure results, as numerators and denominators were not provided. • Of 9,786 enrollees who screened positive for health-related social needs within the calendar year, 80.3% (7,856) were assigned to a Social Determinants of Health coordinator for follow-up. This was a statistically significant 23.2 percentage point increase from the prior year.
Intervention 2: Addressing Identified Health Related Social Needs and Follow-up *(Implemented 2024 Q2)*	• Unable to verify measure results, as numerators and denominators were not provided.

Conclusions Drawn from the Data

Humana aimed to increase both the percentage of enrollees who were screened for unmet food, housing, and transportation needs and the percentage of enrollees who receive a corresponding intervention after screening positive. Changes in six PIP outcome measure rates were to be assessed (three for screening and three for corresponding interventions related to food, housing, and transportation). Specific goals for the increases in each measure were expected to be established in Q3 2025 once baseline rates were identified; however, Humana reported that limitations in their HEDIS dashboard data prevented calculation of those rates. Because no rates were reported for the PIP outcome measures, KFMC was unable to assess evidence of improvement as part of this evaluation.

Since numerators and denominators were not provided for most intervention-level data, the following results should be interpreted with caution. The reported percentages indicated most goals were not achieved. Humana attributed these results in part to the timing of intervention implementation and to process changes. However, the annual report did not include sufficient supporting information to substantiate these explanations. Two exploratory analyses were presented in the report. Though one of these analyses lacked detailed technical specifications, notable findings were that the overall screening rate for enrollees decreased from 2024 to 2025 and the referral rate for enrollees under 30 years of age with positive screens was lower than the referral rate for their older counterparts with positive screens. To address the age disparity that was identified from exploratory analysis, Humana implemented an automatic referral process.

Additional data, interpretations, and details for this activity period are expected to be included in the next annual report along with updated results from the next activity period.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- Based on results of exploratory data analysis, Humana implemented an automated process to refer enrollees who screen positive to a Social Determinants of Health staff member who can help address identified needs.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Information Gaps
  - Conclusions about the effectiveness of Interventions 1 and 2 were not supported by the data presented.
  - Tables in the report were not labeled, making it difficult to refer to a specific table when necessary.
- Reporting Discrepancies
  - Intervention interpretations were not supported by the reported data.

Recommendations for Quality Improvement

See Appendix C for details on the 14 recommendations made regarding opportunities for improvement in 2025.

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3. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Background/Objectives

The Medicaid and CHIP Managed Care regulations require performance of independent, external reviews of the quality, timeliness of, and access to care and services provided to Medicaid and CHIP beneficiaries by CEs.[6] The objective of KFMC's review is to assess CE compliance with federal standards. A full review is required every three years and may be completed over the course of the three years. The Dental CEs have provided SoonerSelect managed care services since February 2024, and the SoonerSelect Medical and CSP CEs since April 2024. KFMC reviewed CE compliance with the Medicaid and CHIP Managed Care regulations updated April 2024.

The current review period is 2024-2026, with KFMC conducting two-thirds of the regulatory compliance review in Years 1 and 2 (2024-2025). The remaining third will be conducted in Year 3 (2026). Follow-up was conducted in Year 2 (2025) and will be completed again in Year 3 (2026). KFMC's compliance review results for the Year 1 and 2 (2024-2025) reviews are included in this *2025-2026 Annual EQR Technical Report*.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

KFMC used Protocol 3, *Review of Compliance with Medicaid and CHIP Managed Care Regulations,* from the *CMS External Quality Review (EQR) Protocols*, dated February 2023, to complete the reviews. In addition, KFMC compiled findings in a worksheet based on the EQR Protocol 3 documentation and reporting tool template developed by CMS.

The protocol involves completion of the following five activities:

- Activity 1: Establish Compliance Thresholds
- Activity 2: Perform Preliminary Review (Pre-Site Visit)
- Activity 3: Conduct CE Site Visit
- Activity 4: Compile and Analyze Findings (Post-Site Visit)
- Activity 5: Report Results to the State

KFMC requested documentation from each CE related to the federal regulations under review. Documentation provided by the CEs on May 14, 2025, included policies, procedures, manuals, and other materials related to the federal regulations, and case files for Coordination and continuity of care, and grievances and appeals was provided on May 13, 2025.

The following Medicaid Managed Care Regulatory Provisions were reviewed in Years 1 and 2 for the CEs.

- Subpart B – State Responsibilities
- Subpart C – Enrollee Rights and Protections
- Subpart D – MCO, PIHP and PAHP Standards

The regulatory areas were divided and categorized by reporting cycle (RC) per CE within the three-year review period (2024–2026), as displayed in Table 3.1.

[6] Managed Care, 42 C.F.R. § 438 (2025). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438

Table 3.1. Standards Reviewed Timeframe (RC 2024–2027)

Regulatory Standard	Reviewed by the EQRO All SoonerSelect CEs		
	RC 2024 – 2025	RC 2025 – 2026	RC 2026 – 2027
Subpart B – State Responsibilities			
§ 438.56 Disenrollment: Requirements and limitations	X		
Subpart C – Enrollee Rights and Protections			
§ 438.100 Enrollee rights	X		
§ 438.114 Emergency and poststabilization services	X		
Subpart D – MCO, PIHP and PAHP Standards			
§ 438.206 Availability of services			X
§ 438.207 Assurances of adequate capacity and services			X
§ 438.208 Coordination and continuity of care		X	
§ 438.210 Coverage and authorization of services	X		
§ 438.214 Provider selection	X		X*
§ 438.224 Confidentiality			X
§ 438.228 Grievance and appeal systems (Requires compliance with Subpart F Grievance and Appeal System [§ 438.402 - § 438.424])		X	
§ 438.402 General requirements		X	
§ 438.404 Timely and adequate notice of adverse benefit determination		X	
§ 438.406 Handling of grievances and appeals		X	
§ 438.408 Resolution and notification: Grievances and appeals		X	
§ 438.410 Expedited resolution of appeals		X	
§ 438.414 Information about the grievance and appeal system to providers and subcontractors		X	
§ 438.416 Recordkeeping requirements		X	
§ 438.420 Continuation of benefits while MCO, PIHP, or PAHP appeal and State fair hearing are pending		X	
§ 438.424 Effectuation of reversed appeal resolutions		X	
§ 438.230 Sub-contractual relationships and delegation			X
§ 438.236 Practice guidelines			X
§ 438.242 Health information systems		X	
Subpart E – Quality Measurement and Improvement; External Quality Review			
§ 438.330 Quality assessment and performance improvement program			X

*Provider Selection case review moved to Year 3 due to OHCA approved delay in provider credentialing.

KFMC utilized the five-point rating compliance scoring (Fully Met [FM], Substantially Met [SM], Partially Met [PM], Minimally Met [MM], and Not Met [NM]) as defined in the EQR Protocol 3; results were compiled into a tabular format for reporting on each regulatory category. The individual CE *2025 Review of Compliance with Medicaid and CHIP Managed Care Regulations* reports contain more detail and are available upon request.

KFMC applies a point system to calculate the compliance score for each regulatory component, subpart, and overall CE compliance. Each regulation potentially has multiple components. Each component earns a compliance score in the following way: Fully Met receives four points; Substantially Met receives three points; Partially Met receives two points; Minimally Met receives one point; and Not Met receives zero points. The *compliance score* for each regulation is a percentage calculated by dividing the total number of points earned by the components within that regulation by the total number of points possible for components within that regulation.

SoonerSelect Dental CEs

Conclusions Drawn from the Data

Compliance

KFMC reviewed all regulatory areas in Subparts B and C and two regulatory areas in Subpart D in Year 1. For Year 2, KFMC reviewed three areas in Subpart D (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 - § 438.424, nine areas]). Subpart B, State Responsibilities, and Subpart C, Enrollee Rights and Protections – Emergency and post-stabilization services, are not included because these requirements are not applicable to the dental plans.

Common Among the SoonerSelect Dental CEs, Years 1 and 2 Reviews – 2024 and 2025

For the areas reviewed in Years 1 and 2, DentaQuest and LIBERTY had the greatest opportunity for improvement within Subpart D for elements within § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System): § 438.408 Resolution and notification – Grievances and appeals and § 438.410 Expedited resolution of appeals.

DentaQuest, Years 1 and 2 Reviews – 2024 and 2025

Overall, DentaQuest was 85% compliant with the federal regulatory requirements reviewed in 2024 and 2025. Of the individual regulatory areas reviewed, in 2024 and 2025, within Subparts C and D, in addition to those areas common among the Dental CEs, DentaQuest had the greatest opportunity for improvement within Subpart D related to regulatory areas § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System) § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP, appeal and State fair hearing are pending. Table 3.2 summarizes the 2024 and 2025 compliance review findings for DentaQuest.

Table 3.2. Summary of Compliance Review Results 2024-2025 – DentaQuest

Federal Regulations	Component Compliance*						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart C – Enrollee Rights and Protections							
§ 438.100 Enrollee rights^† § 438.10 Information requirements^ § 438.3(j) Standard contract requirements: Advance directives	20	(11/20)	(9/20)	(0/20)	(0/20)	(0/20)	89% (71/80)
SUBPART C TOTAL	**20**	**(11/20)**	**(9/20)**	**(0/20)**	**(0/20)**	**(0/20)**	**89% (71/80)**
Subpart D – MCO, PIHP and PAHP Standards							
§ 438.208 Coordination and continuity of care¶	6	(6/6)	(0/6)	(0/6)	(0/6)	(0/6)	100% (24/24)
§ 438.210 Coverage and authorization of services†	12	(10/12)	(2/12)	(0/12)	(0/12)	(0/12)	96% (46/48)
§ 438.214 Provider selection‡	5	(5/5)	(0/5)	(0/5)	(0/5)	(0/5)	100% (20/20)

*Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^And related provision(s)
†Regulatory component documentation reviewed in Year 1 (2024).
‡Regulatory component documentation reviewed in Year 1 (2024). Case Review will occur in Year 3 (2026).
¶Regulatory component documentation reviewed in Year 2 (2025).

Table 3.2. Summary of Compliance Review Results 2024-2025 – DentaQuest							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§ 438.228 Grievance and appeal systems^¶ (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424])	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§ 438.402 General requirements¶	5	(3/5)	(1/5)	(1/5)	(0/5)	(0/5)	85% (17/20)
§ 438.404 Timely and adequate notice of adverse benefit determination¶	9	(4/9)	(3/9)	(2/9)	(0/9)	(0/9)	81% (29/36)
§ 438.406 Handling of grievances and appeals¶	2	(1/2)	(0/2)	(1/2)	(0/2)	(0/2)	75% (6/8)
§ 438.408 Resolution and notification¶	15	(2/15)	(4/15)	(7/15)	(1/15)	(1/15)	58% (35/60)
§ 438.410 Expedited resolution of appeals¶	3	(0/3)	(2/3)	(1/3)	(0/3)	(0/3)	67% (8/12)
§ 438.414 Information about grievance and appeal system to providers and subcontractors^¶ § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§ 438.416 Recordkeeping requirements¶	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§ 438.420 Continuation of benefits while appeal and state fair hearing are pending¶	4	(0/4)	(3/4)	(0/4)	(0/4)	(1/4)	56% (9/16)
§ 438.424 Effectuation of reversed appeal resolutions¶	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§ 438.242 Health information systems¶	15	(15/15)	(0/15)	(0/15)	(0/15)	(0/15)	100% (60/60)
Subpart D Total	**81**	**(49/81)**	**(16/81)**	**(13/81)**	**(1/81)**	**(2/81)**	**84% (271/324)**
Overall Compliance	**101**	**(60/101)**	**(25/101)**	**(13/101)**	**(1/101)**	**(2/101)**	**85% (342/404)**

*Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^And related provision(s)
ǂRegulatory component documentation reviewed in Year 1 (2024).
‡Regulatory component documentation reviewed in Year 1 (2024). Case Review will occur in Year 3 (2026).
¶Regulatory component documentation reviewed in Year 2 (2025).

LIBERTY, Years 1 and 2 Reviews – 2024 and 2025

Overall, LIBERTY was 86% compliant with the federal regulatory requirements reviewed in 2024 and 2025. Of the individual regulatory areas reviewed, in 2024 and 2025, within Subparts C and D, in addition to those areas common among the Dental CEs, LIBERTY had the greatest opportunity for improvement within Subpart D for elements within § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System): § 438.404 Timely and Adequate Notice of Adverse Benefit Determination. Table 3.3 summarizes the 2024 and 2025 compliance review findings for LIBERTY Dental.

Table 3.3. Summary of Compliance Review Results 2024-2025 – LIBERTY Dental

Federal Regulations	Component Compliance*						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart C – Enrollee Rights and Protections							
§ 438.100 Enrollee rights^ǂ § 438.10 Information requirements^ § 438.3(j) Standard contract requirements: Advance directives	20	(10/20)	(10/20)	(0/20)	(0/20)	(0/20)	88% (70/80)
SUBPART C TOTAL	**20**	**(10/20)**	**(10/20)**	**(0/20)**	**(0/20)**	**(0/20)**	**88% (70/80)**
Subpart D – MCO, PIHP and PAHP Standards							
§ 438.208 Coordination and continuity of care¶	6	(6/6)	(0/6)	(0/6)	(0/6)	(0/6)	100% (24/24)
§ 438.210 Coverage and authorization of servicesǂ	12	(9/12)	(1/12)	(2/12)	(0/12)	(0/12)	90% (43/48)
§ 438.214 Provider selection‡	5	(5/5)	(0/5)	(0/5)	(0/5)	(0/5)	100% (20/20)
§ 438.228 Grievance and appeal systems^¶ (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424])	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§ 438.402 General requirements¶	5	(4/5)	(0/5)	(1/5)	(0/5)	(0/5)	90% (18/20)
§ 438.404 Timely and adequate notice of adverse benefit determination¶	9	(4/9)	(0/9)	(4/9)	(1/9)	(0/9)	69% (25/36)
§ 438.406 Handling of grievances and appeals¶	2	(1/2)	(1/2)	(0/2)	(0/2)	(0/2)	88% (7/8)
§ 438.408 Resolution and notification¶	15	(6/15)	(3/15)	(5/15)	(0/15)	(1/15)	72% (43/60)
§ 438.410 Expedited resolution of appeals¶	3	(1/3)	(0/3)	(2/3)	(0/3)	(0/3)	67% (8/12)

*Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^And related provision(s)
ǂ Regulatory component documentation reviewed in Year 1 (2024).
‡Regulatory component documentation reviewed in Year 1 (2024). Case Review will occur in Year 3 (2026).
¶Regulatory component documentation reviewed in Year 2 (2025).

Table 3.3. Summary of Compliance Review Results 2024-2025 – LIBERTY Dental							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§ 438.414 Information about grievance and appeal system to providers and subcontractors^¶ § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: Enrollee handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§ 438.416 Recordkeeping requirements¶	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§ 438.420 Continuation of benefits while appeal and state fair hearing are pending¶	4	(2/4)	(1/4)	(1/4)	(0/4)	(0/4)	81% (13/16)
§ 438.424 Effectuation of reversed appeal resolutions¶	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§ 438.242 Health information systems¶	15	(15/15)	(0/15)	(0/15)	(0/15)	(0/15)	100% (60/60)
Subpart D Total	**81**	**(56/81)**	**(8/81)**	**(15/81)**	**(1/81)**	**(1/81)**	**86% (279/324)**
OVERALL COMPLIANCE	**101**	**(66/101)**	**(18/101)**	**(15/101)**	**(1/101)**	**(1/101)**	**86% (349/404)**

*Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^And related provision(s)
ƚ Regulatory component documentation reviewed in Year 1 (2024).
‡Regulatory component documentation reviewed in Year 1 (2024). Case Review will occur in Year 3 (2026).
¶Regulatory component documentation reviewed in Year 2 (2025).

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

As a result of KFMC's 2024 and 2025 compliance reviews, the following strengths were identified:

Common Among the SoonerSelect Dental CEs

- Both CEs utilized an online knowledge base that customer service agents have access to. DentaQuest encouraged the use of the database rather than have staff memorize information to ensure accuracy and consistency of information going to members. LIBERTY noted that the Member Services staff can utilize a keyword search to pull up articles to have consistent information to enrollees.
- DentaQuest and Liberty have an established care coordination and case management framework.
- DentaQuest and LIBERTY staff are knowledgeable about their jobs and the services provided to Oklahoma SoonerSelect members.

DentaQuest

- The Provider Engagement Department initiated a call campaign to educate providers on the case management services offered by DentaQuest.
- The Customer Service Department utilized Kahoot to offer pop-quizzes for customer service representatives to ensure education and training are understood.
- DentaQuest's inter-rater reliability process was rigorous and went beyond what is required of the contract and URAC accreditation requirements.
- DentaQuest collects around 90 points of provider information on the portal.

LIBERTY

- Member Services Representatives utilized warm transfers whenever connecting members to other entities, such as the SoonerSelect Choice Counseling or medical and CSP plans.
- LIBERTY utilized a texting campaign, after tornados struck some Oklahoma communities, to ensure members were safe and to see if they had any immediate needs due to the natural disaster.
- LIBERTY utilized partnerships with community entities and connected their members to community resources. An example is LIBERTY's partnership with the Oklahoma Homeless Alliance in which LIBERTY sent staff out to meet with their members experiencing homelessness.
- LIBERTY collaborated with the Oklahoma Dental Foundation to increase access to care across the State through five new mobile dental units. Through this program, fourth year dental students have the opportunity to train on the mobile units related to the established Case Management and Care Coordination framework, LIBERTY uses multiple data points to identify enrollees for the program. To ensure enrollees needs are met, LIBERTY keeps cases open for one year after the last treatment and completes a follow-up call prior to closing the case.
- LIBERTY was proactive in updating member materials, and receiving State approval, when readability issues are identified and/or reported to Member Services Staff.
- LIBERTY had a diverse governing board that included nondental professionals, including mental health professionals.
- LIBERTY is proactive in looking for new Information Technology systems to use that could provide more efficiency.
- LIBERTY aims to automate processes to help ensure consistent data reporting.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

The following are the opportunities identified from the 2024 and 2025 reviews (See Appendix C for more detail).

Common Among the Dental CEs

As a result of KFMC's 2024 and 2025 compliance reviews for DentaQuest and LIBERTY, both need to follow-up on KFMC's findings related to the following areas:

- Addition or revision of federal regulatory and/or State Contract language in the *SoonerSelect Member Handbook*, policies and procedures, DentaQuest/LIBERTY websites, and *Office Reference Manual* (DentaQuest)/*Provider Reference Guide* (LIBERTY), and provider agreement:
  - § 438.10(c)(6)(v), (f)(1), (g)(2)(ii)(A-B) and (g)(2)(ix) Information requirements
  - § 438.100(b-c) Enrollee rights: Specific rights and Free exercise of rights
  - § 438.210(c) and (d)(1)(i-ii) Coverage and authorization of services: Notice of adverse benefit determination and Timeframe for decisions

  - § 438.402(c)(1)(ii) General requirements: Filing requirements – Authority to file
  - § 438.404(b)(6) Timely and adequate notice of adverse benefit determination: Content of notice
  - § 438.406(b)(1 and 5) Handling of grievances and appeals: Special requirements
  - § 438.408(a), (b)(1-2), (c)(1-2), and (e)(2)(ii-iii) Resolution and notification: Grievances and appeals – Basic rule; Specific timeframes; Extension of timeframes; and Content of notice of appeal resolution
  - § 438.410(b) and (c)(1-2) Expedited resolution of appeals: Punitive action and Action following denial of a request for expedited resolution
  - § 438.416(c) Recordkeeping requirements (Maintenance and accessibility of records)
  - § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending
- Staff education and refinement of internal processes related to KFMC's grievance and appeal case review findings in the following:
  - § 438.402(c)(1) General requirements: Filing requirements – Authority to file
  - § 438.408(b)(1), (c)(1-2), (d)(2)(ii), and (e)(1) Resolution and notification: Grievances and appeals – specific timeframes; Extension of timeframes; Format of notice-Appeals; and Content of notice of appeal resolution
  - § 438.416(b)(3 and 5) Recordkeeping requirements

DentaQuest

As a result of KFMC's 2024 and 2025 compliance reviews for DentaQuest, the following opportunities were identified:

- Addition or revision of federal regulatory and/or State Contract language in the *SoonerSelect Member Handbook*, policies and procedures, document, DentaQuest website, and *Office Reference Manual*:
  - § 438.56(d)(2)(i) Disenrollment: Requirements and limitations – Procedures for disenrollment-Cause for disenrollment
  - § 438.10(c)(4), (g)(2)(xi)(A), and (g)(4) Information requirements
  - § 438.402(c)(2)(ii) General requirements: Filing requirements – Authority to file
  - § 438.406(b)(2 and 4) Handling of grievances and appeals: Special requirements
  - § 438.408(b)(3), (c)(3), and (d)(1) Resolution and notification: Grievances and appeals
  - § 438.410(a) Expedited Resolution of appeals: Punitive action
  - § 438.416(b) Recordkeeping requirements
- Staff education and refinement of internal processes related to KFMC's grievance and appeal case review findings for:
  - § 438.406(b)(1) Handling of grievances and appeals: Special requirements (grievance and appeal acknowledgement)
  - § 438.408 (b)(2-3), (d)(1) and (2)(i), and (e)(2)(i-ii) Resolution and notification: Grievances and appeals – Specific Timeframes; Format of notice-Grievances and appeals; and Content of notice of appeal resolution
  - Issues not specific to a regulatory area

LIBERTY

As a result of KFMC's 2024 and 2025 compliance reviews for LIBERTY, KFMC identified opportunity for improvement for addition or revision of federal regulatory and/or State Contract language in policies and procedures, LIBERTY website, *Adverse Benefit Determination* letter, *Provider Reference Guide*, and appeal resolution letter template for the following:

- § 438.56(b)(3) and (c)(1-2) Disenrollment: Requirements and limitations – Disenrollment requested by the MCO, PIHP, PAHP, PCCM, or PCCM entity and Disenrollment requested by the enrollee
- § 438.10(d)(4) and (h)(3)(i)(B) Information requirements
- § 438.210(d)(2)(i-ii) Coverage and authorization of services – Timeframe for decisions: Expedited authorization decisions
- § 438.408(d)(2)(ii) Resolution and notification: Grievances and appeals – Format of notice-Appeals
- § 438.408(e)(2)(iii) Resolution and notification: Grievances and appeals

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Between May 2025 and June 2025, KFMC obtained from each CE a series of updates to the progress tracking document that included KFMC's EQRO recommendations from 2024. KFMC provided each CE with suggestions on how to bring outstanding recommendations into full compliance and each CE was given the opportunity to respond on their progress. The following summaries include the 2024 review.

DentaQuest

There are 17 recommendations included in Appendix D, Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed. KFMC noted, in 2025, eleven (11) moved to fully addressed and six (6) are in progress.

LIBERTY

There are 25 recommendations included in Appendix D. KFMC noted, in 2025, eight (8) moved to fully addressed and seventeen (17) are in progress.

Recommendations for Quality Improvement

A recommendation indicates where a CE change is needed to be in full compliance with the stated regulation. See Appendix C for details.

DentaQuest

Year 1 Review – 2024

Based on the areas identified for improvement, KFMC made 17 recommendations:

- Eleven related to Information requirements
- Four related to Coverage and authorization of services
- One related to Disenrollment
- One related to Enrollee rights

Year 2 Review – 2025

Based on the areas identified for improvement, KFMC made 60 recommendations:

- Five related to grievance and appeal issues not specific to a regulatory area
- Two related to Filing requirements: Authority to file and Timing
- Twenty related to grievance and appeal case review

Recommendations for Quality Improvement

Year 2 Review – 2025 (Continued)

- One related to Timely and adequate notice of adverse benefit determination
- Seven related to Handling of grievances and appeals
- Sixteen related to Resolution and notification of grievances and appeals
- Three related to Expedited resolution of appeals
- Three related to Record keeping requirements for grievances and appeals
- Three related to Continuation of benefits while the CE appeal and the State Fair hearing are pending

LIBERTY

Year 1 Review – 2024

Based on the areas identified for improvement, KFMC made 25 recommendations:

- Eleven related to Information requirements
- Eleven related to Coverage and authorization of services
- Two related to Disenrollment
- One related to Enrollee rights

Year 2 Review – 2025

Based on the areas identified for improvement, KFMC made 32 recommendations:

- One related to Filing requirements: Authority to file
- Eight related to grievance and appeal case review
- One related to Timely and adequate notice of adverse benefit determination
- Two related to Handling of grievances and appeals
- Thirteen related to Resolution and notification of grievances and appeals
- Two related to Expedited resolution of appeals
- One related to Record keeping requirements for grievances and appeals
- Four related to Continuation of benefits while the CE appeal and the State Fair hearing are pending

Summary of 2024 Compliance Review

Table 3.4 details a summary of the CEs' overall 2024 and 2025 compliance review results for Subpart C and five parts of Subpart D (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424] that includes nine parts). Subpart B – Disenrollment: Requirements and Limitations is not included because for regulation § 438.56 Disenrollment: Requirements and Limitations, the State, through its fiscal agent, is responsible for disenrollment, and the CEs are not able to disenroll members.

Table 3.4. Summary of Compliance Review Results 2024-2025 for Dental CEs		
Federal Regulation	**Compliance Score**	
	DQ	**LD**
Subpart C – Enrollee Rights and Protections		
§ 438.100 Enrollee rights	89%	88%
Subpart C Total	**89%**	**88%**
Subpart D – MCO, PIHP and PAHP Standards		
§ 438.208 Coordination and continuity of care	100%	100%
§ 438.210 Coverage and authorization of services	96%	90%
§ 438.214 Provider selection	100%	100%
§ 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424])	50%	75%
§ 438.402 General requirements	85%	90%
§ 438.404 Timely and adequate notice of adverse benefit determination	81%	69%
§ 438.406 Handling of grievances and appeals	75%	88%
§ 438.408 Resolution and notification	58%	72%
§ 438.410 Expedited resolution of appeals	67%	67%
§ 438.414 Information about grievance and appeal system to providers and subcontractors § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	100%	100%
§ 438.416 Recordkeeping requirements	75%	75%
§ 438.420 Continuation of benefits while appeal and state fair hearing are pending	56%	81%
§ 438.424 Effectuation of reversed appeal resolutions	100%	100%
§ 438.242 Health information systems	100%	100%
Subpart D Total	**84%**	**86%**
OVERALL COMPLIANCE	**85%**	**86%**

SoonerSelect Medical and CSP CEs

Conclusions Drawn from the Data

Compliance

Common Among the SoonerSelect Medical and CSP CEs, Years 1 and 2 Reviews – 2024 and 2025

For the areas reviewed for the SoonerSelect Medical and CSP CEs in Years 1 and 2, all three had the greatest opportunity for improvement within Subpart D for elements within § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System): § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP, appeal and State fair hearing are pending.

Aetna, Years 1 and 2 Reviews – 2024 and 2025

KFMC reviewed all regulatory areas in Subparts B and C and two regulatory areas in Subpart D in Year 1 and three parts in Year 2 (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424] that includes nine parts). Overall, Aetna was 85% compliant with the federal regulatory requirements reviewed in 2024 and 2025. Subpart B State Responsibilities is not included because these requirements are not applicable to the health plan. Of the individual regulatory areas reviewed within Subparts C and D that were reviewed in 2024 and 2025, in addition to those areas common among SoonerSelect Medical and CSP CEs, Aetna had the greatest opportunity for improvement within Subpart D for elements within § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System): § 438.408 Resolution and Notification: Grievances and appeals and § 438.416 Recordkeeping requirements. Table 2.5 summarizes the 2024 and 2025 compliance review findings for Aetna.

Table 3.5. Summary of Compliance Review Results 2024-2025 – Aetna							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart C – Enrollee Rights and Protections							
§ 438.100 Enrollee rights^†‡ § 438.10 Information requirements^ § 438.3(j) Standard contract requirements: Advance directives	26	(18/26)	(5/26)	(3/26)	(0/26)	(0/26)	89% (93/104)
SUBPART C TOTAL	**26**	**(18/26)**	**(5/26)**	**(3/26)**	**(0/26)**	**(0/26)**	**89% (93/104)**
Subpart D – MCO, PIHP and PAHP Standards							
§ 438.208 Coordination and continuity of care**	10	(6/10)	(4/10)	(0/10)	(0/10)	(0/10)	90% (36/40)
§438.210 Coverage and authorization of services‡	13	(10/13)	(2/13)	(1/13)	(0/13)	(0/13)	92% (48/52)
§438.214 Provider selection¶	5	(4/5)	(0/5)	(1/5)	(0/5)	(5/5)	90% (18/20)
§ 438.228 Grievance and appeal systems^** (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424])	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§ 438.402 General requirements**	5	(3/5)	(1/5)	(1/5)	(0/5)	(0/5)	85% (17/20)
§ 438.404 Timely and adequate notice of adverse benefit determination**	9	(4/9)	(2/9)	(3/9)	(0/9)	(0/9)	78% (28/36)
§ 438.406 Handling of grievances and appeals**	2	(1/2)	(1/2)	(0/2)	(0/2)	(0/2)	88% (7/8)
§ 438.408 Resolution and notification**	15	(5/15)	(3/15)	(6/15)	(0/15)	(1/15)	68% (41/60)
§ 438.410 Expedited resolution of appeals**	3	(2/3)	(0/3)	(1/3)	(0/3)	(0/3)	83% (10/12)

*Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^And related provision(s)
†ABH's Provider Incentive Program does not meet the definition of a Physician Incentive Plan, therefore, § 438.10(f)(3) and related provision § 438.3(i) are not applicable.
‡Regulatory component documentation reviewed in Year 1 (2024).
¶Regulatory component documentation reviewed in Year 1 (2024). Case Review will occur in Year 3 (2026).
**Regulatory component documentation reviewed in Year 2 (2025).

Table 3.5. Summary of Compliance Review Results 2024-2025 – Aetna							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§ 438.414 Information about grievance and appeal system to providers and subcontractors^** § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: Enrollee handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§ 438.416 Recordkeeping requirements**	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§ 438.420 Continuation of benefits while appeal and state fair hearing are pending**	4	(0/4)	(0/4)	(4/4)	(0/4)	(0/4)	50% (8/16)
§ 438.424 Effectuation of reversed appeal resolutions**	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§ 438.242 Health information systems**	15	(12/15)	(3/15)	(0/15)	(0/15)	(0/15)	95% (57/60)
Subpart D Total	**86**	**(50/86)**	**(16/86)**	**(19/86)**	**(0/86)**	**(1/86)**	**83% (286/344)**
Overall Compliance	**112**	**(68/112)**	**(21/112)**	**(22/112)**	**(0/112)**	**(1/112)**	**85% (379/448)**

*Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^And related provision(s)
†ABH's Provider Incentive Program does not meet the definition of a Physician Incentive Plan, therefore, § 438.10(f)(3) and related provision § 438.3(i) are not applicable.
‡Regulatory component documentation reviewed in Year 1 (2024).
¶Regulatory component documentation reviewed in Year 1 (2024). Case Review will occur in Year 3 (2026).
**Regulatory component documentation reviewed in Year 2 (2025).

Humana, Years 1 and 2 Reviews – 2024 and 2025

KFMC reviewed all regulatory areas in Subparts B and C and two regulatory areas in Subpart D in Year 1 and three parts in Year 2 (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424] that includes nine parts). Overall, Humana was 83% compliant with the federal regulatory requirements reviewed in 2024 and 2025. Subpart B State Responsibilities is not included because these requirements are not applicable to the health plan. Of the individual regulatory areas reviewed within Subparts C and D that were reviewed in 2024 and 2025, in addition to those areas common among SoonerSelect Medical and CSP CEs, Humana had the greatest opportunity for improvement within Subpart D for elements within § 438.228 Grievance and appeal systems (requires compliance with Subpart F Grievance and Appeal System): § 438.408 Resolution and Notification: Grievances and appeals, § 438.416 Recordkeeping requirements, and § 438.424 Effectuation of reversed appeal resolution. Table 3.6 summarizes the 2024 and 2025 compliance review findings for Humana.

Table 3.6. Summary of Compliance Review Results 2024-2025 – Humana Healthy Horizons							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart C – Enrollee Rights and Protections							
§ 438.100 Enrollee rights^† § 438.10 Information requirements^ § 438.3(j) Standard contract requirements: Advance directives § 438.114 Emergency and poststabilization services	27	(10/27)	(12/27)	(5/27)	(0/27)	(0/27)	80% (86/108)
SUBPART C TOTAL	**27**	**(10/27)**	**(12/27)**	**(5/27)**	**(0/27)**	**(0/27)**	**80% (86/108)**
Subpart D – MCO, PIHP and PAHP Standards							
§ 438.208 Coordination and continuity of care¶	10	(7/10)	(0/10)	(3/10)	(0/10)	(0/10)	85% (34/40)
§ 438.210 Coverage and authorization of services†	13	(10/13)	(3/13)	(0/13)	(0/13)	(0/13)	94% (49/52)
§ 438.214 Provider selection‡	5	(5/5)	(0/5)	(0/5)	(0/5)	(5/5)	100% (20/20)
§ 438.228 Grievance and appeal systems^¶ (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424])	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§ 438.402 General requirements¶	5	(4/5)	(1/5)	(0/5)	(0/5)	(0/5)	95% (19/20)
§ 438.404 Timely and adequate notice of adverse benefit determination¶	9	(4/9)	(3/9)	(2/9)	(0/9)	(0/9)	81% (29/36)
§ 438.406 Handling of grievances and appeals¶	2	(1/2)	(0/2)	(1/2)	(0/2)	(0/2)	75% (6/8)
§ 438.408 Resolution and notification¶	15	(5/15)	3/15)	(7/15)	(0/15)	(0/15)	72% (43/60)
§ 438.410 Expedited resolution of appeals¶	3	(2/3)	(0/3)	(1/3)	(0/3)	(0/3)	83% (10/12)

*Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^And related provision(s)
† Regulatory component documentation reviewed in Year 1 (2024).
‡Regulatory component documentation reviewed in Year 1 (2024). Case Review will occur in Year 3 (2026).
¶Regulatory component documentation reviewed in Year 2 (2025).

Table 3.6. Summary of Compliance Review Results 2024-2025 – Humana Healthy Horizons							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§ 438.414 Information about grievance and appeal system to providers and subcontractors^¶ § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§ 438.416 Recordkeeping requirements¶	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§ 438.420 Continuation of benefits while appeal and State fair hearing are pending¶	4	(0/4)	(0/4)	(3/4)	(1/4)	(0/4)	44% (7/16)
§ 438.424 Effectuation of reversed appeal resolutions¶	2	(1/2)	(0/2)	(0/2)	(0/2)	(1/2)	50% (4/8)
§ 438.242 Health information systems¶	15	(15/15)	(0/15)	(0/15)	(0/15)	(0/15)	100% (60/60)
Subpart D Total	**86**	**(54/86)**	**(10/86)**	**(20/86)**	**(1/86)**	**(1/86)**	**83% (287/344)**
Overall Compliance	**113**	**(64/113)**	**(22/113)**	**(25/113)**	**(1/113)**	**(1/113)**	**83% (373/452)**

*Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^And related provision(s)
ƚ Regulatory component documentation reviewed in Year 1 (2024).
‡Regulatory component documentation reviewed in Year 1 (2024). Case Review will occur in Year 3 (2026).
¶Regulatory component documentation reviewed in Year 2 (2025).

OCH, Years 1 and 2 Reviews – 2024 and 2025

KFMC reviewed all regulatory areas in Subparts B and C and two regulatory areas in Subpart D in Year 1 and three parts in Year 2 (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424] that includes nine parts). Overall, both OCH and OCH CSP were 88% compliant with the federal regulatory requirements reviewed in 2024 and 2025. Subpart B State Responsibilities is not included because these requirements are not applicable to the health plan. No additional regulatory areas for improvement were identified beyond those common to the SoonerSelect Medical and CSP CEs. Table 3.7 summarizes the 2024 and 2025 compliance review findings for OCH.

Table 3.7. Summary of Compliance Review Results 2024-2025 – Oklahoma Complete Health (Medical & CSP)

Federal Regulations	Component Compliance*						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart C – Enrollee Rights and Protections							
§ 438.100 Enrollee rights^† § 438.10 Information requirements^ § 438.3(j) Standard contract requirements: Advance directives	27	(19/27)	(8/27)	(0/27)	(0/27)	(0/27)	93% (100/108)
SUBPART C TOTAL	**27**	**(19/27)**	**(8/27)**	**(0/27)**	**(0/27)**	**(0/27)**	**93% (100/108)**
Subpart D – MCO, PIHP and PAHP Standards							
§ 438.208 Coordination and continuity of care¶	10	(7/10)	(0/10)	(3/10)	(0/10)	(0/10)	85% (34/40)
§ 438.210 Coverage and authorization of services†	13	(10/13)	(2/13)	(1/13)	(0/13)	(0/13)	92% (48/52)
§ 438.214 Provider selection‡	5	(5/5)	(0/5)	(0/5)	(0/5)	(5/5)	100% (20/20)
§ 438.228 Grievance and Appeal Systems^¶ (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424])	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§ 438.402 General requirements¶	5	(3/5)	(2/5)	(0/5)	(0/5)	(0/5)	90% (18/20)
§ 438.404 Timely and adequate notice of adverse benefit determination¶	9	(5/9)	(2/9)	(2/9)	(0/9)	(0/9)	83% (30/36)
§ 438.406 Handling of grievances and appeals¶	2	(1/2)	(1/2)	(0/2)	(0/2)	(0/2)	88% (7/8)
§ 438.408 Resolution and notification¶	15	(6/15)	(5/15)	(3/15)	(0/15)	(1/15)	75% (45/60)
§ 438.410 Expedited resolution of appeals¶	3	(2/3)	(0/3)	(1/3)	(0/3)	(0/3)	83% (10/12)

*Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^And related provision(s)
†Regulatory component documentation reviewed in Year 1 (2024).
‡Regulatory component documentation reviewed in Year 1 (2024). Case Review will occur in Year 3 (2026).
¶Regulatory component documentation reviewed in Year 2 (2025).

Table 3.7. Summary of Compliance Review Results 2024-2025 – Oklahoma Complete Health (Medical & CSP)							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§ 438.414 Information about grievance and appeal system to providers and subcontractors^¶ § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§ 438.416 Recordkeeping requirements¶	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§ 438.420 Continuation of benefits while appeal and State fair hearing are pending¶	4	(0/4)	(0/4)	(4/4)	(0/4)	(0/4)	50% (8/16)
§ 438.424 Effectuation of reversed appeal resolutions¶	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§ 438.242 Health information systems¶	15	(15/15)	(0/15)	(0/15)	(0/15)	(0/15)	100% (60/60)
Subpart D Total	**86**	**(57/86)**	**(14/86)**	**(14/86)**	**(0/86)**	**(1/86)**	**87% (289/344)**
OVERALL COMPLIANCE	**113**	**(76/113)**	**(22/113)**	**(14/113)**	**(0/113)**	**(1/113)**	**88% (398/452)**

*Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^And related provision(s)
†Regulatory component documentation reviewed in Year 1 (2024).
‡Regulatory component documentation reviewed in Year 1 (2024). Case Review will occur in Year 3 (2026).
¶Regulatory component documentation reviewed in Year 2 (2025).

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

As a result of KFMC's 2024 and 2025 compliance reviews, the following strengths were identified:

Common Among the SoonerSelect CEs

- Aetna, Humana, OCH, and OCH-CSP staff are knowledgeable about their jobs and the services provided to Oklahoma SoonerSelect members.
- There were no common areas identified from KFMC's 2024 and 2025 compliance reviews for Aetna, Humana, and OCH.

Aetna

- In 2024, Aetna conducted Provider Tours around the state to ensure that all providers are aware of what managed care has to offer and the services that Aetna provides to members. In 2025, Aetna worked to improve care for their members through initiatives and programs with their network

providers. Some examples include, the Delegated Care Management Program that provides incentives to providers for getting their members into primary care, establishing Project ECHO [Extension for Community Healthcare Outcomes] for Certified Community Behavioral Health Clinics (CCBHCs) for integrating Primary Care Providers (PCPs) into the community health setting, and identifying providers that have a history of few prior authorization denials, to no longer have to submit prior authorizations (Gold Pass).

- Aetna was highly involved in community-level initiatives in 2024 and 2025, including attendance at events such as Community Baby Showers, the Rural Health Innovation Challenge, and a Back to School Bash.
- In 2024 and 2025, Aetna described a robust health equity program that includes initiatives to address Social Determinants of Health. These included initiatives such as the Workforce Innovation Centers, the Community Resource Center, and improving housing access with affordable housing units being built or remodeled. Aetna incorporated the Member REACH team, Care Advocate Team, and value-added benefits to address members' health related social needs. Aetna also has internal implicit bias training and the "Health Equity Minute" newsletter.
- Aetna staff demonstrated a clear understanding of their roles and the services available to Oklahoma SoonerSelect members.
- Aetna prioritizes members that have not had a visit with Health Home Visit (HHV), and through partnerships with Federal Qualified Health Centers (FQHC's).
- In 2024, Aetna had innovative ways to track emergency department utilization and wait times, as well as fraud, waste, and abuse.
- In 2025, Aetna actively explored technologies to streamline internal processes.

Humana

- In 2024, Humana put an emphasis on ensuring members feel welcome when they join the health plan and that their needs were met.
- Humana had a customer service approach to their organization with having many teams that were customer facing, including the care management team (Community Health Workers), the Community Engagement Team, and the Equitable and Population Health Management Team.
- Humana utilized their Mentor system that outlined internal processes and made it easy for Customer Service Advocates to address member needs quickly and consistently.
- In 2024, Humana developed a culturally and linguistically appropriate training for staff that was specific to Oklahoma's Indigenous Population. This training was developed by internal Humana staff and Humana also partnered with the Southern Plains Tribal Health Board to help develop this training.
- Humana partnered with many community organizations in 2024 to reduce gaps in care across the state and address member needs. Examples of partnerships included, but were not limited to, Pivot, Patient Care Network of Oklahoma (PCNOK), Volunteer of America, and many others.
- In 2025, Humana partnered with Community Organizations to improve sustainability and impact on health outcomes and access to care (e.g., Partnerships with City Care to create a respite facility for members experiencing or transitioning from homelessness to a place to stay post-hospitalization, and Volunteers for America to create a residential treatment facility for mothers experiencing a substance use disorder).
- Humana works to identify innovative ways to deliver care to members (e.g., Emergency Department Diversion Case Management Program).

- Humana's internal goals go beyond member satisfaction, and included provider satisfaction scores, as well as employee satisfaction.
- Humana staff are knowledgeable about their current processes, and actively work to improve processes and focus on process improvement (e.g., provider submitting a Primary Care Provider change form while the member is in the office).

OCH and OCH-CSP

- Members were called within 48 hours to notify of provider terminations.
- In 2024, Related to authorization of services, OCH had collaboration huddles, where they brought examples to a joint forum to discuss them. There was daily open communication between the clinicians and Medical Directors.
- OCH partnered with Oklahoma University Health-Fostering Hope Clinic, in 2024, to provide trauma-informed medical homes to CSP members.
- In 2024, OCH had a variety of Value-Added Benefits tailored to the unique needs of the populations within CSP.
- OCH had staff with personal and professional experience with the populations within the Children's Specialty Program.
- In 2024, OCH sent notification to each member to celebrate their birthday.
- Employees have access to Centene University for self-directed learning with more than 1,000 training modules and more than 10,000 courses for licensed clinical employees.
- During the recredentialing process, in 2024, a form was sent out to various departments within OCH to review the quality of care of providers. The information was then used for determination of credentialing.
- In 2024, OCH required National Adoption Competency Mental Health Training Initiative (NTI) for staff.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

The following are the opportunities identified from the 2024 and 2025 reviews (See Appendix C for more detail):

Common Among the SoonerSelect CEs

As a result of KFMC's 2024 and 2025 compliance reviews for Aetna, Humana, and OCH, the following opportunities were identified:

- Addition or revision of federal regulatory and/or State Contract language in the *SoonerSelect Member Handbook*, policies and procedures, *Member Welcome Notice*, *Provider Manual, Notice of Adverse Determination* letters/template, and CE's website:
  - § 438.10(c)(6)(v), (d)(3-5), and (g)(2)(ix) and (xii) Information requirements
  - § 438.210(c) and (d)(1-2) Coverage and authorization of services
  - § 438.402(c)(1) General requirements: Filing requirements – Authority to file
  - § 438.404(b)(6) Timely and adequate notice of adverse benefit determination: Content of notice
  - § 438.406(b)(1 and 5) Handling of grievances and appeals: Special requirements
  - § 438.408(a), (b)(1-2), (c)(1-2),(e)(2)(iii), and (f)(2) Resolution and notification: Grievances and appeals – Basic rule; Specific timeframes; Extension of timeframes; Content of notice of appeal resolution; and Requirements for state fair hearings
  - § 438.410(c)(1-2) Expedited resolution of appeals: Action following denial of a request for expedited resolution

  - § 438.416 Recordkeeping requirements
  - § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending
- Staff education and refinement of internal processes related to KFMC's care coordination case review findings in the following:
  - § 438.208(b)(3) Coordination and continuity of care: Care and coordination of services for all MCO, PIHP, and PAHP enrollees
  - § 438.208(c)(2) Coordination and continuity of care: Additional services for enrollees with special health care needs
- Staff education and refinement of internal processes related to KFMC's grievance and appeal case review findings in: § 438.406(b)(1) Handling of grievances and appeals: Special requirements

Aetna

As a result of KFMC's 2024 and 2025 compliance review for Aetna, the following opportunities were identified:

- Addition or revision of federal regulatory and/or State Contract language in the *SoonerSelect Member Handbook*, policies and procedures, *Member Welcome Notice*, Aetna website, and *Provider Manual*:
  - § 438.56(f)(1) Disenrollment: Requirements and limitations – Notice and appeals
  - § 438.10(g)(2)(ii)(A-B) Information requirements
  - § 438.214(e) Provider selection: State requirements
  - § 438.242(b) Health information systems: Basic elements of a health information system and related provision § 431.60(b) Beneficiary access to and exchange of data: Accessible content
  - § 438.402(c)(2) General requirements: Filing requirements – Timing
  - § 438.406(b)(2) Handling of grievances and appeals: Special requirements
  - § 438.408(c)(1 and 3) and (d)(2)(ii) Resolution and notification: Grievances and appeals – Extension of timeframes and Format of notice (Appeals)
- Staff education and refinement of internal processes related to KFMC's care coordination case review findings in § 438.208(c)(3) Coordination and continuity of care: Additional services for enrollees with special health care needs or who need LTSS (Treatment/service plans)
- Staff education and refinement of internal processes related to KFMC's grievance and appeal case review findings in the following:
  - § 438.402(c)(1) General requirements: Filing requirements – Authority to file
  - § 438.408(b)(1), (d)(1), and (e)(2)(iii) Resolution and notification: Grievances and appeals – Specific timeframes; Extension of timeframes; Format of notice-Appeals; and Content of notice of appeal resolution
  - Issues not specific to a regulatory area

Humana

As a result of KFMC's 2024 and 2025 compliance review for Humana, the following opportunities were identified:

- Addition or revision of federal regulatory and/or State Contract language in the *SoonerSelect Member Handbook*, policies and procedures, Humana documents, Humana website, and *Provider Manual*:
  - § 438.56(a-b), (e)(2), and (f)(1-2), and (g) Disenrollment: Requirements and limitations – Applicability; Disenrollment requested by the MCO, PIHP, PAHP, PCCM, or PCCM entity;

Timeframe for disenrollment determinations; Notice and appeals; and Automatic reenrollment-Contract requirement
  - § 438.10(f)(1) and (h-i) Information requirements
  - § 438.100(a)(1) and (b)(1-2) Enrollee rights: General rule and Specific rights
  - § 438.114(c)(1)(i-ii) and (d)(1-3) Emergency and poststabilization: Coverage and payment: Emergency services and Additional rules for emergency services
  - § 438.402(c)(1)(i)(B) General requirements: Filing requirements – Authority to file-External medical review
  - § 438.404(c)(4-5) Timely and adequate notice of adverse benefit determination: Timing of notice
  - § 438.408(d)(2)(i-ii) and (f)(1)(ii) Resolution and notification: Grievances and appeals – Format of notice-Appeals and Requirements for State fair hearings-Availability (External medical review)
  - § 438.424(b) Effectuation of reversed appeal resolutions: Services furnished while the appeal is pending
- Staff education and refinement of internal processes related to KFMC's grievance and appeal case review findings for § 438.408(b)(1-3), (c)(1-2), (d)(1), (d)(2)(i), (e)(1) and (2)(iii) Resolution and notification: Grievances and appeals – Specific timeframes; Extension of timeframes; Format of notice; and Content of notice of appeal resolution

OCH and OCH-CSP

As a result of KFMC's 2024 and 2025 compliance reviews for OCH, the following opportunities were identified:

- Addition or revision of federal regulatory and/or State Contract language in the *SoonerSelect Member Handbook*, policies and procedures, OCH website, and *Provider Manual*:
  - § 438.10(f)(1) Information requirements: Basic rules
  - § 438.228(a-b) Grievance and appeal systems
  - § 438.402(c)(2) General requirements: Filing requirements - Timing
  - § 438.408(c)(2)(ii) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension
- Staff education and refinement of internal processes related to KFMC's care coordination case review in the following:
  - Findings in § 438.208(c)(3) Coordination and continuity of care: Additional services for enrollees with special health care needs or who need LTSS – Treatment/Service plans
  - Issues not related to the regulatory areas
- Staff education and refinement of internal processes related to KFMC's grievance and appeal case review findings in the following:
  - § 438.402(c)(1) General requirements: Filing requirements – Authority to file
  - § 438.408(b)(2) and (d)(2)(ii) Resolution and notification: Grievances and appeals – Specific timeframes and Format of notice-Appeals
  - Issues not specific to a regulatory area

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Between May 2025 and July 2025, KFMC obtained from each CE a series of updates to the progress tracking document that included KFMC's EQRO recommendations from 2024. KFMC provided each CE with suggestions on how to bring outstanding recommendations into full compliance and each CE was given the opportunity to respond on their progress. The following summaries include the 2024 review.

Aetna

There are 18 recommendations included in Appendix D. In 2025, 17 moved to fully addressed and 1 is in progress.

Humana

There are 33 recommendations included in Appendix D. In 2025, 32 moved to fully addressed and 1 was partially addressed.

OCH

There are 13 recommendations included in Appendix D. In 2025, 3 moved to fully addressed, 5 were partially addressed, 4 were not addressed, and 1 is in progress.

Recommendations for Quality Improvement

A recommendation indicates where a CE change is needed to be in full compliance with the stated regulation. See Appendix C for details.

Aetna

Year 1 Review – 2024

Based on the areas identified for improvement, KFMC made 18 recommendations:

- Ten related to Information requirements
- Six related to Coverage and authorization of services
- One related to Disenrollment
- One related to Provider selection

Year 2 Review – 2025

Based on the areas identified for improvement, KFMC made 48 recommendations:

- Four related to care coordination case review
- Two related to Health information systems
- Three related to grievance and appeal issues not specific to a regulatory area
- Eight related to grievance and appeal case review
- Five related to Filing requirements
- One related to Timely and adequate notice of adverse benefit determination
- Six related to Handling of grievances and appeals
- Twelve related to Resolution and notification of grievances and appeals
- One related to Expedited resolution of appeals
- Two related to Record keeping requirements
- Four related to Continuation of benefits

Recommendations for Quality Improvement (Continued)

Humana

Year 1 Review – 2024

Based on the areas identified for improvement, KFMC made 33 recommendations:

- Nineteen related to Information requirements
- Seven related to Disenrollment
- Five related to Coverage and authorization of services
- Two related to Emergency and poststabilization services

Year 2 Review – 2025

Based on the areas identified for improvement, KFMC made 48 recommendations:

- Three related to care coordination case review
- Eleven related to grievance and appeal case review
- Two related to Filing requirements
- Three related to Timely and adequate notice of adverse benefit determination
- Three related to Handling of grievances and appeals
- Eighteen related to Resolution and notification of grievances and appeals
- One related to Expedited resolution of appeals
- One related to Record keeping requirements
- Five related to Continuation of benefits
- One related to Effectuation of reversed appeal resolutions

OCH and OCH-CSP

Year 1 Review – 2024

Based on the areas identified for improvement, KFMC made 13 recommendations:

- Eight related to Information requirements
- Five related to Coverage and authorization of services

Year 2 Review – 2025

Based on the areas identified for improvement, KFMC made 43 recommendations:

- Five related to care coordination case review
- Four related to grievance and appeal case review
- One related to care coordination issues not specific to a regulatory area
- One related to grievance and appeal issues not specific to a regulatory area
- One related to Grievance and appeal systems
- Five related to Filing requirements
- One related to Timely and adequate notice of adverse benefit determination
- Three related to Handling of grievances and appeals
- Fourteen related to Resolution and notification of grievances and appeals
- One related to Expedited resolution of appeals
- One related to Record keeping requirements
- Six related to Continuation of benefits

Summary of 2024 and 2025 Compliance Reviews

Table 3.8 details a summary of the CEs' overall 2024 and 2025 compliance review results for Subpart C and five parts of Subpart D (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424] that includes nine parts). Subpart B – Disenrollment: Requirements and Limitations is not included because for regulation § 438.56 Disenrollment: Requirements and Limitations, the State, through its fiscal agent, is responsible for disenrollment, and the CEs are not able to disenroll members.

Table 3.8. Summary of Compliance Review Results 2024-2025 for Medical and CSP CEs

Federal Regulation	Compliance Score		
	ABH	HHH	OCH
Subpart C – Enrollee Rights and Protections			
§ 438.100 Enrollee rights	89%	80%	93%
Subpart C Total	**89%**	**80%**	**93%**
Subpart D – MCO, PIHP and PAHP Standards			
§ 438.208 Coordination and continuity of care	90%	85%	85%
§ 438.210 Coverage and authorization of services	92%	94%	92%
§ 438.214 Provider selection	90%	100%	100%
§ 438.228 Grievance and Appeal Systems (requires compliance with Subpart F Grievance and Appeal System [§ 438.402 – § 438.424])	50%	50%	75%
§ 438.402 General requirements	85%	95%	90%
§ 438.404 Timely and adequate notice of adverse benefit determination	78%	81%	83%
§ 438.406 Handling of grievances and appeals	88%	75%	88%
§ 438.408 Resolution and notification	68%	72%	75%
§ 438.410 Expedited resolution of appeals	83%	83%	83%
§ 438.414 Information about grievance and appeal system to providers and subcontractors § 438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	100%	100%	100%
§ 438.416 Recordkeeping requirements	50%	50%	75%
§ 438.420 Continuation of benefits while appeal and State fair hearing are pending	50%	44%	50%
§ 438.424 Effectuation of reversed appeal resolutions	100%	50%	100%
§ 438.242 Health information systems	95%	100%	100%
Subpart D Total	**83%**	**83%**	**87%**
OVERALL COMPLIANCE	**85%**	**83%**	**88%**

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4. Early and Periodic Screening, Diagnostic, and Treatment

Background/Objectives

The purpose of this activity was to evaluate each CE's compliance with the Early and Periodic Screening, Diagnostic, and Treatment requirements set forth in the OHCA SoonerSelect Dental Contract, the SoonerSelect Medical Contract, and the SoonerSelect Children's Specialty Program Contract. The 2025 evaluation consisted of a desk review to assess adherence to the SoonerSelect EPSDT contract requirements, and the quality of notification and education provided to EPSDT-eligible enrollees and participating providers. A targeted case review examined the appropriateness and timeliness of medical necessity determinations and assessed the CE's handling of specific prior authorization denials and appeals. Future review will include assessing provider records to ensure SoonerSelect Members are receiving timely and appropriate EPSDT services.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

The CEs, in the administration of their EPSDT programs, must comply with 42 CFR §438.206: Availability of services, 42 CFR Part 441 Subpart B (441.50-441.61), and the EPSDT and medical necessity requirements as stated in the SoonerSelect Contracts. For the 2025 review, KFMC requested documentation from the CEs related to EPSDT. KFMC reviewed the submitted documents to assess the CE compliance with the federal regulations and State requirements. For a list of the SoonerSelect Contract sections reviewed for this reporting cycle, see Appendix B, Methodologies: EPSDT Review for more detail.

In addition to OHCA's CE contract requirements and the associated federal regulations, KFMC considered additional CMS guidance provided in the State Health Official letter #24-005, *Best Practices for Adhering to EPSDT Requirements* during the review process. The guidance is intended to provide an overview of EPSDT requirements and how states can meet the compliance requirements for optimal EPSDT implementation.[7]

For the 2025 review, KFMC conducted a desk review, which assessed all EPSDT-related documentation submitted by the CEs, including policies and procedures, provider manuals, member handbooks, training materials, member outreach materials, and additional supporting documents. In addition, KFMC conducted a case review on a sample of denied prior authorizations and appeals not wholly resolved in favor of the member. All documentation related to those cases was requested from the CEs. See Appendix B for a detailed list of the documents reviewed for each CE.

The compliance definitions used for the EPSDT documentation review are displayed in Table 4.1.

Table 4.1. Rating Definitions for EPSDT Documentation Review	
Met (M)	After review of the documentation, it is determined that the CE has met all the requirements.
Partially Met (PM)	Required documentation is incomplete or inconsistent with practice.
Not Met (NM)	After review of the documentation, it is determined that the CE has not met the requirements.

[7] Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) State Health Official letter #24-005, Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements, September 26, 2024.

The compliance definitions used for the EPSDT case review are displayed in Table 4.2.

Table 4.2. Rating Definitions for EPSDT Case Review	
Fully Met (FM) 100%	After review of the documentation, it is determined that all cases met the component reviewed.
Substantially Met (SM) 75-99%	Most cases met the component reviewed.
Partially Met (PM) 50-74%	Some of the cases met the component reviewed.
Minimally Met (MM) 1-49%	Fewer than half the cases met the component reviewed.
Not Met (NM) 0%	None of the cases met the component reviewed.

Conclusions Drawn from the Data

SoonerSelect Dental CEs

Table 4.3 summarizes the 2025 EPSDT documentation and case review findings for DentaQuest and LIBERTY.

Table 4.3. Summary of EPSDT Review Results 2025 – DentaQuest and LIBERTY		
Documentation Review Component	**Compliance Rating**	
	DQ	**LD**
EPSDT Program Structure *Evaluate whether the CE has a structured and accountable system for managing and overseeing EPSDT services*		
Integration with QAPI Program		
EPSDT-related performance measures are collected and reported to the State. 42 CFR § 438.330, 1.10.3.1(b) QAPI Program	M	M
Operational Oversight (42 CFR §438.206)		
Internal controls exist to ensure EPSDT services are provided timely and appropriately.	M	M
Prior authorization policies are aligned with EPSDT requirements.	M	M
The CE ensures provider network adequacy for EPSDT services (e.g., pediatric specialists, behavioral health).	M	M
The CE ensures compliance with appointment wait time standard for pediatric services.	M	M
Education and Outreach to Enrollees *Assess whether the CE effectively identifies, educates, and engages EPSDT-eligible enrollees about EPSDT services.*		
Identification and Outreach		
The CE has a process to identify all Medicaid enrollees under age 21. 1.7.4 EPSDT	M	M
Newly eligible enrollees are informed about EPSDT within 60 days of enrollment. 42 CFR 441.56(a)(4)	**NM**	**NM**
Education and Communication		
EPSDT benefits are explained using clear, non-technical language. 42 CFR 441.56(a)(2)	M	M
Both written and oral methods are used to inform families about EPSDT (social media, websites, text reminders, and educational videos). 42 CFR 441.56(a)(1)	M	M
Enrollees/their caregivers are informed about: • Preventive health care benefits • Available EPSDT services and how to access them • Access to most appropriate NEMT transportation • Scheduling assistance • No-cost coverage for services under age 21 42 CFR 441.56(a)(2), 1.7.4 EPSDT	**PM**	**PM**

Table 4.3. Summary of EPSDT Review Results 2025 – DentaQuest and LIBERTY		
Documentation Review Component (Continued)	**Compliance Rating**	
	DQ	**LD**
Education and Outreach to Providers *Assess whether the CE effectively educates and engages providers about services related to EPSDT*		
The CE offers EPSDT-specific training to providers on how to request services 1.13.4 Provider Manual, 1.11.2 Cultural Competency	M	M
The Provider Manual provides clarity on EPSDT coverage (e.g., "children are entitled to broader services than adults") 1.7.4 EPSDT, 1.13.4 Provider Manual	M	M
The CE has developed referral policies and procedures to ensure that EPSDT-eligible enrollees have access to participating specialty providers for medically necessary care. 42 CFR 441.61(b)	M	M
Case Review Component	**Compliance Rating**	
	DQ	**LD**
Prior Authorizations		
The decision was made on a case-by-case basis, considering the member's specific health needs.	SM	SM
The reviewer considered all medically necessary services under EPSDT, even if not typically covered by the plan.	SM	SM
The service was not denied solely due to plan limitations.	SM	SM
Reviewers were qualified clinicians.	SM	SM
The prior authorization was reviewed within the required timeframe (standard or expedited).	SM	FM
The authorization process avoided delays that could impact timely access to necessary care.	SM	FM
Appeals		
The appeal was reviewed using evidenced-based guidelines for medical necessity, regardless of whether the service is a State Plan covered service.	FM	FM
The reviewer reassessed medical necessity based on the child's specific health needs.	FM	FM
The appeal process avoided delays that could impact timely access to care.	FM	FM

SoonerSelect Medical and CSP CEs

Table 4.4 summarizes the 2025 EPSDT documentation review findings for Aetna, Humana, OCH, and OCH-CSP

Table 4.4. Summary of EPSDT Review Results 2025 – Aetna, Humana, and OCH				
Documentation Review Component	**Compliance Rating**			
	ABH	**HHH**	**OCH**	**OCH-CSP**
EPSDT Program Structure *Evaluate whether the CE has a structured and accountable system for managing and overseeing EPSDT services*				
Integration with QAPI Program				
EPSDT-related performance measures are collected and reported to the state. 42 CFR § 438.330, 1.11.3.1(b) QAPI Program	M	M	M	M
Operational Oversight (42 CFR § 438.206)				
Internal controls exist to ensure EPSDT services are provided timely and appropriately.	M	M	M	M
Prior authorization policies are aligned with EPSDT requirements.	M	M	M	M
The CE ensures provider network adequacy for EPSDT services (e.g., pediatric specialists, behavioral health).	M	M	M	M
The CE ensures compliance with appointment wait time standard for pediatric services.	M	M	**NM**	**NM**

Table 4.4. Summary of EPSDT Review Results 2025 – Aetna, Humana, and OCH				
Documentation Review Component (Continued)	**Compliance Rating**			
	ABH	**HHH**	**OCH**	**OCH-CSP**
Education and Outreach to Enrollees *Assess whether the CE effectively identifies, educates, and engages EPSDT-eligible enrollees about EPSDT services.*				
Identification and Outreach				
The CE has a process to identify all Medicaid enrollees under age 21. 1.7.11 EPSDT	M	M	M	M
Newly eligible enrollees are informed about EPSDT within 60 days of enrollment. 42 CFR 441.56(a)(4)	**NM**	M	M	M
Reminders are sent to enrollees/their caregivers who have not utilized EPSDT services. 1.7.11 EPSDT	M	M	M	M
Outreach efforts are tailored to specific age groups or health milestones. 1.7.11 EPSDT	M	M	M	M
Education and Communication				
EPSDT benefits are explained using clear, non-technical language. 42 CFR 441.56(a)(2)	M	M	**PM**	**PM**
Both written and oral methods are used to inform families about EPSDT (social media, websites, text reminders, and educational videos). 42 CFR 441.56(a)(1)	M	M	M	M
Enrollees/their caregivers are informed about: • Preventive health care benefits • Available EPSDT services and how to access them • Access to most appropriate NEMT transportation • Scheduling assistance • No-cost coverage for services under age 21 42 CFR 441.56(a)(2), 1.7.11 EPSDT, 1.7.7.2 NEMT Covered Services	M	M	M	M
Engagement and Follow-up (activities to increase EPSDT screening visit rates)				
The CE sends timely notifications when periodic screenings or services are due 1.7.11 EPSDT	M	M	M	M
Mechanisms are in place to track and follow up with enrollees/their caregivers who miss appointments 1.7.11 EPSDT	M	M	M	M
Reminders are sent for immunizations and developmental screenings 1.7.11 EPSDT	M	M	M	M
Education and Outreach to Providers *Assess whether the CE effectively educates and engages providers about services related to EPSDT*				
The CE offers EPSDT-specific training to providers on how to request services 1.15.4 Provider Manual, 1.12.2 Cultural Competency, 1.8.1 Medically Necessary Services	M	M	M	M
The Provider Manual provides clarity on EPSDT coverage (e.g., "children are entitled to broader services than adults") 1.15.4 Provider Manual	M	M	M	M
The CE has developed referral policies and procedures to ensure that EPSDT-eligible enrollees have access to participating specialty providers for medically necessary care. 42 CFR 441.61(b)	M	M	M	M
Quarterly gap-in-care reports are sent to providers 1.7.11 EPSDT	M	M	M	M
Provider outreach to enrollees is tracked using their gap-in-care reports. 1.7.11 EPSDT	M	M	M	M

Table 4.4. Summary of EPSDT Review Results 2025 – Aetna, Humana, and OCH (Continued)				
Case Review Component	**Compliance Rating**			
	ABH	**HHH**	**OCH**	**OCH-CSP**
Prior Authorizations				
The decision was made on a case-by-case basis, considering the member's specific health needs.	FM	FM	**SM**	**SM**
The reviewer considered all medically necessary services under EPSDT, even if not typically covered by the plan.	**SM**	FM	**SM**	**SM**
The service was not denied solely due to plan limitations.	**SM**	FM	**SM**	**SM**
Reviewers were qualified clinicians.	FM	FM	**PM**	**SM**
The prior authorization was reviewed within the required timeframe (standard or expedited).	FM	FM	FM	FM
The authorization process avoided delays that could impact timely access to necessary care.	FM	FM	FM	FM
Appeals				
The appeal was reviewed using evidenced-based guidelines for medical necessity, regardless of whether the service is a State Plan covered service.	FM	**SM**	**SM**	FM
The reviewer reassessed medical necessity based on the child's specific health needs.	**PM**	**SM**	**SM**	FM
The appeal process avoided delays that could impact timely access to care.	FM	FM	FM	**SM**

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

Based on findings from each CE's 2025 EPSDT review, KFMC identified the following opportunities for improvement.

DentaQuest

- More information is needed in the *Member Handbook* and on the DentaQuest website to identify and explain EPSDT benefits.
- Clarification of the EPSDT eligibility age range is needed in the *Office Reference Manual*.
- Prior authorization requests were inconsistently reviewed and documented by a licensed dentist, and adherence to the required timeframes for processing prior authorizations was also inconsistent.
- Improvement is needed to ensure that members are informed of EPSDT benefits within 60 days of enrollment.

LIBERTY

- More information is needed in the *Member Handbook* and on the LIBERTY website to identify and explain EPSDT benefits.
- Prior authorization requests were inconsistently reviewed and documented by a licensed dentist, and the plan needs to ensure that all medical record documentation is considered when making determinations of medical necessity for some cases.
- Improvement is needed to ensure that members are informed of EPSDT benefits within 60 days of enrollment.
- It was not apparent whether LIBERTY has member materials specific to EPSDT benefits.

Aetna

- The *Member Handbook* did not include direct access to EPSDT information and resources.

- Prior authorization requests were not consistently reviewed for medical necessity beyond the plan limitations (e.g., age restrictions).
- Aetna needs to ensure that criteria used for medical necessity determinations are age and condition appropriate, and meet current clinical standards or have support from pediatric literature.
- There was inconsistency regarding the review of appeal requests by providers with the appropriate experience and specialty, as well as whether all medical record documentation submitted was considered when making determinations of medical necessity.
- Improvement is needed to ensure that members are informed of EPSDT benefits within 60 days of enrollment.

Humana

- Humana needs to ensure authorization requests are reviewed based on EPSDT requirements and not denied solely on the absence of corresponding codes in the Medicaid Fee Schedule.

OCH and OCH-CSP

- The *Member Handbook* did not include direct access to EPSDT information and resources.
- The plan needs to revise the EPSDT information on the OCH SoonerSelect websites to be straightforward, intuitive to navigate, and written at an appropriate reading level for members.
- Review and refine internal processes to ensure prior authorization requests are reviewed by a physician with appropriate qualifications, and appropriate medical necessity criteria is applied.
- Ensure that criteria used for medical necessity determinations is age and condition appropriate and meets current clinical standards or has support from pediatric literature.
- Review and refine internal processes to ensure appeal requests are reviewed by appropriately qualified clinical reviewers and completed in a timely manner.
- Appeal requests were inconsistently reviewed by the appropriate qualified clinical reviewers, and improvement is needed to complete these requests in a timely manner.
- The plan needs to ensure that wait time standards for EPSDT services are met.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

KFMC referenced the State Health Official letter #24-005, *Best Practices for Adhering to EPSDT Requirements*. Implementing these best practices are considered strengths, as they are not required elements by State contract or Federal regulations. KFMC also evaluated additional education and outreach activities directed toward members and providers. Although these activities are not explicitly required by the State contract, they are recognized as strategies that can enhance EPSDT screening rates. When implemented, these activities are considered strengths.

DentaQuest

- Care coordinators or case managers are involved in EPSDT engagement.
- The Healthy Beginnings Program includes outreach to the member's parent/guardian at birth and first and second birthdays to provide them with information on oral care, how to locate a dentist and reminders to schedule dental visits for the member.
- DentaQuest conducts outreach to members who have missed dental appointments and have pediatric-specific marketing materials.
- DentaQuest is implementing a clinical Performance Improvement Project related to an EPSDT service, *Increase the Percentage of Children Receiving a Dental Visit by their First Birthday*.

LIBERTY

- Reminders are sent to members who have not completed recommended dental screenings or treatments and targeted educational campaigns inform members about the importance of preventive dental visits, the EPSDT periodicity schedule, and how to access covered services.
- LIBERTY partners with community and school-based organizations to identify children's oral health needs early. Key partners include Head Start programs, Sunbeam schools, Oklahoma City Public Schools, and neighborhood service organizations.
- Although LIBERTY does not administer a designated EPSDT program, EPSDT-related activities and metrics are reviewed during the quarterly Utilization Management Committee meetings.
- LIBERTY has a PIP impacting EPSDT-eligible members, *Increase Preventive Services for Children*.
- LIBERTY offers case management services for members with complex dental needs or special healthcare needs.

Aetna

- EPSDT is included in Aetna's strategic planning and organizational goals.
- Aetna has an EPSDT coordinator who works under the Health Care Quality Manager.
- The Quality Management Oversight Committee provides executive oversight of EPSDT.
- EPSDT quality goals are included in the Annual QAPI Documentation Plan and EPSDT data and activities are reviewed in Quality Management/Medical Management Committee Meetings.
- Case managers collaborate with providers and external case management entities, such as Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Infant Crisis Center, OKC Crisis Nursery, and M28 Ministries.
- At the end of each member service call, the Member Service Representative checks for gaps in care and offers enrollee assistance in finding a provider, scheduling an appointment, arranging transportation, and accessing additional resources.
- Aetna is also implementing a PIP that impacts the EPSDT eligible population, *Childhood Immunization Status Combo 3*.

Humana

- EPSDT is incorporated into Humana's strategic planning and organizational goals.
- Humana designates an EPSDT Coordinator and an EPSDT Senior Quality Compliance Professional, both of whom report to the Quality Improvement Manager.
- Executive oversight of EPSDT is provided by the Director of Quality Improvement.
- EPSDT quality goals are integrated into the Annual QAPI Documentation Plan.
- Humana utilizes a case management EPSDT process tool that identifies members under age 21 and flags them for the EPSDT workflow, which includes reviewing past and upcoming well-child visits and providing resources related to vaccinations and immunization schedules.
- Comprehensive EPSDT information is readily accessible on Humana's website with minimal navigation required.
- EPSDT information is introduced to new mothers and pregnant members through the Humana Beginnings program, with relevant content available in both the program brochure and on the webpage.
- Humana employs the Humana Healthy Children Tracker, a tool designed to monitor key pediatric health indicators, including immunizations and well-child visits.

OCH and OCH-CSP

- OCH designates an EPSDT Coordinator who reports to the Quality Improvement Manager.
- Executive oversight of EPSDT is provided by the Vice President, Quality Improvement.
- OCH staff receive training on EPSDT services and eligibility requirements.
- OCH's EPSDT Coordinators and Connections staff conduct telephonic reminder outreach to members who are past due for EPSDT services. This outreach includes education, counseling, notification of upcoming periodic assessments, and follow-up on missed appointments.
- OCH partners with SMS Health to send co-branded text messages to assigned members with EPSDT screening gaps, providing a direct link to the provider's website to support appointment scheduling.

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

During the 2025 review, KFMC assessed the degree to which each CE addressed the 2024 EQRO recommendations. Aetna and Humana did not have any recommendations made in 2024. Detail of the following summary is included in Appendix D.

In 2025, the following was noted:

- For DentaQuest, 1 was partially addressed, and 5 were not addressed.
- For LIBERTY, 5 were not addressed.
- For OCH, 1 was not addressed.
- For OCH-CSP, 1 was partially addressed and 2 were not addressed.

Recommendations for Quality Improvement

A summary of the recommendations KFMC made in 2025 is as follows. See Appendix C for the detailed recommendations for each CE.

DentaQuest

Based on the areas identified for improvement, KFMC made 6 recommendations:

- One related to Education and Outreach to Enrollees, Identification and Communication
- Three related to Education and Outreach to Enrollees, Education and Communication
- Two related to the Prior Authorizations case review

LIBERTY

Based on the areas identified for improvement, KFMC made 6 recommendations:

- Two related to Education and Outreach to Enrollees, Identification and Communication
- Two related to Education and Outreach to Enrollees, Education and Communication
- Two related to the Prior Authorizations case review

Aetna

Based on the areas identified for improvement, KFMC made 6 recommendations:

- One related to Education and Outreach to Enrollees, Identification and Communication
- One related to Education and Outreach to Enrollees, Education and Communication
- One related to the Prior Authorizations case review
- Two related to the Appeal case review
- One related to the Prior Authorization and Appeal case reviews

Recommendations for Quality Improvement (Continued)

Humana

Based on the areas identified for improvement, KFMC made 1 recommendation related to the Appeal case review

OCH & CSP

Based on the areas identified for improvement, KFMC made 9 recommendations:

- One related to EPSDT Program Structure, Operational Oversight
- Two related to Education and Outreach to Enrollees, Education and Communication
- One related to the Prior Authorizations case review
- Three related to the CSP Prior Authorizations case review
- One related to the Appeal case review
- One related to the CSP Appeal case review

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5. Quality Assessment and Performance Improvement Review

Background/Objectives

The QAPI approach is continuous, systematic, comprehensive, and data driven. Implementing this approach allows organizations to improve on identified challenges as well as plan for future opportunities.[8] The SoonerSelect CEs must implement a QAPI program, as required by the OHCA SoonerSelect contracts and the Medicaid and CHIP Managed Care Regulations (SoonerSelect contract sections 1.10.3 [Dental] and 1.11.3 [Medical/CSP]; CFR §438.330).

KFMC is conducting a three-year progressive review that follows the CE development of their QAPI program to support a comprehensive and actionable evaluation. Each annual review will focus on distinct components of the QAPI requirements, enabling an in-depth analysis of program design and implementation, with the goal of assessing the impact and effectiveness of the CE's QAPI program.

KFMC's objective for this review was to assess the CE QAPI documentation submitted in September 2025 by the SoonerSelect Dental CEs (DentaQuest and LIBERTY), the SoonerSelect Medical CEs (Aetna, Humana, and OCH), and the SoonerSelect CSP CE (OCH-CSP). In subsequent years, KFMC's main objective for this activity will be to evaluate the impact and effectiveness of the CEs' QAPI programs.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

The CE's QAPI documentation must comply with the SoonerSelect contract section 1.10.3 [Dental]/1.11.3 [Medical/CSP], Quality Assessment and Performance Improvement, subsection 1.10.3.3/1.11.3.3, QAPI Documentation. Annually, the CE is to complete the SoonerSelect DEN/SEL-1600 *Annual QAPI Documentation Plan* and DEN/SEL-1601 *Annual QAPI Documentation Evaluation*. For the 2025 review, KFMC utilized those reports to assess the CEs' compliance with State requirements, documenting findings in a worksheet (see Appendix B, Methodologies, for more detail).

Conclusions Drawn from the Data

KFMC assessed whether each CE's QAPI documentation, as documented through the SoonerSelect quality reports, DEN/SEL-1600 and DEN/SEL-1601, included the required elements outlined in the SoonerSelect contract, Quality Assessment and Performance Improvement subsection, QAPI Documentation. Of the 41 total requirements reviewed, KFMC identified areas where a CE was less than fully compliant:

- DentaQuest was less than fully compliant for 1 requirement, which was partially met.
- LIBERTY was less than fully compliant for 19 requirements, 9 of which were partially met and 10 were not met.
- Aetna was less than fully compliant for 2 requirements, which were partially met.
- Humana fully met all requirements.
- OCH and OCH-CSP were each less than fully compliant for 2 requirements, which were partially met.

DentaQuest

Table 5.1 lists the SoonerSelect QAPI Documentation contract requirement for DentaQuest was less than fully met.

[8] QAPI Description and Background. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition. Updated September 10, 2024.

Table 5.1. 2025 QAPI Review Requirements Less Than Fully Met - DentaQuest	
SoonerSelect QAPI Documentation Contract Requirement	**Rating***
1.10.3.3 QAPI Documentation	
QAPI program committee structure, including specific committees, committee representatives and why the representatives were chosen, identification and inclusion of Local Oklahoma Provider Organization (LOPO) members	PM
*Ratings indicate whether CE QAPI documentation included the required elements from the SoonerSelect contract section, Quality Assessment and Performance Improvement, Subsection, QAPI Documentation. Partially Met (PM) indicates where the CE included some, but not all, of the required content, and Not Met (NM) indicates the CE did not include required content.	

- DentaQuest's QAPI documents did not identify LOPO members by name, position, role, or organizational affiliation. The QIC membership table in the Quality Improvement Organizational Chart submitted did not list any individuals identified as LOPOs, and it is unclear whether the external consultants included in the table are LOPO representatives. Additionally, the documents did not identify a LOPO member serving as the required QIC chair or co-chair.

LIBERTY

Table 5.2 lists the SoonerSelect QAPI Documentation contract requirements for LIBERTY that were less than fully met.

Table 5.2. 2025 QAPI Review Requirements Less Than Fully Met - LIBERTY	
SoonerSelect QAPI Documentation Contract Requirement	**Rating***
1.10.3.1 QAPI Program	
The QAPI program shall assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs (letter d)	NM
1.10.3.2 Oversight of QAPI Program	
Direct task forces or committees in specific improvement areas (letter d)	NM
Publicize findings to appropriate staff and departments within the CE's organization (letter f)	NM
Report findings and recommendations to the CE's executive management team (letter g)	NM
CE's QAPI program description, work plan and program evaluation shall be submitted exclusively to Oklahoma Medicaid	PM
The QAPI program description shall include:	
Guiding philosophy and strategic direction for the QAPI program (letter a)	NM
Communication mechanism between the CE's executive management team and the QIC (letter b)	PM
QAPI program committee structure, including specific committees, committee representatives and why the representatives were chosen, identification and inclusion of Local Oklahoma Provider Organization members (letter c)	PM
Roles of SoonerSelect Dental Enrollee and Provider representatives on the QIC (letter d)	PM
Process for selecting and directing task forces or subcommittees (letter e)	NM
Process to report findings to appropriate executive leadership, staff, and departments within the CE's organization, as well as relevant stakeholders, such as Participating Providers (letter i)	PM
Methodology for which and how many Participating Providers to profile and how measures for profiling will be selected (letter j)	NM
Process for selecting evaluation and study design procedures (letter k)	NM
How data will be collected and used (letter l)	PM
*Ratings indicate whether CE QAPI documentation included the required elements from the SoonerSelect contract section, Quality Assessment and Performance Improvement, Subsection, QAPI Documentation. Partially Met (PM) indicates where the CE included some, but not all, of the required content, and Not Met (NM) indicates the CE did not include required content.	

Table 5.2. 2025 QAPI Review Requirements Less Than Fully Met - LIBERTY	
SoonerSelect QAPI Documentation Contract Requirement (Continued)	**Rating***
1.10.3.3 QAPI Documentation	
How the CE will ensure that QAPI program activities take place throughout the CE's organization and the procedures to document results (letter m)	PM
The Health Management Information systems that will support the QAPI program (letter n)	NM
Process for reporting findings to OHCA, Participating Providers, and Enrollees (letter o)	PM
Process for annual program evaluation (letter p)	PM
The annual QAPI program evaluation shall include:	
Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, OHCA scorecards, and other performance measure results (letter f)	NM
*Ratings indicate whether CE QAPI documentation included the required elements from the SoonerSelect contract section, Quality Assessment and Performance Improvement, Subsection, QAPI Documentation. Partially Met (PM) indicates where the CE included some, but not all, of the required content, and Not Met (NM) indicates the CE did not include required content.	

- LIBERTY'S *Program Description* did not include the following:
  - The tools and/or processes used to assess the quality and appropriateness of care provided to enrollees with special health care needs.
  - Identification of specific stakeholder groups or a description of the processes the QIC uses to distribute findings to stakeholders.
  - An explanation of the process for reporting findings to the executive management team.
  - Market-specific and operational detail to clearly illustrate how the QAPI program is implemented and functions on a day-to-day basis.
  - Explanation of LIBERTY's guiding philosophy or strategic direction of the QAPI program.
  - The methodology explaining the selection criteria for provider profiling, including the number of participating providers to profile and how the measures for profiling will be selected.
  - A description of the process to collect data, including specific criteria and activities, involved in selecting evaluation and study design procedures.
  - An explanation of how LIBERTY ensures these QAPI program activities take place throughout the organization.
- The following was noted in LIBERTY'S *Program Description:*
  - The subcommittees were noted to be organized around specific programs and operate under individual charters, however, there was no explanation on how the task forces or subcommittees are selected, directed, or structured.
  - LIBERTY described how the CE's executive management team communicates policy and regulatory updates to the quality department, but it did not outline the communication process between the QIC and the CE's executive management team.
  - The roster of QIC members did not identify the members of the subcommittees or describe the criteria used to select them.
  - The types of data collected and the departments involved in validating and reviewing information was described, however, there was no explanation of how data are collected or how those data are systematically used to support QAPI activities.
  - LIBERTY indicated that the Managed Information System is used to aggregate utilization, enrollment, and claims data, but did not identify the specific systems used, their functionalities, or how they enable QAPI activities beyond basic data aggregation.
  - LIBERTY mentioned creating a comprehensive QAPI report for OHCA and producing audience-specific summaries for participating providers and members; however, the process for disseminating information to members and providers was not described.

- LIBERTY described its process for completing the *Work Plan* but did not explain how the *Program Description*, *Work Plan*, and annual *QAPI Program Evaluation* interact to inform the comprehensive assessment of the QAPI program.
- LIBERTY's annual *QAPI Evaluation* included some internal metrics, but benchmark use was inconsistent. While some measures used contractual standards as benchmarks, others did not identify a benchmark or its source. CAHPS Survey results were not included in the annual *QAPI Program Evaluation*.

Aetna

Table 5.3 lists the SoonerSelect QAPI Documentation contract requirements that Aetna is less than fully met.

Table 5.3. 2025 QAPI Review Requirements Less Than Fully Met - Aetna	
SoonerSelect QAPI Documentation Contract Requirement	**Rating***
QAPI Program Description shall	
Describe the mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs and related findings. (1.11.3.1 QAPI Documentation)	PM
Describe the methodology for which and how many Participating Providers to profile and how measures for profiling will be selected. (1.11.3.3 QAPI Documentation)	PM
*Ratings indicate whether CE QAPI documentation included the required elements from the SoonerSelect contract section, Quality Assessment and Performance Improvement, Subsection, QAPI Documentation. Partially Met (PM) indicates where the CE included some, but not all, of the required content, and Not Met (NM) indicates the CE did not include required content.	

- Aetna did not provide details of the mechanisms used to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
- Aetna outlined the objectives and provided a high-level overview of the participating provider profile selection process but did not detail the selection methodology in the *Program Description*.

OCH and OCH-CSP

Table 5.4 lists the SoonerSelect QAPI Documentation contract requirements that OCH and OCH-CSP is less than fully met.

Table 5.4. 2025 QAPI Review Requirements Less Than Fully Met – OCH and OCH-CSP	
SoonerSelect QAPI Documentation Contract Requirement	**Rating***
QAPI Program Description shall	
Details and discusses the data indicators and performance measures to be used (1.11.3.1 QAPI Program)	PM
Describe the methodology for which and how many Participating Providers to profile and how measures for profiling will be selected (1.11.3.3 QAPI Documentation)	PM
*Ratings indicate whether CE QAPI documentation included the required elements from the SoonerSelect contract section, Quality Assessment and Performance Improvement, Subsection, QAPI Documentation. Partially Met (PM) indicates where the CE included some, but not all, of the required content, and Not Met (NM) indicates the CE did not include required content.	

- OCH and OCH-CSP outlined the processes used to monitor quality, including the use of dashboards, scorecards, baseline analyses, and alignment with HEDIS, CAHPS, CMS, and OHCA measures. However, the *Program Description* did not include rates or baselines for the measures described.
- OCH and OCH-CSP provided a general description of their approach to selecting participating providers for profiling and identifying performance measures; however, they did not describe the selection process or how many providers will be profiled.

Humana

Humana was fully compliant with all requirements for the 2025 review.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

As the CEs' QAPI programs and documentation continue to be in development, KFMC did not identify strengths during this review.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

Common Among the CEs

The review identified several opportunities for improving quality, timeliness, and access to health care services that were common among three or more of the CEs.

- Performance measurement baselines and benchmarks were incomplete in the QAPI documents although reference to HEDIS, CAHPS, or internal metrics without reporting associated rates, baselines, benchmark sources, or timelines for availability (DentaQuest, LIBERTY, OCH and OCH-CSP).
- Provider profiling and measure-selection methodologies lack sufficient operational detail. Processes are described at a high level without standardized, systematic criteria for which/how many providers to profile and/ or how measures are chosen (LIBERTY, Aetna, OCH and OCH-CSP).
- Operationalization of the QAPI program is under-described. Day-to-day implementation, CE-specific quality improvement initiatives/activities, and how the program functions across the organization are not clearly documented (DentaQuest, LIBERTY, OCH and OCH-CSP).
- Data management and performance monitoring processes need greater specificity. The processes for collecting, validating, and using to drive QAPI activities is not consistently described (LIBERTY, Aetna, OCH and OCH-CSP).

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

During the 2025 review, KFMC assessed the degree to which each CE addressed the 2024 EQRO recommendations. For the detailed assessments, see Appendix D.

- DentaQuest: Of the 8 recommendations made in 2024, 5 were fully addressed and 3 were partially addressed in 2025.
- LIBERTY: Of the 6 recommendations made in 2024, 1 was fully addressed, 2 were partially addressed, and 3 were not addressed in 2025.
- Aetna: Of the 6 recommendations made in 2024, all were fully addressed in 2025.
- Humana: Of the 7 recommendations made in 2024, all were fully addressed in 2025.
- OCH: Of the 6 recommendations made in 2024, 4 were fully addressed and 2 were partially addressed in 2025.
- OCH-CSP: Of the 7 recommendations made in 2024, 4 were fully addressed and 3 were partially addressed in 2025.

Recommendations for Quality Improvement

DentaQuest, LIBERTY, Aetna, Humana, OCH, and OCH-CSP

Based on the areas identified for improvement, KFMC made one recommendation for DentaQuest, seventeen recommendations for LIBERTY, two recommendations for Aetna, OCH, and OCH-CSP (see Appendix C for CE-specific details).

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6. Network Adequacy Validation

Background/Objectives

SoonerSelect CEs must maintain sufficient provider networks to deliver timely and accessible care to their members across the continuum of services. The contracts between OHCA and the SoonerSelect CEs specify requirements for provider directory fields that are to be accurate and kept up-to-date. In 2025, KFMC validated data and methods used to assess and report, or to reflect (i.e., provider directories), CE network adequacy.

KFMC focused the Network Adequacy Validation on assessing the accuracy and completeness of the provider directories and validating the November 2025 CE Network Adequacy Reports. This focus is in line with the Medicaid and CHIP Managed Care Access, Finance, and Quality, Final Rule, which requires online provider directories to be validated to ensure accurate, up-to-date information. The proposed rule stipulates the verification of four pieces of data: active network status, street address, telephone number, and whether the provider is accepting new enrollees. CMS states in the proposed rule, "We believe these are the most critical pieces of information that enrollees rely on when seeking network provider information. Inaccuracies in this information can have a tremendously detrimental effect on enrollees' ability to access care since finding providers that are not in the managed care plan's network, have inaccurate addresses and phone numbers, or finding providers that are not accepting new patients listed in a plan's directory can delay their ability to contact a network provider and ultimately, receive care."

Technical Methods of Data Collection and Analysis/Description of the Data Obtained

As part of Protocol 4, Activity 1, KFMC met with OHCA to define the scope of the validation for 2025. The following were considered when defining the scope of activities: the recent network build; the development of directories in Oklahoma; the requirements laid out in Protocol 4; other EQR activities; and the Medicaid and CHIP Managed Care Access, Finance, and Quality, Final Rule. For the 2025 Network Adequacy Validation activity, KFMC used the CMS EQR Protocol 4: Validation of Network Adequacy.

A full network adequacy validation could not be completed this year because KFMC did not yet have access to the State's provider tables needed to verify CE-submitted network data. KFMC will continue to work with OHCA to obtain access to the necessary provider data, and the full validation of CE provider networks will be completed in subsequent years.

The following were conducted for the 2025 Network Adequacy Validation activity.

- Directory Validation Calls
- Assessment of Provider Directories
- Validation of November 2025 Network Adequacy Reports

KFMC requested the following data sources to perform the 2025 validation activities:

- Data from SoonerSelect dental, medical, and CSP CEs
    - November 2025 Network Adequacy Report – a report from each CE submitted to the State detailing the number of participating providers and locations that SoonerSelect members have access to. This is also sometimes referred to as the SEL-1101 for medical CEs or the DEL-1101 for dental CEs.

  - Cleaned provider network file – a copy of the table used to derive the counts of unique providers and locations reported on the November 2025 Network Adequacy Report.
  - CE process documentation – instructions, technical specifications, and coding steps for creating the Provider List tab and for calculating the counts of providers and locations reported on the Network Adequacy Report. This portion of the data from the CEs may be outdated due to the timing of KFMC's initial data request and the format change for the Network Adequacy Report described in Activity 1 above.
- Data from the State
  - State provider table – a copy of State records of provider data as of December 2025 were provided to KFMC by the State for EQR activities. Since this table was dated slightly later than the November 2025 Network Adequacy Reports, slight discrepancies between these data and the data from the CEs is expected.
- Other EQR activities
  - 2024 ISCA Reports and related documentation – ISCAs are conducted biannually to collect information to validate the capabilities of the CEs' information systems, processes, and data.
- Data from Directory Validation Calls conducted by KFMC

Directory Validation Calls

The primary method for validation of the CEs' online provider directories was to call a random sample of phone numbers and have the call recipient confirm basic directory information. To simulate the SoonerSelect member experience of calling a provider's office, for each phone number on a CE's provider list, one service location was randomly selected to represent the phone number. If the phone number was selected to be called, the caller would ask for information on up to three practitioners contracted with the same CE.

Since the dental CEs had fewer phone numbers in the sample frames than the medical and CSP CEs, records were selected for Primary Care Dentists (PCDs) before PCPs. Because Oklahoma Complete Health used the same provider network for its medical and CSP plans, the same sample frame and sample were used for both.

For each CE, a sample of 150 phone numbers was randomly selected from the sample frame. In all, 750 phone numbers were selected, representing 1,332 providers. Phone numbers were selected once (within a CE's sample and across all CEs' samples) to reduce both provider abrasion and the potential for the results to over-represent larger practices with multiple providers with same phone number. However, this approach could capture the same provider practicing at different locations with different phone numbers.

KFMC's caller documented findings from each call in an application developed from specific elements regarding the objectives, requirements, and standards described throughout. Calls were first categorized according to the resulting contact type of the call (e.g., reached intended provider, reached answering machine, wrong number). Calls were classified according to the caller's ability to verify five pieces of information: valid active network status, provider type, street addresses, telephone number, and acceptance of new enrollees. See Appendix B, for additional details regarding call monitoring, data analysis, and information regarding how calls were performed and classified.

Assessment of Provider Directories

The method for validation of the CEs' provider directories was to manually review directory pages to confirm basic State-required directory information had been populated. The source data were either provided by the CEs in the form of directories in PDF file format or downloaded from the CEs' websites. KFMC reviewed each record and recorded how well the following directory fields were populated:

- Gender of provider
- Street Address
- Telephone Number
- Website or URL information
- Language Spoken
- Accepting New Patients
- Accessible Facility
- Cultural Competency Training
- Certification in Evidence Based Treatment
- Provider Type
- Specialty Type
- Provider Name

Additional details related to creating the sample frame and selecting the samples are contained in Appendix B.

Validation of November 2025 Network Adequacy Reports

Calculation of Counts of Providers and Locations

The CE provider network files and process documentation were used to confirm that the counts of providers and locations reported for November 2025 could be reproduced.

Comparison of Provider Network Files to the State's Provider Table

Following discussion between KFMC and the State, another focus for this year's validation was determined to be a comparison between the data that the CEs use for reported counts of providers and locations, and the data in the State's provider table. To assess the integrity of the data, the November 2025 Network Adequacy Report records were compared to the State's provider table records (as of December 2025). The State indicated that its data are to be the source of truth for provider data. Records were matched using a combination of some address fields (i.e., primary address number, city, state, and zip code) and National Provider Identifier (NPI) fields. Once records were matched between the provider network files and the State provider table, additional fields were compared.
A full description of the methodology is provided in Appendix B.

Conclusions Drawn from the Data

Directory Validation Calls

Calls occurred from February 2025, through March 2025. After calling was completed, a dataset was created for analysis that combined fields from the sample frame with additional fields from the call application. The additional fields described call placement (e.g., caller name, date), provider type, specific findings, and disposition of the inter-rater review. Summary tables were created that included counts of records, levels of evaluation criteria met, percentages of totals within each category, and counts and percentages by contact type (e.g., all records leading to answering machine recordings).

Calls were categorized according to the resulting contact type of the call (e.g., reached intended provider, reached answering machine, wrong number), then according to the level of quality.

Call Results by Contact Type

The distribution of results for calls are displayed in Table 1 by contact type and CE. Of the 1,332 calls made to providers listed in the CEs directories, less than half reached the intended provider's office (420 calls, 32% of calls). A fifth of the calls resulted in reaching an unidentified voice recording or no answer (166 calls, 20% of calls). Many calls led to a confirmed wrong number or a disconnected line (480 calls, 36% of calls.)

Table 6.1. Calls by Contact Type

Contact Type	ABH		HHH		OCH		DentaQuest		LIBERTY	
Provider Type	Records		Records		Records		Records		Records	
	229		242		265		293		303	
Intended Provider or Intended Provider's Voice Recording	70	31%	92	38%	139	52%	119	41%	166	55%
Voice Recording without All Information Listed or No Answer	55	24%	55	23%	38	14%	52	18%	66	22%
Wrong Number or Disconnected Line	104	45%	95	39%	88	33%	122	41%	71	23%

Results by CE are as follows for calls reaching the intended provider.

- For Aetna, only 31% (70) reached the intended provider.
- For Humana, only 38% (92) reached the intended provider.
- For OCH, 52% (139) reached the intended provider.
- For DentaQuest, 41% (119) reached the intended provider.
- For LIBERTY, 55% (166) reached the intended provider.

Overall percentages of total calls that reached the intended provider are displayed below by CE.

- For Aetna, 12% (70 of 586) reached the intended provider.
- For Humana, 16% (92 of 586) reached the intended provider.
- For OCH, 24% (139 of 586) reached the intended provider.
- For DentaQuest, 20% (119 of 586) reached the intended provider.
- For LIBERTY, 28% (166 of 586) reached the intended provider.

Standards for Directory Validation

The following standards were created by KFMC to assess directory record outcomes:

- **Pass** – Records where calls to the listed telephone number to assess valid active network status, provider type, street address, telephone number, and acceptance of new enrollees was confirmed by speaking with an individual representing the provider.
- **Partial Pass** – Records where calls to the listed telephone number resulted in KFMC's caller not having an opportunity to verify all data. Partial verification may have occurred when a voice mail confirmed KFMC had reached the correct practice and provider, but no respondent was available to answer further questions. This category also includes instances where a respondent confirmed some information but then ended the call.

- **Fail** – Records where calls to the listed telephone number resulted in a confirmed Wrong Number or a Disconnected Number, or when the person answering the phone provided information that contradicted the information listed in the directory. Confirmed Wrong Numbers are categorized as such when either an individual or a voice recording identifies an incorrect business name or individual as the party reached. In several instances, the recording or person reached indicated that the telephone number dialed was for the billing department and explicitly stated that this was the incorrect number for scheduling. In other cases, KFMC callers were connected to the correct provider's scheduling department but the individual answering the phone provided information that contradicted the information listed in the directory.
- **Unable to Rate –** Records where calls to the listed telephone number were never answered or when calls reached a voice message that did not provide identifying information about the provider or practice (did not state practice, provider name, etc.) For example, several voice messages simply stated: "We are unable to take your call at this time. Please try again later." This category also included records where callers were hung up on repeatedly. Callers made at least two attempts to reach each number.

The distribution of results by quality rating and CE are displayed in Table 6.2.

Table 6.2. Quality Ratings Results of Sampled Directory Records

Provider Type	ABH		HHH		OCH		DentaQuest		LIBERTY	
Quality Rating	Records	%	Records	%	Records	%	Records	%	Records	%
Providers	**229**		**242**		**265**		**293**		**303**	
Pass	19	8%	56	23%	77	29%	73	25%	112	31%
Partial Pass	2	<1%	0	0%	4	2%	8	3%	4	2%
Fail	153	67%	131	54%	146	55%	160	55%	115	46%
Unable to	55	24%	55	23%	38	14%	52	18%	72	21%

Directory Records Rated as Pass

Of the 1,332 practitioner records reviewed, 337 (25%) were rated as Pass.

CE records rated as Pass are as follows:

- Aetna accounted for 6% (19) of records rated as Pass.
- Humana accounted for 17% (56) of records rated as Pass.
- OCH accounted for 23% (77) of records rated as Pass.
- DentaQuest accounted for 22% (73) of records rated as Pass.
- LIBERTY accounted for 33% (112) records rated as Pass.

Directory Records Rated as Partial Pass

There were 18 out of 1,332 (1%) records rated as Partial Pass. Often, some of the questions could not be assessed due to answering machines only providing partial information.

CE records categorized as Partial Pass are as follows.

- Aetna had 2 (11% of 18) records rated as Partial Pass.
- Humana had no records rated as Partial Pass.
- OCH had 4 (22% of 18) records rated as Partial Pass.
- DentaQuest had 8 (44% of 18) records rated as Partial Pass.
- LIBERTY had 4 (22% of 18) records rated as Partial Pass.

Directory Records Rated as Fail
Of the total number of records, 705 (53%) were rated as Fail. Of these 705 records, KFMC's caller reached a confirmed wrong number for 480 (68%) records.

CE records categorized as Fail are as follows.
- Aetna had 153 (22%) records rated as Fail.
- Humana had 131 (19%) records rated as Fail.
- OCH had 146 (21%) records being rated as Fail.
- DentaQuest had 160 (23%) records rated as Fail.
- LIBERTY had 115 (16%) records being rated as Fail.

Directory Records Unable to be Rated
KFMC's caller reached an answering machine that did not provide all required information for the practice group or provider, or calls were simply not answered for 272 (20% of 1,332) practitioner records. Note that sometimes the partial information provided in the answering machine messages allowed the KFMC callers to determine that they had reached a wrong number. In such cases, the record was rated as Fail. If, however, there was not sufficient information available to rate the call, the record was categorized as Unable to be Rated.

CE records Unable to be Rates are as follows.
- Aetna had 55 (20% of 272) records that were Unable to be Rated.
- Humana had 55 (20% of 272) records that were Unable to be Rated.
- OCH had 38 (14% of 272) records that were Unable to be Rated.
- DentaQuest had 52 (19% of 272) records that were Unable to be Rated.
- LIBERTY had 72 (26% of 272) records that were Unable to be Rated.

Assessment of Provider Directories
This validation activity assessed the completeness of the CEs' online provider directories. The review of the directories occurred in December 2025. After the review was completed, a dataset was created for analysis. Summary tables were created that included descriptive statistics such as percentages of populated records within each directory field as well as numbers and percentages by provider type.

Though the OHCA contracts do not specify thresholds for directory completeness, KFMC found that certain fields were almost always complete for all CEs while other fields were rarely or never complete. In the tables below, the results of KFMC's assessment of directory field completeness are grouped into three categories: Fields Mostly Populated, Fields Sometimes Populated, and Fields Rarely Populated.

For both individual practices as well as group practices, Table 6.3 shows all CEs fully populated the Provider Name, Provider Type, and Provider Specialty fields. For Humana, there appear to be duplicate records included in their Other Health Care Providers directory pages. Some providers found in the Other Health Care Providers section were found in the Specialist and PCP sections as well. For this review, KFMC credited all pharmacies with populating the Provider Specialty field. The Street Address and Telephone Number fields were also well populated by all CEs.

Table 6.3. Directory Review Results – Percentage of Records with Fields Mostly Populated						
Provider Type and Fields Assessed	**DentaQ.**	**LIBERTY**	**Aetna**	**Humana**	**OCH**	**OCH-CSP**
Individuals						
Number of Providers	190	664	304	221	165	162
Provider Name	100%	100%	100%	100%	100%	100%
Provider Type	100%	100%	100%	100%	100%	100%
Provider Specialty	100%	100%	97%	100%	100%	100%
Street Address	100%	100%	100%	99%	100%	98%
Telephone Number	100%	100%	100%	99%	100%	99%
Groups or Facilities						
Number of Providers		128	152	310	160	155
Provider Name		100%	100%	100%	100%	100%
Provider Type		100%	100%	100%	100%	100%
Provider Specialty		100%	95%	100%	89%	89%
Street Address		100%	100%	98%	100%	99%
Telephone Number		100%	100%	100%	100%	100%
Note: The DentaQuest directory only included individual providers, not specific groups or facilities. See Appendix B.						

Regarding Fields Sometimes Populated, Table 4 shows the completion rates for the Provider Gender, Accommodations for Persons with Disabilities, Languages Available, and Accepting New Patients fields. Except for the Accepting New Patients field, these fields were well populated by DentaQuest. LIBERTY populated all fields displayed in Table 6.4 at levels above 95%.

Table 6.4. Directory Review Results – Percentage of Records with Fields Sometimes Populated						
Provider Type and Fields Assessed	**DentaQ.**	**LIBERTY**	**Aetna**	**Humana**	**OCH**	**OCH-CSP**
Individuals						
Number of Providers	190	664	304	221	165	162
Provider Gender	0%	96%	82%	96%	0%	0%
Accommodations for Persons with Disabilities	100%	100%	74%	96%	0%	0%
Languages Available	100%	96%	11%	45%	15%	13%
Accepting New Patients	0%	100%	97%	100%	99%	98%
Groups or Facilities						
Number of Providers		128	152	310	160	155
Provider Gender						
Accommodations for Persons with Disabilities		100%	72%	46%	0%	0%
Languages Available		99%	11%	23%	0%	0%
Accepting New Patients		100%	30%	100%	0%	4%
Note: The DentaQuest directory only included individual providers, not specific groups or facilities. See Appendix B.						

Among the medical CEs, only Aetna and Humana populated the fields of Gender or Accommodations for Persons with Disabilities. Both OCH and OCH-CSP directories list all handicap accessibility fields as “Details Pending.” Incorrect or absent information related to accessible facilities impacts access.

Of the medical CEs, none populated the field of Languages Available at 100% for the records reviewed. For all CEs, the Accepting New Patients field is well populated for individuals but not well populated for

groups or facilities. Humana's directory noted that all providers listed in their directory can be assumed to be accepting new patients "unless otherwise noted."

Fields Rarely Populated is displayed in Table 6.5. The Website URL, Completion of Cultural Competency Training, and Certification in Evidence Based Treatment directory fields were populated at very low levels for most CEs. No CE populated the Website URL field above 40%. No records reviewed for DentaQuest showed the Website URL field to be populated. Only LIBERTY, Aetna, and Humana occasionally populated the Website URL field for Individual Providers (if a CE populated the Website URL field with any web address associated with the provider or group in question, KFMC credited the CE with completing this field). No CE populated the Cultural Competency field above 25%.

Table 6.5. Directory Review Results – Percentage of Records with Fields Rarely Populated

Provider Type and Fields Assessed	DentaQ.	LIBERTY	Aetna	Humana	OCH	OCH-CSP
Individuals						
Number of Providers	190	664	304	221	165	162
Website URL	0%	39%	30%	9%	0%	0%
Completion of Cultural Competency Training	0%	0%	18%	25%	4%	3%
Certification in Evidence Based Treatment	0%	1%	100%	100%	13%	14%
Groups or Facilities						
Number of Providers		128	152	310	160	155
Website URL		29%	40%	3%	19%	12%
Completion of Cultural Competency Training		0%	0%	10%	1%	0%
Certification in Evidence Based Treatment						

Note: The DentaQuest directory only included individual providers, not specific groups or facilities. See Appendix B.

Validation of November 2025 Network Adequacy Reports

This validation activity assessed the accuracy and completeness of the CEs' Network Adequacy Reports by comparing the data used to derive the reported counts against the State's provider data. Data expected by KFMC to be comparable included addresses, provider types, and specialties. In addition to verifying specialty codes, the specialty category for providers was considered, that is, the specialty category that a provider would be counted under on the Network Adequacy Report. A single category can include multiple specialty codes (e.g., specialty codes 312 and 550 are in the cardiology category), thus verifying specialty category is less strict (sometimes substantially so) than verifying specialty code. The network provider table files used as source data for the November 2025 Network Adequacy Report were compared to the State's provider table (as of December 2025).

Counts of Unique Providers and Locations

Documentation submitted by Aetna in October 2025 appeared to apply to the previous reporting template. Based on a comparison of counts from prior reports and the counts generated using the updated template, the methods for counting providers and locations appeared to remain unchanged. The documentation indicated that provider counts were based on the number of provider records within each provider group; however, no definition was provided for what constituted a provider group. Based on the data provided, it appeared that the grouping corresponded to the specialty category assigned to each provider for the Network Adequacy Report. When grouping records by county in addition to provider group, the provider counts calculated by KFMC generally matched those reported

by Aetna. After excluding categories in which provider counts were zero, KFMC was unable to reproduce 29 of the 1,699 non-zero reported provider counts. For these mismatches, KFMC's calculated counts were consistently higher than those reported by Aetna. In some categories where Aetna reported zero providers, KFMC identified more than zero. These discrepancies suggest that additional exclusion criteria may have been applied by Aetna that were not documented or available for KFMC's review.

Technical specifications used by Aetna state that provider "location counts are based on distinct latitude and longitude coordinates." However, the provider file submitted did not include latitude and longitude fields. Counts based on distinct address fields should have yielded comparable results, but the counts reported by Aetna were inconsistent with counts derived from distinct addresses. For example, Aetna reported 1,054 for Adult Mental Health provider locations for Adair County, but 11 distinct addresses remained after cleaning; the reported count was close to a count of provider records (1,068) rather than distinct address fields. These discrepancies indicate that Aetna did not count provider locations as documented, and the basis for the reported counts is unclear. Therefore, KFMC does not consider the location counts reported by Aetna to be valid.

A significant issue that KFMC noted was that Aetna did not include county-level counts of pharmacy providers, despite those counts being required. This issue was also identified with Humana's reported county-level pharmacy counts.

Humana submitted documentation which stated that providers were counted based on distinct NPIs in a given county on the Network Adequacy Report. The documentation did not appear to be relevant for the updated Network Adequacy Reporting template. KFMC attempted to reproduce the reported counts using the methods described. The network provider file submitted by Humana did not include an identifier that clearly linked a provider record to its corresponding category on the Network Adequacy Report. The only potentially relevant column included categories that are not used on the Network Adequacy Report; therefore, KFMC cross walked the Oklahoma specialty code provided by Humana to their corresponding specialty categories using a state-provided crosswalk.

Using the network provider table submitted for the November 2025 Network Adequacy Report, counts of providers were reproduced for some specialty categories, but significant discrepancies were identified for others. For Cleveland County, KFMC was able to reproduce the reported count of locations, but the number of providers reported by Humana (111) far exceeded the number of providers calculated by KFMC (48). Similar discrepancies were observed for counts of PCPs and mental health providers. Counts of locations calculated by KFMC generally matched counts reported by Humana.

Humana's initial submission included a provider network table aligned with the August 2025 Network Adequacy Report, and KFMC was able to reproduce the corresponding reported counts from that file. Documentation of the process for preparing data and counting providers and locations using standardized mapping software for the Network Adequacy Report was provided by OCH and OCH-CSP. Only providers participating in the OCH or OCH-CSP networks are included on the reports. Reports are submitted separately for OCH and OCH-CSP. Additional data cleaning of provider records includes removing records for hospital-based providers, records for providers that failed credentialing, and records with an invalid address. OCH and OCH-CSP only include providers listed as active on the provider master list sent by OHCA in their reports. The method for determining the ages served variable was described. For providers with a value listed, those that serve only members 21 and older are counted as

serving adults, while those that serve only members under 21 are counted as a pediatric provider. Those that serve any overlap of these two ranges and those with no data regarding the ages that the provider serves are counted as serving both adult and pediatric members.

Counts of providers, stratified by specialty code and county, are determined from distinct NPIs. OCH and OCH-CSP stated that practitioners are only to be counted at locations in which they are providing services. This is determined via provider rosters sent to OCH and OCH-CSP by their providers. The documentation stated that location counts are based on “unique locations by specialty and service area.” KFMC attempted to match the number of locations by counting distinct addresses, stratified by specialty and county. Most counts of providers and locations could be reproduced; however, zero providers and locations were reported for Le Flore County, but there were many provider records with this county included in the provider network files that were submitted. There were also small discrepancies in counts of providers and locations for some mental health, therapist, and primary care providers for a few counties.

The documentation submitted by LIBERTY referenced Florida Medicaid, though it was similar to documentation submitted for KFMC’s 2024 Network Adequacy Validation. The documentation provided an outline of how member and provider data are prepared prior to being loaded into standardized mapping software used for reporting.

KFMC attempted to use the specialty field, in combination with the NPI and address fields from the provider network table that was submitted, to reproduce counts on LIBERTY’s November 2025 Network Adequacy Report. However, there were only three distinct specialties listed, dentist, pediatric dentist, and general practitioner specializing in pediatric dentistry. There are several additional specialties in the Network Adequacy Report for which LIBERTY reported non-zero counts of providers. Several Oklahoma counties which LIBERTY reported had dentists were not represented in the network provider file (e.g., Adair County). Additionally, two specialties (general dentistry oral pathologist and general dentistry prosthodontist) did not have provider or location counts populated on the report. Due to these inconsistencies, KFMC determined that the counts of providers and locations reported by LIBERTY are not valid.

DentaQuest did not submit a provider network file for validation and KFMC was unable to complete required validation activities for this CE.

Table 6.6 describes the percentage of records from the network provider tables that matched on NPI to at least one record in the State’s provider table. Generally, there were very few records for which an NPI could not be found in the State’s provider table.

Table 6.6. Records that matched on NPI to the State's Provider Table		
LIBERTY	**N**	**%**
Records under evaluation	1,119	100%
Minus – No Match on NPI	5	<1%
CE Records that Matched on NPI to State records	**1,114**	**>99%**
Aetna	**N**	**%**
Records under evaluation	1,013,829	100%
Minus – No Match on NPI	1,002	<1%
CE Records that Matched on NPI to State records	**1,012,827**	**>99%**
Humana	**N**	**%**
Records under evaluation	147,130	100%
Minus – No Match on NPI	349	<1%
CE Records that Matched on NPI to State records	**146,781**	**>99%**
OCH	**N**	**%**
Records under evaluation	52,080	100%
Minus – No Match on NPI	37	<1%
CE Records that Matched on NPI to State records	**52,043**	**>99%**
OCH-CSP	**N**	**%**
Records under evaluation	51,967	100%
Minus – No Match on NPI	35	<1%
CE Records that Matched on NPI to State records	**51,932**	**>99%**

Source: CE Provider Network tables for November 2025 submitted December 2025, Oklahoma Provider Network table as of December 2025.

Matching Records for Individual Providers

KFMC stratified the results of matching on provider specialty information and provider address information by whether the NPI for the provider was listed as a business NPI or individual NPI. Results are presented for records of individuals that matched on location information in Table 6.7. For Humana, OCH, and OCH-CSP, a substantial number of records matched on address information, but not provider type code. All CEs had a large portion of records that were unable to be matched on the address fields or provider type codes that were checked.

Table 6.7. Locations Verified Using NPI – Individuals		
LIBERTY	**N**	**%**
Records under evaluation	1,114	100%
Minus – No Match on location	745	67%
Minus – Matched on location, not provider type code*		
CE Records Fully Matched to State records	**369**	**33%**
Aetna	**N**	**%**
Records under evaluation	997,892	100%
Minus – No Match on location	848,139	85%
Minus – Matched on location, not provider type code*		
CE Records Fully Matched to State records	**149,753**	**15%**
Humana	**N**	**%**
Records under evaluation	107,958	100%
Minus – No Match on location and provider type code	61,126	57%
Minus – Matched on location, not provider type code	5,069	5%
CE Records Fully Matched to State records	**41,763**	**39%**

Source: CE Provider Network tables for November 2025 submitted December 2025 Oklahoma Provider Network table as of December 2025.
*LIBERTY and Aetna did not include provider type codes in the data table that they submitted, so provider type codes for their providers could not be validated. Thus, this aspect of the validation is less rigorous for LIBERTY and Aetna than the other CEs.

Table 6.7. Locations Verified Using NPI – Individuals (Continued)		
OCH	**N**	**%**
Records under evaluation	45,712	100%
Minus – No Match on location and provider type code	25,442	56%
Minus – Matched on location, not provider type code	11,243	25%
CE Records Fully Matched to State records	**9,027**	**20%**
OCH-CSP	**N**	**%**
Records under evaluation	45,588	100%
Minus – No Match on location and provider type code	25,383	56%
Minus – Matched on location, not provider type code	11,116	24%
CE Records Fully Matched to State records	**9,089**	**20%**

Source: CE Provider Network tables for November 2025 submitted December 2025 Oklahoma Provider Network table as of December 2025.
*LIBERTY and Aetna did not include provider type codes in the data table that they submitted, so provider type codes for their providers could not be validated. Thus, this aspect of the validation is less rigorous for LIBERTY and Aetna than the other CEs.

Of LIBERTY's records for individual providers, 33% matched on primary address number, city, state, and ZIP code to a State record.

Of Aetna's records for individual providers, 15% matched on primary address number, city, state, and ZIP code to a State record.

Of Humana's records for individual providers, 39% matched on primary address number, city, state, ZIP code, and provider type to a State record.

Of OCH's and OCH-CSP's records for individual providers, 20% matched on primary address number, city, state, ZIP code, and provider type to a State record.

Results for records of individuals that matched on specialty information are shown in Table 6.8. Generally, the results indicated alignment between the data from the State's provider table and the CEs' network provider files. A substantial portion of records for Humana, OCH, and OCH-CSP were only able to be matched on specialty category, not specialty code.

Table 6.8. Specialties Verified Using NPI – Individuals		
Aetna	**N**	**%**
Records with specialties under evaluation	997,892	100%
Minus – Not Matched on Specialty Category	32	<1%
CE Records with Specialties Verified	**997,860**	**>99%**
Verified Specialty Code and Category*		
Verified Specialty Category, not Code	997,860	100%
Humana	**N**	**%**
Records with specialties under evaluation	107,958	100%
Minus – Matched Neither Specialty Code or Category	3,039	3%
CE Records with Specialties Verified	**104,919**	**97%**
Full Matches (Verified Specialty Code and Category)	87,024	83%
Verified Specialty Category, not Code	17,895	17%

Source: CE Provider Network tables for November 2025 submitted December 2025, Oklahoma Provider Network table as of December 2025.
*Aetna did not include provider specialty codes in the data table that they submitted, so specialty codes for their providers could not be validated. Thus, this aspect of the validation is less rigorous for Aetna than the other CEs.

Table 6.8. Specialties Verified Using NPI – Individuals (Continued)		
OCH	**N**	**%**
Records with specialties under evaluation	45,712	100%
Minus – Matched Neither Specialty Code or Category	901	2%
CE Records with Specialties Verified	**44,811**	**98%**
Full Matches (Verified Specialty Code and Category)	36,733	82%
Verified Specialty Category, not Code	8,081	18%
OCH-CSP	**N**	**%**
Records with specialties under evaluation	45,588	100%
Minus – Matched Neither Specialty Code or Category	896	2%
CE Records with Specialties Verified	**44,692**	**98%**
Full Matches (Verified Specialty Code and Category)	36,720	82%
Verified Specialty Category, not Code	7,972	18%

Source: CE Provider Network tables for November 2025 submitted December 2025, Oklahoma Provider Network table as of December 2025.
*Aetna did not include provider specialty codes in the data table that they submitted, so specialty codes for their providers could not be validated. Thus, this aspect of the validation is less rigorous for Aetna than the other CEs.

Matching Records for Business Providers

Counts of November 2025 Network Adequacy Report records for business providers, stratified by CE, are shown in Table 6.9. The number and percentage of those records that matched to the State's provider table on address and provider type information are shown.

Table 6.9. Locations Verified Using NPI – Businesses		
Aetna	**N**	**%**
Records under evaluation	14,935	100%
Minus – No Match on location	95	<1%
Minus – Matched on location, not provider type code*		
CE Records Fully Matched to State records	**14,840**	**>99%**
Humana	**N**	**%**
Records under evaluation	38,823	100%
Minus – No Match on location and provider type code	10,415	27%
Minus – Matched on location, not provider type code	22,712	59%
CE Records Fully Matched to State records	**5,696**	**15%**
OCH	**N**	**%**
Records under evaluation	6,331	100%
Minus – No Match on location and provider type code	1,813	29%
Minus – Matched on location, not provider type code	534	8%
CE Records Fully Matched to State records	**3,984**	**63%**
OCH-CSP	**N**	**%**
Records under evaluation	6,344	100%
Minus – No Match on location and provider type code	1,787	28%
Minus – Matched on location, not provider type code	536	8%
CE Records Fully Matched to State records	**4,021**	**63%**

Source: CE Provider Network tables for November 2025 submitted December 2025 Oklahoma Provider Network table as of December 2025.
*Aetna did not include provider type codes in the data table that they submitted, so provider type codes for their providers could not be validated. Thus, this aspect of the validation is less rigorous for Aetna than the other CEs.

Of Aetna's records for business providers, over 99% were able to be matched to a record in the State's provider table on primary address number, city, state, and ZIP code. Although most records for Aetna were considered fully matched, recall that provider type codes were not validated, so this aspect of the analysis was not as rigorous as intended.

Of Humana's records for business providers, 15% were fully matched to a record in the State's provider table on primary address number, city, state, ZIP code, and provider type. An additional 59% of records matched on primary address number, city, state, and ZIP code.

Of OCH's and OCH-CSP's records for business providers, 63% were fully matched to a record in the State's provider table. An additional 8% of records matched on primary address number, city, state, and ZIP code.

Results for records of businesses that matched on specialty information are shown in Table 6.10. For Aetna, OCH, and OCH-CSP, the results indicated alignment between the data from the State's provider table and the CEs' network provider files. For Humana, a majority of records (71%) were validated.

Table 6.10. Specialties Verified Using NPI – Businesses

Aetna	N	%
Records with specialties under evaluation	14,935	100%
Minus – Matched Neither Specialty Code or Category	9	<1%
CE Records with Specialties Verified	**14,926**	**>99%**
Full Matches (Verified Specialty Code and Category)*		
Verified Specialty Category, not Code	14,926	100%
Humana	**N**	**%**
Records with specialties under evaluation	38,823	100%
Minus – Matched Neither Specialty Code or Category	11,089	29%
CE Records with Specialties Verified	**27,734**	**71%**
Full Matches (Verified Specialty Code and Category)	3,077	11%
Verified Specialty Category, not Code	24,657	89%
OCH	**N**	**%**
Records with specialties under evaluation	6,331	100%
Minus – Matched Neither Specialty Code or Category	575	9%
CE Records with Specialties Verified	**5,756**	**91%**
Full Matches (Verified Specialty Code and Category)	4,147	72%
Verified Specialty Category, not Code	1,609	28%
OCH-CSP	**N**	**%**
Records with specialties under evaluation	6,344	100%
Minus – Matched Neither Specialty Code or Category	563	9%
CE Records with Specialties Verified	**5,781**	**91%**
Full Matches (Verified Specialty Code and Category)	4,156	72%
Verified Specialty Category, not Code	1,625	28%

Source: CE Provider Network tables for November 2025 submitted December 2025, Oklahoma Provider Network table as of December 2025.
*Aetna did not include provider specialty codes in the data table that they submitted, so specialty codes for their providers could not be validated. Thus, this aspect of the validation is less rigorous for Aetna than the other CEs.

Limitations

- The comparison of provider network files to the State's provider table identified discrepancies within the data. NPIs are specific to people or businesses, but not to service locations. Therefore, matching provider network records to State records using NPI returned results for multiple service locations. Consequently, issues identified through NPIs may be understated.
- Effective and end dates were not considered when determining whether a record in a CE's network provider table matched a State record; therefore, issues matching on provider specialty information may also be understated.

- KFMC's data request was not fulfilled by DentaQuest. As such, KFMC was unable to complete the required validation activities for this CE.
- KFMC reviewed the CE's PDF directories for this year's validation efforts. More detailed information may be available on the CE's websites in their online provider directories.
- KFMC received a modified version of the Provider Master List that is sent to the CEs on a weekly basis. It is possible that not all active provider locations were captured in the file received.
- The street address fields may be subject to data cleaning and standardization; thus, they were not suitable for matching to State records. To account for this, records were compared on the primary address number instead of street address fields.

Conclusions

Directory Validation Calls

Each CE has the opportunity for improvement regarding their online directories. In all cases the percentage of Failing records far exceeded the percentage of records rated as Pass within each CE. OCH and LIBERTY had a higher proportion of calls reaching the intended providers, but still only slightly more than half. DentaQuest had less than half of the telephone numbers reaching the correct provider while Aetna and Humana had only around a third of the telephone numbers called reaching the correct provider. Incorrect provider telephone numbers may hinder members' ability to reach providers, which could affect timely access to services for certain populations.

Overall percentages of total calls that reached the intended provider are displayed below by CE.

- For Aetna, 12% (70 of 586) reached the intended provider.
- For Humana, 16% (92 of 586) reached the intended provider.
- For Oklahoma Complete Health, 24% (139 of 586) reached the intended provider.
- For DentaQuest, 20% (119 of 586) reached the intended provider.
- For LIBERTY, 28% (166 of 586) reached the intended provider.

The reasons for failure were most commonly due to confirmed wrong numbers. Other reasons for failure included wrong addresses and wrong service types. Some records resulted in multiple errors. LIBERTY had the least confirmed wrong numbers with 71 records (62% of their 115 records rated as Fail). LIBERTY had 44 (38% of 115) records rated as Fail for other reasons. Aetna had 104 records (68% of their 153 records rated as Fail) that reached a confirmed wrong number and 49 (32% of 153) records rated as Fail for other reasons. Humana had 95 records (73% of their 131 records rated as Fail) that reached a confirmed wrong number and 36 (27% of 131) records rated as Fail for other reasons. OCH had 88 records (60% of their 146 records rated as Fail) that reached a confirmed wrong number and 58 (40% of 146) records rated as Fail for other reasons. Finally, DentaQuest had 122 records (76% of their 160 records rated as Fail) that reached a confirmed wrong number and 38 (24% of 160) records rated as Fail for other reasons.

Assessment of Provider Directories

For both individual practices as well as group practices, all CEs fully populated the Provider Name, Provider Type, and Provider Specialty fields. The Street Address and Telephone Number fields were also well populated by all CEs.

Fields Sometimes Populated include Provider Gender, Accommodations for Persons with Disabilities, Languages Available, and Accepting New Patients fields. KFMC made a recommendation last year that

the CEs should populate the Accommodations for Persons with Disabilities directory field. As the CEs' contracts with OHCA call for all directory fields to be complete, the very low levels at which important fields such as Accommodations for Persons with Disabilities were populated is noteworthy.

Finally, the Certification in Evidence-Based Treatment field was not consistently populated. Though Aetna and Humana populated the Certification in Evidence Based Treatment field at 100%, no other CE populated this field at even 15%. The Aetna and Humana directories used a symbol to indicate board certification. It is unclear whether providers without the symbol could be board certified or not. Since the Certification in Evidence Based Treatment and Cultural Competency fields are required by OHCA, all CEs should work to include these fields in their directories.

Validation of November 2025 Network Adequacy Reports

The network provider table submitted by LIBERTY could not be used to reproduce counts of providers and locations on the November 2025 Network Adequacy Report. In addition, data elements from the submitted table were largely inconsistent with the State's provider data. DentaQuest did not submit the requested table; therefore, their counts and provider data could not be validated.

Even though counts of providers and locations could be reproduced for some of the specialty categories for the medical CEs, inconsistencies within the Network Adequacy Reports, and between the CEs' data and the State's data, prevented KFMC from determining the extent to which the State's access standards were met.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- The State and CEs continue working towards improving the completeness, consistency, and accuracy of provider data.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

Directory Validation Calls

KFMC found that a large portion of calls to providers resulted in a rating of "Fail." A large portion of these calls reached wrong numbers. Wrong numbers listed in provider directories limit members' ability to find providers and access care.

Assessment of Provider Directories

- CEs have not fully populated all required directory fields.

Validation of November 2025 Network Adequacy Reports

- Documentation regarding the techniques used by Aetna to calculate the number of unique locations did not appear to be accurate. Most location counts could not be reproduced for this CE.
- While counts of providers and locations were reproduced for some CEs, data integrity issues highlighted in this report limit KFMC's confidence in the accuracy of all reported counts of providers and locations.
- The unique record identifiers used by the State are not maintained by the CEs. Because the State's data serve as the source of truth, these identifiers are necessary to verify data integrity.

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

The State and CEs provided updates on the extent to which the 2024 recommendations were addressed. KFMC assessed these updates and determined all four recommendations from 2024 remain in progress. Please see Appendix D for more details.

Recommendations for Quality Improvement

1. Populate the Accommodations for Persons with Disabilities directory field at 100%.
2. Ensure that the technical specifications for the network adequacy report are explicit.
3. CEs should work together, and with the State, to ensure that providers and locations are counted consistently among all medical and the dental CEs.
4. Investigate the cause for discrepancies between CE provider directories, the State's provider data, and information reported directly by providers (e.g., identifying and correcting wrong phone numbers and address information).

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7. Quality Strategy

The Oklahoma SoonerSelect Quality Strategy includes aims, goals, and objectives to improve the health outcomes of adult and child SoonerSelect members. As stated in the Introduction, OHCA's aims for the SoonerSelect program are to: improve the health of Oklahoma Medicaid members and the health of Oklahoma communities and the State as a whole; improve care delivery through a provider-led model with emphasis on access to high-quality, person-centered, and coordinated care; improve member experience; improve provider experience; and improve financial sustainability of the Oklahoma Medicaid Program. In accordance with CFR § 438.364(a)(4), KFMC compared our findings to the SoonerSelect Quality Strategy to identify how the State can target goals and objectives, to better support improvement in the quality, timeliness, and access to health care services furnished to enrollees. Table 7.1 contains the SoonerSelect Quality Strategy aims, goals, and objectives related to findings from KFMC's EQR activities completed in the 2025-2026 reporting cycle.

Table 7.1. SoonerSelect Quality Strategy and EQR Activities

Aim 1: Improve the health of Oklahoma Medicaid members and the health of Oklahoma communities and the State as a whole

Goal 1: Promote wellness and prevention

Objective 1.1 Promote child health, development, and wellness

There are two PIPs related to this objective. The final methodologies for these PIPs were approved during this reporting cycle. Please see the PIP section of this report for more details.

- Childhood Immunization Status Combo 3 (Aetna)
- Improve Performance of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (OCH-CSP)

The EPSDT activity evaluated CE compliance with the EPSDT requirements set forth in the CE contracts, including the quality of notification and education provided to EPSDT-eligible enrollees and participating providers, and a targeted case review of prior authorizations and appeals to examine the appropriateness and timeliness of medical necessity determinations. Please see the EPSDT section of this report for more details.

The case review portion of the Compliance Review assessed CE records for compliance with the State and federal regulations related to care coordination. A requirement of the Medical and CSP CEs is to perform a health screen on all new members, including children, to identify gaps in care and the need for care coordination or care management services. Please see the Review of Compliance with Medicaid and CHIP Managed Care Regulations section of this report for more details.

Objective 1.4: Improve access to oral health care for SoonerSelect dental plan enrollees

There are two PIPs related to this objective. The final methodologies for these PIPs were approved during this reporting cycle. Please see the PIP section of this report for more details.

- Increase the Percentage of Children Receiving a Dental Visit by their First Birthday (DentaQuest)
- Improving Access to Care through Appointment Scheduling and Transportation Assistance (LIBERTY)

KFMC validated the following PIP related to improving access to oral health care for SoonerSelect dental plan enrollees.

- Increasing Preventive Services for Children (LIBERTY)
    - All three of the active interventions were implemented by LIBERTY, however, only one intervention was able to be validated.
    - LIBERTY analyzed claims data to identify priority cities and narrowed their focus to 114 cities with a below average utilization rate of 52,680 members combined.

For more details, see the Performance Improvement Project Validation section of this report.

Table 7.1. SoonerSelect Quality Strategy and EQR Activities
Aim 1: Improve the health of Oklahoma Medicaid members and the health of Oklahoma communities and the State as a whole (Continued)
Goal 2: Improve behavioral and chronic condition management
Objective 2.1: Improve behavioral health care
There are three PIPs related to this objective. The final methodologies for these PIPs were approved during this reporting cycle. Please see the PIP section of this report for more details. • Improve Rate of Follow-Up Care for Children Prescribed ADHD Medication, Initiation and Continuation Sub Measures (Aetna) • Follow-up After Hospitalizations for Mental Illness (Humana) • Improve Performance of the Follow-Up After Hospitalization for Mental Illness (FUH) (OCH and OCH-CSP) The case review portion of the Compliance Review assessed CE records for compliance with the State and federal regulations related to care coordination. A requirement of the Medical and CSP CEs is to perform a health screen on all new members to identify behavioral health concerns. As part of the review, KFMC sampled from a list of members that received at least one behavioral health service within the sample timeframe to review the CE's process for identification for care coordination or care management services and development of a care plan. Please see the Review of Compliance with Medicaid and CHIP Managed Care Regulations section of this report for more details.
Objective 2.2: Improve diabetes management
There is one PIP related to this objective. The final methodology for this PIP was approved during this reporting cycle. Please see the PIP section of this report for more details. • Comprehensive Diabetes Care (Hemoglobin HbA1c Control for Patients with Diabetes) (Humana) The case review portion of the Compliance Review assessed CE records for compliance with the State and federal regulations related to care coordination. A requirement of the Medical and CSP CEs is to perform a health screen on all new members to identify those members that need diabetes management. As part of the review, KFMC sampled from a list of members that had a diagnosis of Diabetes Mellitus Types 1 and 2, within the sample timeframe to review the CE's process for identification for care coordination or care management services and development of a care plan. Please see the Review of Compliance with Medicaid and CHIP Managed Care Regulations section of this report for more details.
Goal 3: Collaborate with community partners and other State agencies to improve population health
Objective 3.1: Address unmet health-related resource needs

There are three PIPs related to this objective. The final methodologies for these PIPs were approved during this reporting cycle. Please see the PIP section of this report for more details.
• Enhancing Oral Health Literacy Among American Indian/Alaska Native Adults: A Culturally Tailored Approach to Improve Oral Health Outcomes and Address Diabetes-Related Disparities (DentaQuest)
• Improving Social Determinants of Health (SDOH) Assessment and Referral in Plan Members (Aetna)
• Foster Care (OCH-CSP)
 	
There is one planned PIP related to this objective. Approval of the methodology is anticipated for some time in early 2026. Please see the PIP section of this report for more details.
• Increase Submissions of Notification of Pregnancy (NOP) Form (OCH)
 	
KFMC validated the following PIP related to improving access to oral health care for SoonerSelect dental plan enrollees.
• Social Needs Screening and Intervention (Humana)
    ○ Both of the active interventions were implemented by Humana, however, there was insufficient data to verify the effectiveness of the interventions.
    ○ Based on results of exploratory data analysis, Humana implemented an automated process to refer enrollees who screen positive to a Social Determinants of Health staff member who can help address identified needs.
 	
The case review portion of the Compliance Review assessed CE records for compliance with the State and federal regulations related to care coordination. A requirement of the Medical and CSP CEs is to perform a health screen on all new members to identify any health-related resources needed. Please see the Review of Compliance with Medicaid and CHIP Managed Care Regulations section of this report for more details.

Table 7.1. SoonerSelect Quality Strategy and EQR Activities
Aim 1: Improve the health of Oklahoma Medicaid members and the health of Oklahoma communities and the State as a whole (Continued)
Objective 3.5: Address obesity
There is one PIP related to this objective. The final methodology for this PIP was approved during this reporting cycle. Please see the PIP section of this report for more details. • Improve Performance of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (OCH and OCH-CSP)
Objective 3.6: Improve maternal and infant outcomes
There is one planned PIP related to this objective. Approval of the methodology is anticipated for some time in early 2026. Please see the PIP section of this report for more details. • Increase Submissions of Notification of Pregnancy (NOP) Form (OCH) The case review portion of the Compliance Review assessed CE records for compliance with the State and federal regulations related to care coordination. A requirement of the Medical and CSP CEs is to perform a health screen on all new members to identify those members that are pregnant or postpartum (up to 1 year after the end of a pregnancy). As part of the review, KFMC sampled from a list of members that had were pregnant or postpartum within the sample timeframe to review the CE's process for identification for care coordination or care management services and development of a care plan. Please see the Review of Compliance with Medicaid and CHIP Managed Care Regulations section of this report for more details.
Aim 2: Improve care delivery through a provider-led model with emphasis on access to high-quality, person-centered, and coordinated care.
Goal 4: Ensure appropriate access to care
Objective 4.1: Ensure services are available geographically **Objective 4.2:** Ensure timely access to care
The Network Adequacy Validation assessed the completeness of provider directories, validated the information in the online directories through calls to a random sample of providers, and validation of the November 2025 Network Adequacy Reports. Please see the Network Adequacy Validation section of this report for more details. There is one PIP related to this objective. The final methodology for this PIP was approved during this reporting cycle. Please see the PIP section of this report for more details. • Improving Access to Care through Transportation Appointment Scheduling and Transportation Assistance (LIBERTY)
Goal 5: Drive patient-centered, whole-person care
Objective 5.1: Address behavioral and physical health conditions
Please refer to the following sections. • Goal 2, Objective 2.1 • Goal 2, Objective 2.2 • Goal 3, Objective 3.5
Objective 5.2: Facilitate member access to appropriate care management and care coordination services
The case review portion of the Compliance Review assessed CE records for compliance with the State and federal regulations related to care coordination. A requirement of the Medical and CSP CEs is to perform a health screen on all new members to identify gaps in care and the need for care coordination or care management services. As part of the review, KFMC sampled from a list of members with specified criteria to assess the CE's process for contacting members new to the health plan and their development of individualized care plans for members identified for care coordination services. The documentation review of the Compliance Review assessed the CE's compliance to the State's requirements regarding care management and care coordination services. Please see the Review of Compliance with Medicaid and CHIP Managed Care Regulations section of this report for more details.
Objective 5.4: Reduce non-emergent ED utilization
The case review portion of the Compliance Review assessed CE records for compliance with the State and federal regulations related to care coordination. A requirement of the Medical and CSP CEs is to perform a health screen on all new members to identify Emergency Department (ED) use to identify gaps in care that could lead to a reduction in ED use. Please see the Review of Compliance with Medicaid and CHIP Managed Care Regulations section of this report for more details.

Table 7.1. SoonerSelect Quality Strategy and EQR Activities
Aim 2: Improve care delivery through a provider-led model with emphasis on access to high-quality, person-centered, and coordinated care.
Objective 5.4: Reduce non-emergent ED utilization (Continued)
The QAPI activity included a review of the CE's QAPI program description and evaluation to assess whether the CEs had a mechanism to detect overutilization of services, including ED utilization. Please see the Quality Assessment and Performance Improvement Review section of this report for more details.

EQRO Suggestions for the State

1. Continue to support the CEs throughout the PIP process, as they work with members to address health needs and improve outcomes.
2. Continue to support the CEs towards increasing the number of new members with a completed health screen.
3. Continue the assessment and improvement of member access to providers.
4. Continue to support the CEs to improve State-required performance measures and continue targeting priority measures in the QS.
5. Consider updating performance targets and baseline data, if available, for the Performance Measures listed in the Quality Strategy.

End of written report

Appendix A

SoonerSelect Program Annual External Quality Review Technical Report

2025-2026 Reporting Cycle

List of KFMC EQR Technical Reports

Table A.1. includes the list of the required and optional EQR activities described in 42 CFR 438.358 that have been completed by KFMC during the 2025-2026 reporting cycle. Included are the reports that were submitted by KFMC to the Oklahoma Health Care Authority.

Table A.1. Timeline of Review for the 2025-2026 Reporting Cycle

CE	Data Period*	Activity Period^	Final Report Name and Date
Performance Measure Validation			
DentaQuest	February – December 2024	December 2025 (Completed)	*2025 Validation of MY 2024 Performance Measures of DentaQuest*, March 3, 2026
LIBERTY			*2025 Validation of MY 2024 Performance Measures of LIBERTY*, March 3, 2026
Aetna	March – December 2024		*2025 Validation of MY 2024 Performance Measures of Aetna*, March 10, 2026
Humana			*2025 Validation of MY 2024 Performance Measures of Humana*, March 9, 2026
OCH			*2025 Validation of MY 2024 Performance Measures of OCH (Medical)*, March 9, 2026
OCH-CSP			*2025 Validation of MY 2024 Performance Measures of OCH CSP*, March 9, 2026
Performance Improvement Project Validation			
LIBERTY	July 1, 2024, to June 30, 2025	January – February 2026	*2025 Evaluation of LIBERTY, Preventive Services PIP*, March 5, 2026
Humana	April 1, 2024, to December 31, 2025	January – February 2026	*2025 Evaluation of Humana, SNS PIP*, March 16, 2026
Review of Compliance with Medicaid and CHIP Managed Care Regulations			
DentaQuest	Cases: February – July 2024 Documentation: May 2025	May – September 2025	*2025 Review of Compliance with Medicaid and CHIP Managed Care Regulations of DentaQuest*, March 31, 2026
LIBERTY		June – September 2025	*2025 Review of Compliance with Medicaid and CHIP Managed Care Regulations of LIBERTY*, March 31, 2026
Aetna	Cases: April – September 2024 Documentation: May 2025	August – November 2025	*2025 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Aetna*, March 31, 2026
Humana		September – December 2025	*2025 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Humana*, March 31, 2026
OCH and OCH-CSP		July – October 2025	*2025 Review of Compliance with Medicaid and CHIP Managed Care Regulations of OCH*, March 31, 2026

**The time frame during which data used to conduct the EQR activity were generated, reported, or maintained by the CEs, including defined measurement periods (e.g., Measurement Year 2024 for performance measures), case selection periods (e.g., compliance or EPSDT case reviews), and/or document submission periods for policies, reports, or program materials.*
^The time frame during which KFMC conducted the EQR activity, including data collection, validation, analysis, and development of findings and conclusions.

Table A.1. Timeline of Review for the 2025-2026 Reporting Cycle (Continued)			
CE	**Data Period***	**Activity Period^**	**Final Report Name and Date**
Early Periodic Screening, Diagnosis, and Treatment			
DentaQuest	Cases: February – July 2024 Documentation: October 2025	October 2025 – February 2026	*2025 Review of EPSDT of DentaQuest,* March 24, 2026
LIBERTY			*2025 Review of the LIBERTY EPSDT Program,* April 9, 2026
Aetna	Cases: April – September 2024 Documentation: October 2025		*2025 Review of the Aetna EPSDT Program,* February 18, 2026
Humana			*2025 Review of the Humana EPSDT Program,* February 25, 2026
OCH			*2025 Review of the OCH (Medical) EPSDT Program,* March 9, 2026
OCH-CSP			*2025 Review of the OCH CSP EPSDT Program,* March 9, 2026
Quality Assessment and Performance Improvement			
DentaQuest	Based on Reports submitted to OHCA in September 2025	October 2025 – February 2026	*2025 Review of the DentaQuest QAPI Program,* April 6, 2026
LIBERTY			*2025 Review of the LIBERTY QAPI Program,* April 9, 2026
Aetna			*2025 Review of the Aetna QAPI Program,* February 13, 2026
Humana			*2025 Review of the Humana QAPI Program,* March 3, 2026
OCH			*2025 Review of the OCH (Medical) QAPI Program,* March 30, 2026
OCH-CSP			*2025 Review of the OCH CSP QAPI Program,* March 30, 2026
Network Adequacy Validation			
All CEs	CE Data from November 2025 State Data from December 2025	Call Completion: February – May 2025 Analysis: June 2025 – February 2026	*2025 Network Adequacy Validation,* March 17, 2026

**The timeframe during which data used to conduct the EQR activity were generated, reported, or maintained by the CEs, including defined measurement periods (e.g., Measurement Year 2024 for performance measures), case selection periods (e.g., compliance or EPSDT case reviews), and/or document submission periods for policies, reports, or program materials.*
^The timeframe during which KFMC conducted the EQR activity, including data collection, validation, analysis, and development of findings and conclusions.

Appendix B

SoonerSelect Program Annual External Quality Review Technical Report

2025-2026 Reporting Cycle

2025 Methodologies

The following EQR Activity methodologies are included in Appendix B:

- PMV
- EPSDT Review
- QAPI Review
- Network Adequacy Validation

Technical Methods of Data Collection and Analysis/Description of Data Obtained – Performance Measure Validation and Evaluation

Performance Measure Validation Methods

The CMS EQR protocol identified key types of data that should be reviewed as part of the validation process. On September 5, 2025, KFMC corresponded with the CEs to provide the project timeline, to request documentation and member-level tables for measures in scope for the audit, and to request documentation related to each CE's CAHPS sampling methodology. Subsequently, KFMC met with CE staff in October 2025 to discuss the measures in scope, documentation requests, project timeline, systems and processes used to generate the rates, any changes to the systems and processes described in the 2024 ISCA, and challenges with rate generation.

Common Among the CEs

KFMC reviewed documentation that included the following:

- 2024 ISCA data collection tool, supporting documentation, and report
- HEDIS MY 2024 Compliance Audit Final Report prepared by the CE's NCQA-certified HEDIS auditor, if an audit was performed
- Member-level detail tables including members in the denominator, numerator, and member-months for the measures in scope
- SEL-1614/DEN-1614 report of MY 2024 performance measures
- Provider type/specialties mapping from source system to the system used to calculate any measures required to be performed by specified types/specialties
- Member race/ethnicity mapping from source system to the system used to calculate any measures stratified by race and ethnicity
- Sampling methodology and vendor reports for CAHPS member surveys

Using CE-provided documentation and information obtained from interviews and correspondence, KFMC evaluated each area requiring validation to instill confidence that the CEs' information systems were configured appropriately and that performance measures were calculated correctly. Appendices to the individual CE PMV reports contained data collection worksheets from the CMS EQR Protocol 2, modified by KFMC and used for this validation.

The appendices to the individual CE PMV reports also contained worksheets whose elements were not measure-specific. The appendices each contained two worksheets:

- "Findings" tables listed the audit elements, the auditor's determination, and comments.
- "Documentation Checklists" listed types of documentation to be reviewed and the file name or a description of the documents of that type that were reviewed.

Another appendix provided information on measure specifications and measure-specific validation results.

Data Integration and Control

KFMC assessed the CEs' ability to link data in a manner that would allow accurate calculation of the performance measures. This activity included review of data management processes and procedures for

- Obtaining needed data from internal and external data sources and storage of these data in an appropriate repository,
- Validation and efforts to ensure the data are clean and accurate,
- Timelines and schedule for obtaining data and making them available for reporting, and
- Methods used to help the report creators select and interpret the data correctly.

Documentation of Data and Processes

Documentation of data and processes used to calculate the performance measures, including the virtual meetings, the 2024 ISCA report and supplemental documentation, supplemental narratives, and member-level detail data were reviewed and evaluated. While the previous section focused on the work of the database administrators and users of the front-end applications, this activity looked at the rules that govern the programmers and analysts that create and run the quality measure reports.

Performance Measure Production

The objective of this activity was to determine the extent to which the performance measure results reported match the requirement specifications. Questions related to this activity included:

- Were the appropriate source data used?
- Were the programs and manual steps executed in the proper order?
- Did the user input the correct parameters for the code?
- Did the code process the parameters and source data according to the technical specifications?

Reported Rates

Table B.1 contains the numerators, denominators, and rates reported by DentaQuest and LIBERTY. The same information for Aetna is included in Table B.2, and the data reported by Humana, OCH, and OCH-CSP are found in Table B.3.

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Table B.1. Adult and Child Dental Performance Measures Reported for MY 2024

Measure	Measure Name and Indicators	DentaQuest			LIBERTY		
		Denom	Num	Rate	Denom	Num	Rate
OEV-CH	**Oral Evaluation, Dental Services**						
	– Age < 3	19,959	4,053	20.3%	29,034	6,031	20.8%
	– Ages 3 to 5	24,774	13,043	52.7%	33,804	17,444	51.6%
	– Ages 6 to 14	72,464	42,632	58.8%	98,356	56,238	57.2%
	– Ages 15 to 20	32,770	14,454	44.1%	51,031	21,718	42.6%
	– Total (Ages ≤ 20)	149,967	74,182	49.5%	212,225	101,431	47.8%
PEV-A-A	**Periodontal Evaluation in Adults with Periodontitis**						
	– Ages 30 to 34	452	42	9.3%	308	119	38.6%
	– Ages 35 to 44	1,015	120	11.8%	680	285	41.9%
	– Age 45 to 54	692	95	13.7%	419	181	43.2%
	– Age 55 to 64	586	86^	14.1%^	297	145^	46.9%^
	– Age 65 and above	23			12		
	– Total	2,768	343	12.4%	1,716	730	42.5%
TFL-CH	**Topical Fluoride for Children**						
	– Dental or Oral Health Services						
	– Ages 1 to 2	8,100	432	5.3%	9,775	548	5.6%
	– Ages 3 to 5	12,531	2,183	17.4%	14,590	2,569	17.6%
	– Ages 6 to 14	38,847	8,834	22.7%	43,107	9,701	22.5%
	– Ages 15 to 20	17,097	2,587	15.1%	19,593	2,807	14.3%
	– Total ages 1 through 20	76,575	14,036	18.3%	87,065	15,625	17.9%
	– Dental Services						
	– Ages 1 to 2	8,100	432	5.3%	9,775	547	5.6%
	– Ages 3 to 5	12,531	2,179	17.4%	14,590	2,565	17.6%
	– Ages 6 to 14	38,847	8,822	22.7%	43,107	9,695	22.5%
	– Ages 15 to 20	17,097	2,579	15.1%	19,593	2,806	14.3%
	– Total ages 1 through 20	76,575	14,012	18.3%	87,065	15,613	17.9%
	– Oral Health Services						
	– Ages 1 to 2	8,100	0	0%	9,775	0	0%
	– Ages 3 to 5	12,531	0	0%	14,590	0	0%
	– Ages 6 to 14	38,847	0	0%	43,107	0	0%
	– Ages 15 to 20	17,097	0	0%	19,593	0	0%
	– Total ages 1 through 20	76,575	0	0%	87,065	0	0%

^In accordance with the CMS Cell Size Suppression Policy, which instructs how to report numbers 1 to 10, numerators for *Ages 55 to 64* and *Age 65 and above* were aggregated so an aggregate rate could be reported. See https://resdac.org/articles/cms-cell-size-suppression-policy.

Table B.2. Adult and Child Medical Performance Measures Reported for MY 2024 – Aetna				
Measure	**Measure Name and Indicators**	**Aetna**		
		Denominator	**Numerator**	**Rate**
CCP-CH CCP-AD	**Contraceptive Care – Postpartum Women**			
	– Most or moderately effective contraception			
	– Within 3 days of delivery			
	– Age 15 to 20	238	NR^	NR
	– Age 21 to 44	1,907	145	7.6%
	– Within 90 days of delivery			
	– Age 15 to 20	238	108	45.4%
	– Age 21 to 44	1,907	784	41.1%
	– Long-acting reversible method of contraception (LARC)			
	– Within 3 days of delivery			
	– Age 15 to 20	238	NR	NR
	– Age 21 to 44	1,907	13	0.7%
	– Within 90 days of delivery			
	– Age 15 to 20	238	47	19.7%
	– Age 21 to 44	1,907	235	12.3%
CDF-CH CDF-AD	**Screening for Depression and Follow-Up Plan**			
	– Ages 12 to 17	25,546	274	1.1%
	– Total 18 and older	57,389	806	1.4%
FUA-CH FUA-AD	**Follow-Up After Emergency Department Visit for Substance Use**			
	– 7 Day Follow-Up			
	– Age 13 to 17	31	NR	NR
	– Age 18 and Older	422	112	26.5%
	– 30 Day Follow-Up			
	– Age 13 to 17	31	NR	NR
	– Age 18 and Older	422	152	36.0%
FUH-CH FUH-AD	**Follow-Up After Hospitalization for Mental Illness**			
	– 7 Day Follow-Up			
	– Age 6 to 17	373	98	26.3%
	– Total 18 and older	535	107	20.0%
	– 30 Day Follow-Up			
	– Age 6 to 17	373	195	52.3%
	– Total 18 and older	535	200	37.4%
FUM-CH FUM-AD	**Follow-Up After Emergency Department Visit for Mental Illness**			
	– 7 Day Follow Up			
	– Age 6 to 17	71	34	47.9%
	– Total 18 and older	163	67	41.1%
	– 30 Day Follow-Up			
	– Age 6 to 17	71	46	64.8%
	– Total 18 and older	163	82	50.3%
HVL-AD	**HIV Viral Load Suppression**			
	– Total 18 and older	127	26	20.5%

*The denominator is the total number of member-months for eligible population as of the 15th day of the month. The rate is admissions per 100,000 member-months.
^Data not reported in compliance with the CMS Cell Size Suppression Policy, which instructs how to report numbers 1 to 10, https://resdac.org/articles/cms-cell-size-suppression-policy.

Table B.2. Adult and Child Medical Performance Measures Reported for MY 2024 – Aetna (Continued)

Measure	Measure Name and Indicators	Aetna Denominator	Aetna Numerator	Aetna Rate
PPC2-CH PPC2-AD	**Prenatal and Postpartum Care**			
	– Timeliness of Prenatal Care			
	– Age Less than 21	321	25	7.8%
	– Age 21 and Older	1,900	215	11.3%
	– Postpartum Care			
	– Age Less than 21	321	152	47.4%
	– Age 21 and Older	1,900	966	50.8%
PQI01-AD	**Diabetes Short-Term Complications Admission Rate***			
	– Total 18 and older	584,760	103	17.6
PQI05-AD	**Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate***			
	– Total 40 and older	204,566	22	10.8
PQI08-AD	**Heart Failure Admission Rate***			
	– Total 18 and older	584,760	89	15.2
PQI15-AD	**Asthma in Younger Adults Admission Rate***			
	– Age 18 to 39	380,194	NR	NR
W30-CH	**Well-Child Visits in the First 30 Months of Life**			
	– First 15 Months (6+ visits)	3,871	620	16.0%
	– 15 to 30 Months (2+ visits)	4,427	1,001	22.6%

*The denominator is the total number of member-months for eligible population as of the 15th day of the month. The rate is admissions per 100,000 member-months.
^Data not reported in compliance with the CMS Cell Size Suppression Policy, which instructs how to report numbers 1 to 10, https://resdac.org/articles/cms-cell-size-suppression-policy.

Table B.3. Adult and Child Medical Performance Measures Reported for MY 2024 – Humana, OCH, and OCH-CSP

Measure	Measure Name and Indicators	Humana Denom	Humana Num	Humana Rate	OCH Denom	OCH Num	OCH Rate	OCH CSP Denom	OCH CSP Num	OCH CSP Rate
CCP-CH CCP-AD	**Contraceptive Care – Postpartum Women**									
	– Most or moderately effective contraception									
	– Within 3 days of delivery									
	– Age 15 to 20	196	NR^	NR	251	NR^	NR	NR^	0	0
	– Age 21 to 44	1,684	162	9.6%	2,111	186	8.8%	NR	0	0
	– Within 90 days of delivery									
	– Age 15 to 20	196	95	48.5%	251	101	40.2%	NR	NR	NR
	– Age 21 to 44	1,684	787	46.7%	2,111	818	38.8%	NR	0	0
	– Long-acting reversible method of contraception (LARC)									
	– Within 3 days of delivery									
	– Age 15 to 20	196	NR	NR	251	NR	NR	NR	0	0
	– Age 21 to 44	1,684	13	0.8%	2,111	28	1.3%	NR	0	0
	– Within 90 days of delivery									
	– Age 15 to 20	196	45	23.0%	251	43	17.1%	NR	NR	NR
	– Age 21 to 44	1,684	218	13.0%	2,111	246	11.7%	NR	0	0

*The denominator is the total number of member-months for the eligible population as of on the 15th day of the month. The rate is admissions per 100,000 member-months.
^Data are not reported in compliance with the CMS Cell Size Suppression Policy, which instructs how to report numbers 1 to 10, https://resdac.org/articles/cms-cell-size-suppression-policy.

Table B.3. Adult and Child Medical Performance Measures Reported for MY 2024 – Humana, OCH, and OCH-CSP (Continued)

Measure	Measure Name and Indicators	Humana			OCH			OCH CSP		
		Denom	Num	Rate	Denom	Num	Rate	Denom	Num	Rate
CDF-CH CDF-AD	**Screening for Depression and Follow-Up Plan**									
	– Ages 12 to 17	19,677	108	0.6%	26,455	333	1.3%	5,672	123	2.2%
	– Total 18 and older	43,550	391	0.9%	61,608	1,118	1.8%	610	NR	NR
HVL-AD	**HIV Viral Load Suppression**									
	– Total 18 and older	306	NR	NR	374	NR	NR	0	0	–
PPC2-CH PPC2-AD	**Prenatal and Postpartum Care**									
	– Timeliness of Prenatal Care									
	– Age Less than 21	199	72	36.2%	259	167	64.5%	NR	NR	NR
	– Age 21 and Older	1,265	540	42.7%	1,580	1,046	66.2%	NR	NR	NR
	– Postpartum Care									
	– Age Less than 21	199	76	38.2%	259	95	36.7%	NR	NR	NR
	– Age 21 and Older	1,265	521	41.2%	1,580	595	37.7%	NR	NR	0
PQI01-AD	**Diabetes Short-Term Complications Admission Rate***									
	– Total 18 and older	618,686	140	22.6	710,943	137	19.3	8,290	NR	NR
PQI05-AD	**Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate***									
	– Total 40 and older	232,288	32	13.8	243,898	44	18.1	0	0	–
PQI08-AD	**Heart Failure Admission Rate***									
	– Total 18 and older	618,686	106	17.1	710,943	128	18.0	8,290	0	0
PQI15-AD	**Asthma in Younger Adults Admission Rate***									
	– Age 18 to 39	386,398	NR	NR	467,045	18	3.9	8,290	0	0

*The denominator is the total number of member-months for the eligible population as of on the 15th day of the month. The rate is admissions per 100,000 member-months.
^Data are not reported in compliance with the CMS Cell Size Suppression Policy, which instructs how to report numbers 1 to 10, https://resdac.org/articles/cms-cell-size-suppression-policy.

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Technical Methods of Data Collection and Analysis/Description of Data Obtained – EPSDT Review

CE EPSDT Requirements

The managed care CEs, in the administration of their EPSDT programs, must comply with the following OHCA SoonerSelect Medical contract sections. The items in bold were reviewed for the 2025 report cycle.

Dental

- **1.7.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program description**
- **1.8. Dental Services Utilization Management**
- 1.10.5 Quality Performance Measures
- **1.11.5.4 SoonerSelect Dental Enrollee Handbook Content**
  (d) Amount, duration, scope of EPSDT benefits
  (h) Information on how to access all services
- **1.13.4.2 Provider Manual Content**
- 1.20.7.3 Determination of Third-Party Payment
  (a) Payment of EPSDT claims
- 1.21.1.10 Covered Benefits Reports
  (a) EPSDT reports
- Appendix 1F: Deliverable 39, EPSDT Data

Medical and CSP

- 1.7.1 Medical and Related Benefits
- 1.7.7.2 Non-Emergency Medical Transportation (NEMT) Covered Services
- **1.7.11 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program description**
  (a) Enrollee education
  (b) Enrollee notification and appointment coordination
  (c) Tracking compliance and missed appointment outreach
  (d) Primary Care Provider (PCP) gap-in-care reports and PCP outreach to enrollee
- **1.8.1 Medically Necessary Services**
- 1.11.5 Quality Performance Measures
  (c) Reporting
- **1.12.5.4 Enrollee Handbook Content**
  (d) Amount, duration, scope of EPSDT benefits
  (h) Information on how to access all services
- **1.15.4 Provider Manual Content**
- 1.22.8.3 Determination of Third-Party Payment
  (a) Payment of EPSDT claims
- 1.23.1.10 Covered Benefit Reports
  (e) EPSDT reports
- Appendix 1F: Deliverable 91, EPSDT Data
- Appendix 1F: Deliverable 92, EPSDT Protocols

The following associated federal regulations were referenced for the 2025 review:

- *42 CFR § 438.206: Availability of services*
- *42 CFR Part 441 Subpart B (441.50-441.61)*

CE Documents Reviewed

For review of compliance with OHCA contract requirements, KFMC assessed the following CE documents:

DentaQuest

- *2024 01 23 - IVR Welcome Call Script*
- *2024 04 01 - Broken Appt IVR Call Script*
- *DEN-1600: Annual QAPI Documentation Plan* (08/25/2025)
- *DEN-1601: Annual QAPI Documentation Evaluation* (08/25/2025)
- *DentaQuest_DEN-1001_20250625_ATT05*
- *DQ2916 OK_Welcome Letter-ID Card_Dental Home_EN_SP (9.23)_Approved*
- *DQ3068_OHM_OK_SS_Calcium_EN-SP (2.24)*
- *DQ3071_OHM_OK_SS_Dentures_EN-SP (2.24)*
- *DQ3072_OHM_OK_SS_NA Tobacco Use (2.24)*
- *DQ3072_OK_Tribal_OHM OK_SS_NA Tobacco (5.25)*
- *DQ3073_OHM_OK_SS_Tobacco Use_EN_SP (2.24)*
- *DQ3097_OHM_OK SS_Bottled Water_EN-SP (1.24) (1)*
- *DQ3098_OHM_OK SS_Brushing Tips_EN-SP (1.24)*
- *DQ3099_OHM_OK SS_Check Your Child's Teeth_EN-SP (1.24)*
- *DQ3100_OHM_OK SS_Early Warning Signs of Tooth Decay_EN-SP (1.24)*
- *DQ3100_OK_Tribal_OHM_OK SS_Early Warning Signs of Tooth Decay (5.25)-printer*
- *DQ3100_OK_Tribal_SS_NA Diabetes (5.25)*
- *DQ3101_OHM_OK SS_Good Health Starts at Birth_EN-SP (1.24)*
- *DQ3102_OHM_OK SS_Keep Your Breath Fresh_EN-SP (1.24)*
- *DQ3103_OHM_OK SS_Sealants_EN-SP (1.24)*
- *DQ3104_OHM_OK SS_Baby Teeth Are Important_EN_SP (1.24)*
- *DQ3105_OHM_OK SS_Snack Facts_EN_SP (1.24)*
- *DQ3105_OK_Tribal_OHM_OK SS_Snack Facts (5.25)*
- *DQ3106_OHM_OK_SS_Pacifiers_EN_SP (1.24)*
- *DQ3107_OHM_OK SS_Healthy Teeth and Gums_EN_SP (1.24)*
- *DQ3108_OHM_OK SS_Dental Dos_EN_SP (1.24)*
- *DQ3124 OK SoonerSelect Welcome Postcard_6x9 (2.24)*
- *DQ3127_OK_SS_Back to School Flyer_EN_SP (2.24)*
- *DQ3128_OK_SS_Dental Care for Disabilities Flyer_EN_SP (2.24)*
- *DQ3129_OK_SS_Event Flyer_EN_SP (2.24)*
- *DQ3129_OK_Tribal_SS_Dental Checkup Flyer (5.25)*
- *DQ3130_OK_SS_Fluoride Flyer_EN-SP (2.24)*
- *DQ3131_OK_SS_Schools Out Flyer_EN_SP (2.24)*
- *DQ3141_OHM_OK_SS_Flossing_EN-SP (2.24)*
- *DQ3193 OK SoonerSelect Healthy Beginnings IVR Call Script (3.24)*
- *DQ3320 OK_SoonerSelect_Event Flyer_EN QR Code (7.24)*

- *DQ3320 OK_SoonerSelect_Event Flyer_SP QR Code (7.24)*
- *Member Handbook*
- *OK Open Enrollment Outreach Plan 2025*
- *OK_OHCA_ORM 7.28.2025* (Office Reference Manual/Provider Manual)
- *PR01-INS-Peer Review*
- *Tribal Outreach Plan 2025*
- *UM Org Structure High Level*
- *UM_Annual Review Meeting Minutes_2024_signed*
- *UM01-INS-Clinical Algorithms*
- *UM08-INS-Authorization Review*
- *UM11-INS-Utilization Management Staff*
- *Utilization Management Program Description*

Liberty

- *00. OK _KMFC_Response_Narrative_Final*
- *01. LDP_UM_Org_Chart*
- *02. Clinical Affairs Org Chart*
- *03. UM PP - Coverage of EPSDT Services*
- *04. UM Committee SD EPSDT*
- *05. Oklahoma UM Committee meeting minutes*
- *06. LDP_LMS_EPSDT_Training*
- *07. LDP_Member_Handbook_snip*
- *08. LDP_Provider_Reference_Guide_EPSDT_snip*
- *DEN-1600: Annual QAPI Documentation Plan* (09/08/2025)
- *DEN-1601: Annual QAPI Documentation Evaluation* (09/02/2025)
- *OK-Medicaid-Provider-Reference-Guide* (Revised 04/01/2023)
- *SoonerSelect-Member-Handbook* (Revised 02/14/2025)

Aetna

- *Aetna SoonerSelect Member Handbook Aetna Better Health of Oklahoma Member Handbook, 4520048-01-01 (02/25)*
- *Aetna Better Health of Oklahoma-Provider Manual (Vol 5 – 7/1/2025)*
- *Quality Management/Medical Management (QMMM) Committee Meeting Minutes (January, March, April, and July 2025)*
- *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Part 1: The Role of a EPSDT Coordinator*
- *Early Periodic Screening Diagnostic and Treatment Program Coordinator-1 Job Description*
- *Aetna Better Health of Oklahoma EPSDT Network Provider Educational Materials*
- *Aetna Better Health of Oklahoma Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program (Staff training)*
- *ABHOK Initiatives VAB Brochure*
- *ABHOK Internal EPSDT Tracking and Monitoring Biweekly Report*
- *ABHOK Member Outreach Materials*
- *ABHOK Quality Department Organizational Chart*

- *ABHOK Redacted Gap in Care Report*
- *Aetna Medicaid Administrators, Prior Authorization Oklahoma Policy, Policy Number 7200.45* (Effective 4/1/2024)
- *Aetna Medicaid Administrators, Approving and Applying Medical Necessity Criteria Oklahoma, Policy Number 7200.84* (Effective 4/1/2024)
- *Aetna Medicaid Administrators, Concurrent Review - Observation Care Oklahoma, Policy Number 7200.89* (Effective 4/1/2024)
- *Aetna Medicaid Administrators, Utilization Management Roles and Responsibilities Oklahoma, Policy Number 7200.98* (Effective 4/1/2024)
- *Aetna Better Health of Oklahoma, Clinical Practice Guidelines and Preventive Services Guidelines, Policy Number 8000.90* (Effective 4/1/2024)
- *Aetna Better Health of Oklahoma, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Service, Policy Number 8300.10* (Effective 4/1/2024)
- *SEL-1600: Annual QAPI Documentation Plan* (8/28/2025)
- *SEL-1601: Annual QAPI Documentation Evaluation* (8/27/2025)

Humana

- *1.0 EPSDT Org Chart*
- *2.0 Manager, Care Management Behavioral Health*
- *2.1 Manager, Care Management Physical Health*
- *2.2 Manager, Transitions Coordinator*
- *2.3 Mom's First Maternity Telephonic Nurse 2 Care Manager*
- *2.4 EPSDT Quality Improvement Coordinator JD*
- *2.5 HEDIS Senior Data and Reporting Professional JD*
- *2.6 Sr EPSDT Quality Compliance Professional JD*
- *3.0 Medical Management Committee Agenda 2.17.25*
- *3.1 Medical Management Committee PowerPoint 2.17.25*
- *3.2 Medical Management Committee Minutes 2.17.25*
- *3.3 Medical Management Committee Agenda 5.12.25*
- *3.4 Medical Management Committee PowerPoint 5.12.25*
- *3.5 Medical Management Committee Meeting Minutes 5.12.25*
- *3.6 Medical Management Committee Agenda 8.11.25 1*
- *3.7 Medical Management Committee PowerPoint 8.11.25*
- *3.8 Medical Management Committee Meeting Minutes 8.11.25 1*
- *4.0 OK.CLI.015 - Medical Management Program Description eff. EPSDT*
- *5.0 MyTool OK CM EPSDT*
- *5.1 Welcome Call Mentor Script (EPSDT)*
- *5.2 Protocols_initiatives to increase the EPSDT screening visit rates*
- *6.0 Internal EPSDT tracking and monitoring reports*
- *7.1 Home _ AAP*
- *7.2 Vaccines & Immunizations _ Vaccines & Immunizations _ CDC*
- *7.3 Vaccine Training 8.29.25*
- *7.4 OK Policies and State contract*
- *8.0 NewMember-Letter_4.8.25 updated*
- *8.1 Welcome Back Letter_07.24.2025*

- *8.2 OK HumanaBeginnings Welcome Letter _2.4.25*
- *8.3 Flyer_612x792_FOR REVIEW*
- *8.4 EPSDT_Brochure_CMYK*
- *8.5 Maternal_Brochure_CMYK_R2*
- *8.6 MCD Member Newsletter Q3 2024 Final_082224 (1)*
- *8.7 MCD Member Newsletter Q4 2024_Clean*
- *8.8 MCD Member Newsletter Q2_update_4-24-25*
- *8.9 MCD Member Newsletter Q3 2025_7.9.25*
- *8.10 OK Flu Text Message1*
- *8.11 OK Measles Text Message1*
- *8.12 HHH2025JanSocialPosts – OK*
- *8.13 OK MBR Feb 2025 Facebook Posts*
- *8.14 OK_MBR_March2025SocialPosts*
- *8.15 OK HHH MBR May 2025 Facebook Posts*
- *8.16 OK_MCD_Q2_2025JuneSocialPost*
- *8.17 OK - HHH September 2025 Facebook Post*
- *8.18 OK - HHH October 2025 Facebook Posts*
- *8.19 HHH Facebook Posts - Child Measles Vaccines*
- *8.20 Humanabeginnings _ Humana Healthy Horizons in Oklahoma*
- *8.21 Kids Health _ Humana Healthy Horizons in Oklahoma*
- *8.22 SMS and Interact_v3_OK (1)*
- *8.23 Welcome Calls for OK Medicaid*
- *8.24 HHH_Well_Child_Campaign_Direct_Mail_Clean_V2_OK*
- *8.25 OK_MBR_Measles alert-enterprise-members*
- *8.26 MCD_EPSDT Campaign Vaccine Chart_7-18*
- *8.27 2025_Member_Handbookpdf*
- *9.0 2025 Notification of Pregnancy Provider Incentive*
- *9.1 Adult Measures flyer packet 3.31.2025*
- *9.2 OK MCD PCP Provider Intro to Quality Recognition Programs Slide Deck (1)*
- *9.3 MaternityQualityRewards OK 2025 prenatal immuniz V1*
- *9.4 MCDR OK Behavioral Health Quality Rewards PPT*
- *9.5 Pediatric Measures flyer packet 3.7.2025*
- *9.6 MCD 2246 General Medicaid Well Child Visit*
- *9.7 Well Child and adolescent Visits provider flyer*
- *9.8 2025 Provider Orientation 8.8.2025*
- *10.0 Quality Stars Report - Measure Detail (Compass)*
- *SEL-1600: Annual QAPI Documentation Plan* (09/01/2025, Revised 02/26/2025)

OCH/OCH-CSP (Documents reviewed for both OCH and OCH-CSP)

- *2025 Provider Manual*
- *210325_-_EPSDT_Coordinator Job Description*
- *Child Immunization Text*
- *Child Preventative Email*
- *Child Preventative Text*

- *Email Outreach to Member (Child)*
- *EPSDT FAQ board 2025*
- *EPSDT 0-6*
- *EPSDT 7-21*
- *EPSDT Child Postcard*
- *EPSDT Dashboard 1*
- *EPSDT Dashboard 2*
- *EPSDT Dashboard 3*
- *EPSDT Example Member Care Gap List For Example Provider*
- *EPSDT Infant Postcard*
- *EPSDT Internal Newsletter*
- *EPSDT Lunch and Learn OCH 21May2025*
- *EPSDT Protocols and Initiatives for increased ESPDT screenings*
- *EPSDT Provider Slide*
- *EPSDT Teen Postcard*
- *EPSDT.Provider – Newsletter*
- *Learning Module in Workday – EPSDT*
- *Medicaid P4P 2025*
- *MyHealth Pays Medical*
- *OCH Child Wellness Visit (EPSDT) Checklist*
- *OK QI Staffing Org Chart EPSDT*
- *OK.QI.20_Early_and_Periodic_Screening_Diagnostic_and_Treatment_(EPSDT)*
- *Quality Improvement Committee Agenda & Minutes 3.18.25*
- *SEL-1600: Annual QAPI Documentation Plan* (08/28/2025)

OCH

- *Member Handbook* (revised May 2025)
- *MyHealth Pays Medical*

OCH-CSP

- *Member Handbook* (created May 2025)
- *MyHealth Pays CSP*

Technical Methods of Data Collection and Analysis/Description of Data Obtained – QAPI Review

KFMC and OHCA completed a preliminary review in June 2025 to assess how well the CEs' evaluation of their QAPI programs aligned with key requirements taken from the Quality Assessment and Performance Improvement (Dental 1.10.3, Medical/CSP 1.11.3) sections of the SoonerSelect contract, 42 CFR § 438.330, and applicable NCQA standards and guidelines. The feedback offered to the CEs was intended to help strengthen their September 2025 Annual QAPI Program Evaluation submission by encouraging the inclusion of more robust details and clearer explanations of each program's structure, processes, and outcomes.

KFMC completed its assessment of the CEs' September 2025 submission. At a minimum, this review included the CEs' QAPI Program Descriptions and Work Plans, as documented in the SoonerSelect reporting templates DEN/SEL-1600, as well as their QAPI Annual Evaluations. Several CEs also submitted additional documentation, which KFMC reviewed as applicable.

CE QAPI Requirements

For the 2025 review, KFMC assessed each CE's QAPI program structure, committees, and oversight, described in Table B.4.

Table B.4. CE QAPI Requirements

State Quality Strategy, State Contract Section, CFR § 438.330, and/or 2025 NCQA Standards and Guidelines	QAPI Requirement
1.10.3.1/1.11.3.1 QAPI Program 42 C.F.R. § 438.330(b)(1-4) 2025 NCQA Standards and Guidelines	• Use standards and guidelines from the CE's Accrediting Entity including standards for Quality Management, Quality Improvement, Quality Assessment, and Performance Improvement Programs • The QAPI program shall include the following: a. PIPs that evaluate clinical and nonclinical areas, b. Collection of and submission of performance measurement data, c. Mechanisms to detect both underutilization and overutilization of services d. Assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs • The CE shall include QAPI activities to improve health care disparities identified through data collection. • The CE shall make all information about its QAPI program available to Providers and Enrollees.
1.10.3.2/1.11.3.2 Oversight of QAPI Program 2025 NCQA Standards and Guidelines	• CE has a Quality Department accountable to the CE's Governing Body and executive management team, who set strategic direction for the QAPI program and ensure that the QAPI plan is incorporated into the CE's operations • The CE shall have a QIC, chaired by the CE's Chief Dental Director/Chief Medical Officer that oversees all QAPI functions. • The QIC meets no less than quarterly. • The QIC develops and implements the QAPI plan, incorporating the strategic direction provided by the Governing Body and executive management team

Table B.4. CE QAPI Requirements	
State Quality Strategy, State Contract Section, CFR § 438.330, and/or 2025 NCQA Standards and Guidelines	**QAPI Requirement (Continued)**
	• The QIC: a. Direct and review QAPI activities b. Analyze and evaluate the results of QAPI activities and suggest new or improved activities c. Ensure that Participating Providers and other stakeholders are involved in the QAPI program d. Direct task forces or committees in specific improvement areas e. Review quality of care complaints f. Publicize findings to appropriate staff and departments within the CE's organization g. Report findings and recommendations to the CE's executive management team h. Direct and analyze periodic reviews of Enrollees' service utilization patterns, institute needed action, and ensure that appropriate follow-up occurs i. Review and approve the QAPI work plan and annual evaluation
1.10.3.3/1.11.3.3 QAPI Documentation 1.21.1.13/1.23.1.14 Quality Improvement Reports 2025 NCQA Standards and Guidelines	• The CE shall submit an annual QAPI program description and associated work plan that addresses its strategies for performance improvement and for conducting quality management activities • The CE shall submit an annual evaluation of the previous year's QAPI program • CE's QAPI program description, work plan and program evaluation shall be submitted exclusive to Oklahoma Medicaid • The QAPI program description shall include: a. Guiding philosophy and strategic direction for the QAPI program b. Communication mechanism between the CE's executive management team and the QIC c. QAPI program committee structure, including specific committees, committee representatives and why the representatives were chosen, identification and inclusion of Local Oklahoma Provider Organization members d. Roles of Enrollee and Provider representatives on the QIC e. Process for selecting and directing task forces or subcommittees f. Types of training, including any quality protocols developed by the CMS, provided to quality staff and QIC members g. Specific components of the QAPI plan h. Process the QAPI program will use to review and suggest new or improved quality activities i. Process to report findings to appropriate executive leadership, staff, and departments within the CE's organization, as well as relevant stakeholders, such as Participating Providers j. Methodology for which and how many Participating Providers to profile and how measures for profiling will be selected k. Process for selecting evaluation and study design procedures l. How data will be collected and used m. How the CE will ensure that QAPI program activities take place throughout the CE's organization and the procedures to document results n. The Health Management Information systems that will support the QAPI program

Table B.4. CE QAPI Requirements	
State Quality Strategy, State Contract Section, CFR § 438.330, and/or 2025 NCQA Standards and Guidelines	**QAPI Requirement (Continued)**
	o. Process for reporting findings to OHCA, Participating Providers, and Enrollees p. Process for annual program evaluation • The annual QAPI program evaluation to OHCA shall include, the following, at minimum: a. A description of ongoing and completed QAPI activities b. Measures that are trended to assess performance c. Year-over-year findings that contain an analysis of demonstrable improvements in the quality of clinical care and service d. Development of future QAPI work plans based on previous year findings e. Results of QAPI projects and reviews f. HEDIS, CAHPS Survey, OHCA scorecards, and other performance measure results g. Monitoring and evaluation of non-clinical aspects of service with timely resolution of problems and improvement in processes h. Monitoring and evaluation of network quality, including, at minimum: i. Credentialing and recredentialing processes ii. PIPs iii. Performance measurement iv. Problem resolution and improvement approach and strategy v. Annual program evaluation vi. Metrics for monitoring the quality and performance of Participating Providers related to their continued participation in the CE's Network
SoonerSelect Quality Strategy	• CE describes opportunities and interventions that focus on improving SDoH to improve outcomes for enrollees

Network Adequacy Validation Methodology

1. Sampling Strategy for Network Validation Calls

KFMC staff obtained for analysis each CE's *Network Adequacy Report* for the reporting period December 1 through December 31, 2024. These reports contained a listing of participating providers as of December 31, 2024, and served as the data sources for the sample frames of primary care providers (PCPs) and primary care dentists (PCDs).

To reduce provider abrasion, phone numbers were only selected once (within a CE's sample and across all CEs' samples). This simplified the data collection processes and reduced the potential for the results to over-represent larger practices with multiple providers at the same phone number. This approach could capture the same provider practicing at different locations with different phone numbers. It also aligns with the purpose of simulating what a SoonerSelect member would experience, since they would typically call the phone number in the directory associated with a specific location.

For each phone number on a CE's provider list, one service location was randomly selected to represent the phone number. If the phone number was selected to be called, the caller would ask for information on up to three practitioners from the same CE. Some service locations, such as Federally Qualified Health Centers, provide both medical and dental services.

Since the dental CEs had fewer phone numbers in the sample frames than the medical CEs, records were selected for PCDs before PCPs. Because Oklahoma Complete Health used the same provider network for its medical and Children's Specialty Program plans, the same sample frame and sample were used for OCH and OCH-CSP.

Sample Size

For each CE, a sample of 150 phone numbers was randomly selected from the sample frame. In all, 750 phone numbers were selected.

Sample Frame Determination

Sample frames of distinct phone numbers were created from the CEs' Network Adequacy Reports. The provider lists were uploaded into a single table and underwent concurrent data cleaning and processing steps. In a few places, detailed below, data cleaning was customized for a CE.

The sample frame was constructed using the following steps:

1. Import the provider lists into a single table, adding a column to identify the CE.
2. Standardize and format the data.
    a. Convert address fields to upper case.
    b. Remove "N/A" from Street Address 1 and Street Address 2 fields.
    c. Create Complete Address field as Street Address 1 plus Street Address 2.
    d. Trim ZIP Code field to 5 characters.
    e. Standardize provider type and specialty descriptions and create fields for provider type and specialty codes.
    f. For dental CEs, convert the single PCD indicator field into Adult PCP and Pediatric PCP fields.

3. Restrict to records with Adult PCP = "Y" or Pediatric PCP = "Y".
4. Remove records with provider types “11 - Behavioral Health Provider,” “53 - Licensed Behavioral Health Practitioner,” “07 - Capitation Provider,” and “08 - Clinic.”
5. Categorize records for PCPs with provider type “09 - Advance Practice Nurse,” “10 - Mid-Level Practitioner,” or “16 - Nurse” or provider specialty “100 - Physician Assistant” or “093 - Certified Nurse Practitioner” as mid-level practitioners.
6. For Humana only, remove records where the name indicates the provider is not an individual.
   a. Delete if Provider Name does not contain a comma (to separate last name from first name).
   b. If Provider Name contains a comma, delete if the name in upper case contains "LLC," "PLLC," "PLC," " INC," "CLINIC," "CENTER," "GROUP," "HEALTH," "MEDIC," "FAMILY," "OSU," "OSU-AJ," or "PEDIATRIC."
7. Remove records that are exact duplicates.
8. Deduplicate to keep one provider type and specialty code per practitioner per service location.
9. Remove records with missing phone numbers.
10. Remove records with addresses not in Oklahoma.
11. Deduplicate on key fields (NPI, Provider Name, Telephone Number, CE, and address fields) prioritizing to keep records indicating the provider is an adult and pediatric PCP and is accepting new patients.
12. Deduplicate to keep one record per CE, NPI, Telephone Number, Complete Address, and City. This removes variations in the provider’s name or ZIP code.
13. Assign random numbers to the records obtained from Step 12 as follows:
    a. To each distinct phone number, assign a unique random number. This random number will be the same for all records having the same phone number.
    b. Assign a unique random number to each service location address for a given phone number.
    c. Assign a unique random number to each CE having in-network practitioners at that service location and phone number. The random number for the CE will be different for each service location and phone number combination.
    d. Assign unique random number to each practitioner record.

The table created in Step 13 was the sample frame. Record counts at several stages of constructing the sample frames are displayed in Table B.5.

Table B.5 Record Counts During Construction of the Sample Frame						
	DentaQuest	**LIBERTY**	**Aetna**	**Humana**	**OCH**	**OCH-CSP**
Records in Network Adequacy Reports	4,348	3,255	250,021	65,295	46,698	46,698
Adult or Pediatric PCPs and PCDs (Step 3)	3,907	2,665	64,599	14,691	5,211	5,211
PCP and PCD Practitioners (Step 6)	3,465	2,072	63,376	9,736	4,585	4,585
Practitioners in Sample Frame (Step 13)	3,129	1,864	57,879	4,657	3,380	3,380
Distinct Phone Numbers in Sample Frame	**456**	**409**	**2,402**	**1,223**	**948**	**948**

Sample Selection

Table B.6 displays the number of phone numbers selected for each sample and the number of practitioners selected for the calls.

Table B.6. Counts of Selected Phone Numbers and Practitioners

	DentaQuest	LIBERTY	Aetna	Humana	OCH	OCH-CSP
Phone Numbers in Sample	150	150	150	150	150	150
Practitioners in Sample	293	303	229	242	265	265

The sample frames for the dental CEs were smaller than the sample frames for the medical CEs. Therefore, the dental samples were selected before the medical samples as follows:

1. Draw all records for DentaQuest and LIBERTY from the sample frame.
2. For each phone number drawn, retain the records having the minimum random number assigned to the service location address and the minimum random number assigned to the CE.
3. For each dental CE, retain records for the phone numbers having the lowest 150 random numbers assigned to the phone number.
4. For each selected phone number, select the practitioners having the lowest random numbers assigned to the NPI, up to three PCDs.

The three medical samples were then selected as follows:

1. Draw from the sample frame all records for the medical CEs, excluding records with phone numbers selected for the dental samples.
2. For each phone number drawn, retain the records having the minimum random number assigned to the service location address and the minimum random number assigned to the CE.
3. For each medical CE, retain records for the phone numbers having the lowest 150 random numbers assigned to the phone number.
4. For each selected phone number, select the practitioners having the lowest random numbers assigned to the NPI, up to three PCPs, selecting first from the physicians and then from the midlevel practitioners.

2. Directory Validation Call Procedures

Application Overview – Provider Network Access Monitoring

For each directory record selected for a validation call, key data fields from the CEs' Online Provider Directory Files were loaded into KFMC's *Provider Network Access Monitoring* application with one record created for each sample record. Each record was assigned a unique sequence number.

Additional fields for each record within the application were organized into three sections:

- **Header** – provider information uploaded to application, caller username, and date fields
- **Call Form** – fields for the caller to record results of call
- **Quality Review** – fields for inter-rater review

Header

The header section included the basic information for each record uploaded from the directory samples: phone number, provider ID, provider name, group name, provider category, provider specialty, and address. For each associated CE, the header also indicated whether the provider was flagged in its directory as a PCP and whether the provider was flagged in its directory as accepting new patients. Additionally, hours of operation were included. On the first save of the call record, call date and caller

were automatically populated with the date and timestamp and user ID, respectively, which were unchanged if the data entry fields were subsequently modified.

Call Form

The data entry section of each record consisted of questions and response options for phone number, street address, in network, accepting new patients, and whether the provider was practicing as a PCP at that phone number and location. The options for phone number were *Yes* and *No*; the other questions had the additional options of *Don't Know* and *Not Applicable*. The data entry section also included online directory look-up fields for each CE with whom the provider was associated, for caller use based on certain call conditions.

Question 1 – Phone

The person answering the call was asked if the phone number was correct for the provider and practice group. Choices were *Yes, the provider was at that number*, or *No, the provider was not at the number*. Fields were available to record a corrected group name and phone number, if provided.

Question 2 –PCP

This question asked the person answering the call if the provider was providing PCP services. Response options were *Yes*, *No*, and *Don't Know*.

Question 3 – Address

The person answering the call was asked if the caller had reached the location at the street address on the record. Response options were *Yes* and *No*; a field was provided to record a different address, if provided.

Question 4 – New Patients

The person answering the call was asked if the provider was accepting new patients at the address. Response options were Yes, No, Don't Know, and Not Applicable.

Question 5 – In Network

Separate question/response options were provided for each associated CE. The person answering the call was asked to confirm that the provider was in-network for the CE. Response options were *Yes*, *No*, *Don't Know*, and *Not Applicable*.

Wrong Number

A checkbox was provided and checked if the person answering the call stated the provider was not at the number dialed. The box was also checked when voice recordings indicated that the incorrect practice and provider had been reached.

No Answer

A checkbox was provided and checked if no one answered the call. This checkbox was also used when it appeared the number that was dialed was reaching a fax machine.

Voice Message – Group and Provider Names

Two dropdown lists were provided, with the options Yes, No, and Unknown. These fields were used when a voice mail or person answered but did not allow the caller to ask the questions. They indicate if the response confirmed the associated practice group name or the provider name.

Information Provided By

A field was available to record the name of the person who answered the phone, if one was provided.

Comments

This field provided analyst comments from the sample selection process as well as additional information from the caller or persons who reviewed the calls.

A checkbox was available for the caller to signal a request for special review of the recorded results by the Quality Reviewer.

Quality Review

The quality review section was reserved for use by the Quality Reviewer and, when necessary, Secondary Reviewer. The disposition of the review (*Agree*, *Disagree*, *Resolved*) was selected from a drop-down menu. The Quality Reviewer's rationale for this disposition was recorded in a free text field. The review date was automatically populated when a disposition was selected.

Directory Validation Call Procedures

Place and Record Call

Calls were placed to the provider's phone number in the record header using *Zoom Phone* via Zoom Video Communications, Inc. Each call was recorded to the cloud and then downloaded locally to be accessible to the *Provider Network Access Monitoring* application. Recordings were renamed using the record's sequence number and accessible via a link on the data entry form.

Address Call Objectives

The caller's goal for each call was to determine, from a member's perspective, the accuracy of information available in the CEs' provider directories. The caller followed a script in all calls in which a person was reached. In these cases, the caller asked the person to verify the phone number, physical address, accepting new patients status, and in-network status of the provide. When a recording was reached, the caller noted if the provider group or provider name were identified on the recording.

Complete Call Form

The data entry section of each record was updated with findings from the call. When indicated, online directory look-up fields were populated. The completed fields provided context to the quality of responses, such as whether incorrect numbers were identified, more accurate numbers were provided, or the provider was practicing at an address different from the location sampled.

Quality Review of Completed Call Records

KFMC staff members made calls to providers, and a sample of completed calls underwent inter-rater review by the Quality Reviewer. Each review included a disposition (*Agree, Resolved* or *Disagree*) and comments on rationale for the disposition. The Quality Reviewer reviewed the first twenty completed calls. Feedback was provided to the caller, and several improvements to the process and call form were made. Thereafter, the Quality Reviewer selected over one-half of completed records for inter-rater review.

Upon a quality review disposition of *Agree*, the call was considered appropriately marked and no further action was taken. For a quality review disposition of *Disagree*, certain aspects of the call record were

perceived by the reviewer as missing necessary marks, inappropriately marked, or possessing other inaccuracies that may affect analysis of the call. The caller was given the opportunity to review the comments of the reviewer and make any changes to the record to address the comments. If the reviewer agreed with changes made, this was recorded in the reviewer comments and the disposition was changed to *Resolved*.

Analysis of Directory Validation Call Activity

Reports were run from the *Provider Network Access Monitoring* application to assist with inter-rater review selection and assess the overall status of the progress and completion of calls. Records within the application were exported into an Excel spreadsheet for analysis. These data were analyzed using descriptive statistics.

Classification by Access and Quality Standards

For interpretation and reporting, records were assessed according to perceived member access and the degree to which the providers' office confirmed the information in the provider directory file. Records were categorized according to four ratings of quality: *Pass*, Partial Pass, Fail, and *Unable to Rate*. Each of the four ratings were mutually exclusive by the criteria included below.

Records Rated as Pass

Records included within these counts clearly met criteria of success for accurate directory information. All calls within this level of achievement were confirmed with a live person representing the provider. Each of these calls resulted in confirmation of the following components of assessment (valid active network status, provider type, street addresses, telephone number, and acceptance of new enrollees).

Records Rated as Partial Pass

Records included within these counts were perceived to have minor issues pertaining to at least one component under assessment. Records were classified as Partial Pass when calls to the listed telephone number resulted in KFMC's caller not having an opportunity to verify all data. Partial verification may have occurred when a voice mail confirmed we had reached the correct practice and provider, but no respondent was available to answer further questions. This category also includes instances where a respondent confirmed some information but then ended the call.

Records Rated as Fail

Records included within these counts were perceived to have clear issues. Records were classified as Fail when calls to the listed telephone number resulted in a confirmed Wrong Number or a Disconnected Number, or when the person answering the phone provided information that contradicted the information listed in the directory.

Records Rated as Unable to Rate

Records included within these counts were not rated due to lack of information. This occurred when calls to the listed telephone number were never answered or when calls reached a voice message that did not provide identifying information about the provider or practice (did not state practice, provider name, etc.) This category also included records where callers were hung up on repeatedly. Callers made at least two attempts to reach each number. Calls were regarded as *No answer* if one or more of the following outcomes were present: there was no answer after the line rang for at least 30 seconds, a

message was reached that indicated the phone number was no longer in service, the call either disconnected or the phone stopped ringing, or another reason beyond those indicated previously.

3. Methodology for Sampling Provider Directories

Sampling Strategy

The CEs' provider directories were reviewed to determine whether certain fields required by the State were populated. The source data were directories available to members that were posted on the CEs' websites. KFMC requested PDFs of current print directories. If a CE did not provide the requested documents, or the documents provided were not current, provider data were obtained by following the website's directions for members. These directions required the user to limit their selection by specifying the type of provider and location (e.g., by city or ZIP). Neither the PDF file nor the online search results were conducive for developing a state-wide listing of providers that could be used for random sampling. Therefore, instead of directly selecting providers for review, directory pages were selected, and provider data listed on those pages were reviewed.

The sample was selected in multiple stages. First, six counties were chosen to represent different regions of Oklahoma and different population sizes.[1] The most populous county, Oklahoma, was chosen because it had the most variety of provider types and specialties. Cleveland was randomly chosen to be a second representative urban county. The rural counties were subdivided by population size and region. Okmulgee and Pontotoc were chosen from the 20 rural counties with the most enrollees; Marshall and Pushmataha represented the remaining 42 rural counties. Okmulgee and Pushmataha are in the East region, and Pontotoc and Marshall counties are in the West region. Next, providers within these counties were identified as individuals or facilities. These two groups were partitioned into provider types matching provider types used within the provider directories. For medical CEs, strata for individuals typically included PCPs, specialists, behavioral health providers, and vision care providers; common strata for facilities were clinics, hospitals, pharmacies, and ancillary services.

Sample sizes were determined to allow conclusions, with 95% confidence, that a directory field was populated throughout the directory if the field was fully populated in all of the records reviewed. For this year's validation, statistically valid estimates of the percentage populated were not required for fields that were not 100% populated. For this, 30 pages were determined to be sufficient. Since the population of fields was expected to differ between individual providers and business providers, 30 pages were selected for each (totaling 60 directory pages reviewed) for every medical CE. DentaQuest's and LIBERTY's provider directories did not have entries for dental offices separate from the entries for dentists; therefore, a single sample of 30 pages was to be drawn. For DentaQuest, a reduced sample of 24 pages was drawn, as its print directory was organized by city and not every selected county had a specialist in a relevant city. Where possible, pages were randomly selected from those that only

[1] Urban counties: Canadian, Cleveland, Comanche, Creek, Garfield, Grady, Logan, Muskogee, Oklahoma, Payne, Pottawatomie, Rogers, Tulsa, Wagoner, Washington; More populous counties in East region: Adair, Bryan, Cherokee, Delaware, LeFlore, Mayes, McCurtain, Okmulgee, Osage, Ottawa, Pittsburg, Seminole, Sequoyah; Less populous counties in East region: Atoka, Choctaw, Coal, Craig, Haskell, Hughes, Latimer, McIntosh, Nowata, Okfuskee, Pawnee, Pushmataha; More populous counties in West region: Caddo, Carter, Garvin, Kay, Lincoln, McClain, Pontotoc, Stephens; Less populous counties in West region: Alfalfa, Beaver, Beckham, Blaine, Cimarron, Cotton, Custer, Dewey, Ellis, Grant, Greer, Harmon, Harper, Jackson, Jefferson, Johnston, Kingfisher, Kiowa, Love, Major, Marshall, Murray, Noble, Roger Mills, Texas, Tillman, Washita, Woods, Woodward

contained records from the county of interest. Note, reviewing 30 records only provides a rough estimate of the percent of records with the field populated throughout the directory if the field was not populated for all records reviewed.

Obtaining Provider Directories

This section provides the steps used to obtain the provider directories. Some CEs provided their print directories to KFMC upon request. For other CEs, the print directories were downloaded from the CEs' websites.

DentaQuest

DentaQuest provided a PDF of their print directory that was dated for September 2025.

LIBERTY

LIBERTY's full provider directory was obtained from their "Find a Dentist" tool. These steps were completed December 23, 2025.

1. Open https://www.libertydentalplan.com/Programs/Medicaid.aspx.
2. In the dropdown menu on the top right of the page, hover over "Members" and select "Find a Dentist."
3. From here, enter a zip code in Oklahoma (e.g., 74114) and select the address line corresponding to the desired location in Oklahoma (the specific location does not matter).
4. Once the address is selected, a "Search By Medicaid Specific" button should appear below the address bar, select it.
5. Select the "OK Medicaid Provider Directory Pdf" file for download.

Aetna

Aetna provided a PDF of their print directory, but the file appeared to be corrupted. Aetna attempted to resubmit another PDF file of their print directory, but the updated file was dated June 2024. As such, KFMC downloaded a directory file from Aetna's website. Aetna's provider directory file, File Vol1 Aetna OK05 Accessible PaperDirectory.pdf, was downloaded November 20, 2025. The cover page of the directory file dates the information as the October 2024 version.

1. Open https://oklahoma.gov/ohca/soonerselect/about.html.
2. From sentence starting with, "You can choose between three health plans," select "Aetna Better Health of Oklahoma." This opens https://www.aetnabetterhealth.com/oklahoma/index.html.
3. Near the bottom of the page, under "Resources and tools" select "Find a provider." This opens https://www.aetnabetterhealth.com/oklahoma/find-provider.
4. At the bottom of the page, under "Choose A Directory," select "Full Directory" and download as a PDF file.

Humana

Humana's provider directory was downloaded November 20, 2025 (files were dated November 1, 2025). The following steps produced 12 PDF files. Of those 12, 6 were used for sampling directory pages.

1. Open https://www.humana.com/medicaid/oklahoma.
2. At top of page choose "Support," then "Member Support," and then "Provider Directories." This opens https://www.humana.com/medicaid/oklahoma/support/provider-directories.

3. For each of the four regions, click on the links for the two directories. A warning about the website not being secure may appear. Select the three dots and select "Keep" and then "Keep Anyway." A PDF file will be returned. Perform a "save as" to save the PDF file onto the network.

OCH and OCH-CSP

OCH and OCH-CSP provided PDFs of their print directories for both networks. The files were dated for September 2025

Selecting Directory Pages and Providers

This section provides the number of directory pages selected for review, by county and provider type. The provider types shown differ among the CEs since they were determined by the way providers were organized in the directories.

DentaQuest

DentaQuest's directory file contained separate sections for general practitioners and various specialists and was the only directory to be organized by city rather than county. Thus, the page ranges for cities in the selected counties were used for selecting the pages to be sampled. Cleveland and Oklahoma were the only two counties that had specialists listed. It was decided that only pages with at least 5 records for the county of interest would be included when determining the sample for this CE. Since the number of records per page was low for most of the selected counties, most pages evaluated were for general dentists in Oklahoma County (see Table B.7).

Table B.7. Number of Directory Pages Selected for Review – DentaQuest

Provider Type	Okla.	Clev.	Okmu.	Pont.	Marsh.	Push.	Total
Dentists – General Practice	**20**	**0**	**1**	**1**	**0**	**0**	**22**
Dentists – Specialists	**2**	**0**	**0**	**0**	**0**	**0**	**2**
Pediatric	2						2
Total	**22**	**0**	**1**	**1**	**0**	**0**	**24**

LIBERTY

The number of directory pages for the rural counties was low; therefore, most pages were selected from Oklahoma County (see Table B.8). Pushmataha and Marshall did not have any specialists. Pontotoc and Okmulgee had a small number of specialists, but not enough to populate a full directory page; as a result, specialists were drawn from Oklahoma and Cleveland counties.

Table B.8. Number of Directory Pages Selected for Review – LIBERTY							
Provider Type	**Okla.**	**Clev.**	**Okmu.**	**Pont.**	**Marsh.**	**Push.**	**Total**
Dentists – General Practice	**14**	**3**	**1**	**1**	**1**	**1**	**21**
Dentists – Specialists	**7**	**2**	**0**	**0**	**0**	**0**	**9**
Endodontics	1	0					1
Oral Surgery	1	1					2
Orthodontics	1	1					2
Pedodontics	2	0					2
Periodontics	1	0					1
Prosthodontics	1	0					1
Total	**21**	**5**	**1**	**1**	**1**	**1**	**30**

Aetna

The provider types were taken from the Table of Contents of Aetna's directory. Page ranges from the Table of Contents were used to randomly select pages to review. Note that the intention was to sample one page of hospitals from each of the selected counties, but Pontotoc did not have hospitals listed. An extra page was selected from the behavioral health care providers for Cleveland County to total 60 pages. The number of pages reviewed per county and claim type are shown in Table B.9.

Table B.9. Number of Directory Pages Selected for Review – Aetna							
Provider Type	**Okla.**	**Clev.**	**Okmu.**	**Pont.**	**Marsh.**	**Push.**	**Total**
Individual	**10**	**7**	**3**	**4**	**3**	**3**	**31**
Primary Care Providers	3	2	1	1	1	1	9
Specialists	3	2	1	1	1	1	9
Vison Providers	1	1	0	1	0	0	3
Behavioral Health Care Providers	3	3	1	1	1	1	10
Groups and Facilities	**8**	**6**	**4**	**3**	**4**	**4**	**29**
Hospitals	1	1	1	0	1	1	5
Pharmacies	3	2	1	1	1	1	9
Clinics	3	2	1	1	1	1	9
Ancillary	1	1	1	1	1	1	6
Total	**18**	**13**	**7**	**7**	**7**	**7**	**60**

Pharmacies included durable medical equipment (DME) and medical supply dealers.

Clinics included group practices for primary care, specialty, vision care, and behavioral health care providers. It also included Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), urgent care clinics, and hospital-based clinics.

Ancillary providers included ambulances, home health agencies, hospices, laboratories, lactation consultants, nursing facilities.

Humana

Humana's regional directories contained providers listed by specialty and county. Marshall County did not have a page for hospital providers; therefore, an extra page was drawn from Oklahoma County. All

labs in Oklahoma County were the same as those listed for the other counties reviewed; consequently, a single representative page from Oklahoma County was reviewed. Page ranges were determined via manual lookup and were used to randomly select pages to review (see Table B.10).

Table B.10. Number of Directory Pages Selected for Review – Humana							
Provider Type	**Okla.**	**Clev.**	**Okmu.**	**Pont.**	**Marsh.**	**Push.**	**Total**
Individual and Groups	**10**	**6**	**4**	**4**	**3**	**3**	**30**
Primary Care Providers	3	2	1	1	1	1	9
Specialists	3	2	1	1	1	1	9
Vison Providers	1	0	1	1	0	0	3
Behavioral Health Care Providers	3	2	1	1	1	1	9
Facilities	**11**	**6**	**3**	**4**	**3**	**3**	**30**
Hospitals	2	1	1	1	0	1	6
Urgent Care Clinics	1	0	0	1	0	0	2
Pharmacies	3	2	1	1	1	1	9
Durable Medical Equipment	1	1	0	0	1	0	3
Laboratory	1	0	0	0	0	0	1
Others	3	2	1	1	1	1	9
Total	**21**	**12**	**7**	**8**	**6**	**6**	**60**

OCH and OCH-CSP

The provider directories for Oklahoma Complete Health's medical and Children's Specialty Program networks were organized the same. The number of pages selected per provider type and county was the same for both directories. However, the random selection and review of pages was done separately (see Table B.11).

Table B.11. Number of Directory Pages Selected for Review – OCH and OCH-CSP							
Provider Type	**Okla.**	**Clev.**	**Okmu.**	**Pont.**	**Marsh.**	**Push.**	**Total**
Individuals	**10**	**7**	**4**	**3**	**2**	**4**	**30**
Primary Care Providers	3	2	1	1	1	1	9
Medical Specialists (including Behavioral Health)	6	5	2	2	1	2	18
Vison Providers	1	0	1	0	0	1	3
Facilities	**8**	**6**	**4**	**4**	**4**	**4**	**30**
Hospitals	1	1	1	1	1	1	6
Primary Care (FQHCs, RHCs, and Urgent Care Clinics)	1	1	1	1	1	1	6
Ancillary	3	2	1	1	1	1	9
Pharmacies	3	2	1	1	1	1	9
Total	**18**	**12**	**8**	**8**	**7**	**7**	**60**

Note that additional pages were selected for review for behavioral health providers, as these providers appeared to be included with other specialists for this category. Several different types of pharmacies were listed in each of OCH's directory files (e.g., retail pharmacies, long-term care pharmacies, etc.).

Pages ranges for sampling for pharmacies included those for each type of pharmacy listed in the directory.

FQHCs and RHCs are also listed in the Primary Care, Clinics, or Urgent Care subcategory, which is logical since they also offer primary and non-primary care services. However, the section labeled FQHC/RHC in the directory table of contents only appeared to contain records for FQHCs, with RHCs appearing in other sections. As such, page ranges for sampling for clinics and urgent care included the FQHC/RHC section of the directory files and it is possible that the pages reviewed for the primary care category included pages with FQHCs or RHCs listed.

4. Validation of Time and Distance Standards

SoonerSelect *network adequacy standards* include minimum distances (expressed in miles) between a member's address and CE network providers. The minimum distances vary depending on provider category and specialty, age of member, and the population density of the county in which the member resides. The *network adequacy indicator* for the standards (a measure assessing the degree to which the standards are being met) reported quarterly by the CEs to the State is the number of enrollees within the access standard. This appendix details the methodology and results of KFMC's validation of a set of indicators reported by DentaQuest, LIBERTY, Aetna, Humana, Oklahoma Complete Health, and OCH-CSP.

KFMC conducted this validation in accordance with the February 2023 Validation of Network Adequacy protocol worksheets and narrative provided by the Centers for Medicare & Medicaid Services. The protocol outlines six activities for the validation and provides multiple questions for consideration:

- Activity 1: Define the Scope of the Validation
- Activity 2: Identify Data Sources for Validation
- Activity 3: Review Information Systems Underlying Network Adequacy Monitoring
- Activity 4: Validate Network Adequacy Monitoring Data, Methods, and Results
- Activity 5: Communicate Preliminary Findings to Managed Care Plans
- Activity 6: Submit Findings to State

Activity 1: Define the Scope of the Validation

In discussions with the State, the network adequacy standards to be evaluated were determined to be the distance measures reported on the DATA_NETWORK_ADEQUACY tab of the CEs' November 2025 Network Adequacy Reports. For medical CEs, there is another tab on the report that contains counts of pharmacies by ZIP code (i.e., the DATA_PHARMACY_NETWORK_ADEQUACY tab). However, KFMC did not complete similar checks of counts of providers and locations for this tab of the report. County-level pharmacy counts are included in the primary tab of the report, so validation of those counts was deemed sufficient. Note that the format of the reporting template was updated for the November 2025 submission, so discrepancies identified related to counts of providers and locations may be partially attributable to this change.

The network adequacy indicator for the distance standard is the "Number of Enrollees with Access." All CEs calculated distances from members to providers "as the crow flies."

The above indicator was not directly assessed. Rather, data used to calculate two additional metrics within the Network Adequacy Report were validated to assess the accuracy and completeness of the CEs' reports. KFMC assumed that if the data used to calculate the following metrics was complete and accurate, then the number of enrollees within the access standard was likely calculated correctly by the CEs' standardized mapping software used to calculate the indicator. These two metrics were:

- Number of providers, and
- Number of provider locations.

Activity 2: Identify Data Sources for Validation

Source data were obtained from the CEs, the State, and other EQR activities:

- Data from SoonerSelect CEs
  - November 2025 Network Adequacy Report – a report from each CE submitted to the State detailing the number of participating providers and locations that SoonerSelect members have access to. This is also sometimes referred to as the SEL-1101 for medical CEs or the DEL-1101 for dental CEs.
  - Cleaned provider network file – a copy of the table used to derive the counts of unique providers and locations reported on the November 2025 Network Adequacy Report.
  - CE process documentation – instructions, technical specifications, and coding steps for creating the Provider List tab and for calculating the counts of providers and locations reported on the Network Adequacy Report. This portion of the data from the CEs may be outdated due to the timing of KFMC's initial data request and the format change for the Network Adequacy Report described in Activity 1 above.
- Data from the State
  - State provider table – a copy of State records of provider data as of December 2025 were provided to KFMC by the State for EQR activities. Since this table was dated slightly later than the November 2025 Network Adequacy Reports, slight discrepancies between these data and the data from the CEs is expected.
- Other EQR activities
  - 2024 ISCA Reports and related documentation – ISCAs are conducted biannually to collect information to validate the capabilities of the CEs' information systems, processes, and data.

Activity 3: Review Information Systems Underlying Network Adequacy Monitoring

From the latest ISCA (conducted during 2024), it was determined that each of the CEs collect data for their network adequacy reports from their internal provider data systems. No significant concerns were noted related to the CEs' systems or processes for storing provider data. No significant systems upgrades, consolidations, or mergers were noted that would affect this year's validation.

Activity 4: Validate Network Adequacy Monitoring Data, Methods, and Results

Validation of November 2025 Network Adequacy Reports

Initial Observations

While reviewing the Network Adequacy Reports and preparing their records for analysis, the following observations were made.

Providers are assigned a Provider ID and Service Location ID(s) at the time of enrollment in Oklahoma Medicaid and are enrolled as either individual providers or business providers.

The two types of providers were distinguished by matching the provider's NPI from the CE's provider table to an NPI in the State's provider table. Records with no NPI populated and records where there was no match on NPI to the State's table were included in some attempts to match counts of providers and locations and were excluded from matching against State records. Note that there are no provider types reported on the Network Adequacy Reports for which an NPI would not be necessary, so if counts of providers and locations were only able to be matched by including records without an NPI populated, this would be worth further investigation by the State and relevant CE(s).

Preliminary Analysis

The general approach to reproducing provider and location counts involved reviewing the relevant documentation submitted by the CE related to counting of providers and locations and counting in the same way as documented. If counts did not match, KFMC attempted a variety of different methods of counting to attempt to reproduce the reported counts (see the Analytic Plan described below for details).

After deduplication using all fields, the provider table submitted by Aetna contained 1,013,843 records. After removing records without an NPI or specialty category populated and records that had NPIs that were registered as both an individual and a business, Aetna's table contained 1,013,829 records. For each remaining provider record, there was an NPI, a name, address information, and a code indicating the provider's specialty category on the Network Adequacy Report (**not** the specialty code). Specialty categories can contain multiple specialty codes, so the validation of this information will not be as strict as validation of the provider's specialty code.

After deduplication using all fields, the provider table submitted by Humana contained 164,205 records. After removing records without an NPI populated, records with specialty codes that did not appear on the Network Adequacy Report, records without address information, and records that had NPIs that were registered as both an individual and a business, there were 147,130 records remaining for comparison against the State's data. From KFMC's 2024 ISCA, "Humana's system matches on NPIs and applies the State's primary location identifier to all addresses for the provider. The Provider Information Management System auto assigns a unique location identifier for each service location. Humana flags the primary service location based on data from its providers." As such, even though there was a provider ID and service location in the table submitted by Humana for each provider record, it could not be used to determine which of the State's records should be used to compare against; thus, NPIs were used to validate provider address and specialty information.

After deduplication using all fields and removal of records that had NPIs that were registered as both an individual and a business, the provider table submitted by OCH contained 52,080 records. After

deduplication using all fields and removal of records that had NPIs that were registered as both an individual and a business, the provider table submitted by OCH-CSP contained 51,967 records. All records contained an NPI. Similar to Aetna, OCH provided the category for each provider record. OCH also provided a provider type code and specialty code for each record and an indicator for whether a record was for a provider or a practitioner, so this field was used to categorize the records for reporting by business or individual rather than using the State's table.

After deduplication using all fields, the provider table submitted by LIBERTY contained 1,119 records. The approach for LIBERTY differed from the other CEs. LIBERTY included columns that seemed to contain the provider type and specialty code for each record, but these seemed to be internal provider type and specialty codes. It also did not appear that these codes were cross walked to codes used for reporting in Oklahoma. For example, the provider type column was populated with 3-digit codes; provider types in the State's table were only 2 digits and the first 2 digits of the codes from LIBERTY did not correspond to any provider type codes used in the Network Adequacy Report. As such, KFMC used the NPIs of the records provided to see if there was at least one specialty for that NPI that appeared on the Network Adequacy Report. There were 5 records that did not match to an NPI in the State's table, so they were removed from further analysis. All remaining records (1,114) had at least one specialty in the State's table that appears on the Network Adequacy report. Since this was the limit of the validation that was able to be completed for specialty information for LIBERTY, they are not included in the results tables that cover provider specialty information. Provider addresses were still validated as with the medical CEs. However, all records from LIBERTY appeared to be for practitioners, so their results are only presented in Table B.8 for individuals.

DentaQuest did not submit a provider table for validation. As such, KFMC was unable to complete required validation activities for this CE.

Regarding the data received from the State, there were 357 records that did not have a primary address number in the address line 1 field for a provider's service location address. Some of these records had a primary address number in the address line 2 field, some records were PO boxes, most records had the primary number in words rather than as a number. See Matching Addresses for how these cases were handled. There were also a small number of NPIs that returned multiple enrollment indicators, meaning the provider was registered as both an individual and a business. As mentioned above, if these NPIs were found in a CE's dataset, they were identified and removed (except for OCH and OCH-CSP since they provided an enrollment indicator in their tables).

Analytic Plan

Here, a brief overview of the methods used for the validation is provided, followed by a detailed description of each step taken for the validation. First, the cleaned provider network tables provided by each CE were used to reproduce the counts of providers and locations reported. Second, the records in the network provider tables were matched to State records to check for consistency between State and CE records.

To verify that the cleaned provider network files could be used to reproduce the reported counts, KFMC conducted the following steps for each CE:

1. Load the respective CE's cleaned provider network table.

2. If provided, follow the CE's process documentation for counting providers and locations from the cleaned provider network table. Otherwise, count providers based on deduplicated counts of NPI and specialty stratum. Note that a provider can have multiple codes in the same stratum. In these cases, count the provider only once for the stratum. For locations, count distinct address information included in the deduplicated tables.
3. If the calculated counts differ from those reported by more than 1% (rounded to the nearest integer) or 1 provider or location, whichever is greater, make additional attempts to match the counts reported, including additional cleaning of address information, counting a combination of address fields if the first attempt only used address line 1, and restricting provider records based on data included in the provider network table (e.g., PCP status).

To verify the provider data used for the November 2025 Network Adequacy Report were consistent with the State's data, KFMC compared each CE's network provider table against the State's provider table. The primary method for identifying State records to compare against was based on NPI. Separate results are presented for individual and business providers. In these steps, the NPI refers to the identifier contained within the provider network files. The State's provider table only contained providers active when the file was created. This meant that changes to provider data made between November 2025 and December 2025 would have caused issues with matching in the steps described below. These issues are expected to have a small impact on the results presented below. To maximize the chance of finding a matching address or specialty record in the State's provider table when comparing to records from each CE, effective and end dates were not used to restrict provider data. Future analyses may account for effective and end dates for all relevant fields to better define the extent of issues related to discrepancies between State and CE provider data. A breakdown of issues found with the matched records is included in the narrative below.

The comparison between State and CE records was completed using the following steps:

1. Load the respective CE's network provider table. The tables include NPIs, name fields, and address fields. They may also include provider type codes, provider specialty codes, and an identifier for the provider category.
2. Clean the data.
    a. Restrict records to only include specialties on the Network Adequacy Report.
    b. Exclude records with missing NPI.
    c. Identify the primary address number (aka, street number or house number). If the first character of Address Line 1 is numeric, then use the leading number of Line 1 as the primary address number. Otherwise, if the first character of the second address line is numeric, use the first number of Line 2 as the primary address number and interchange the contents of Line 1 and Line 2 (this interchanging often moves post office box numbers to the second line and the street address to the first line). If neither of the above conditions are met, use the entire Address Line 1 as the primary address number.
    d. Remove spaces and non-alphanumeric characters from each relevant field (NPI, primary address number, city, state, ZIP code, provider type, provider specialty, and provider category).
    e. Exclude records that were not able to be matched on NPI to the State's table. Records not matched on NPI are presented in Table B.12 below.
    f. Add leading zeros stripped by Excel to ZIP codes and specialty codes.
    g. Add a unique record identifier.

3. Obtain the service locations corresponding to the network provider record. Crosswalk the NPIs to service locations using the NPIs in the State's provider table. An NPI may match to multiple service locations.
4. For each service location identified in Step 3, compare addresses from the provider network tables to each service location address available from the State's address table. See Matching Addresses for details.
5. Compare specialty codes and categories from records in the provider network tables to records collected from the State's provider table. All records for individuals and businesses had specialties checked regardless of whether a full match was found for the provider's address information. This may be updated in future years if, for example, KFMC determines that provider specialties should be location specific for businesses. See Matching Specialties for details.

Matching Addresses

This section provides details to Step 4 of the analytic plan. The first part explains how address information was obtained from the State's provider table and cleaned in preparation for comparing to network provider table addresses. The second part details the algorithm for matching addresses.

Creating the Table of Addresses

The resulting *Table of Addresses* included these fields:

- NPI
- Enrollment Type Code – indicates whether the provider was enrolled as a business (B), or an individual (P)
- Provider Type Code – two-digit code identifying the provider type (e.g., 01 – hospital)
- City, State, and ZIP code – stored in separate fields, five digits for ZIP code
- Primary Address Number – determined from Address Lines 1 and 2

The Table of Addresses was created as follows:

1. Using the NPIs collected in Step 2 above, collect the following information from the State's provider table.
    a. Collect the provider type code and enrollment type code from the State's provider table.
    b. For individuals and businesses, collect all service location address information, including the address lines, city, state, and five-digit ZIP code from the addresses table using the NPIs; determine the primary address number as above.
    c. Drop any unused columns (e.g., Address Lines 1 and 2 after determining the primary address number)

Criteria for Matching Addresses

Address data were cleaned prior to comparison. The relevant fields were converted to upper case and all non-alphanumeric characters were removed, including spaces. Where applicable, provider type code was extracted from the CEs' data for comparison along with the address information, since the provider type code was expected to be location-specific. Records that had the same NPI, primary address number, city, state, five-digit ZIP code, and provider type code were considered to have a *full match*. Records that had the same NPI, city, five-digit ZIP code, primary address number, state, but not provider type code were not a full match. Those records that could not be fully matched to the State's provider table were excluded from further analysis. These steps may return more than one match for a single record. The counts and percentages of records matched to State's provider table were calculated and

presented in Activity 5 below. Counts and percentages are based on unique record identifiers from each CE's data created in Step 2 above.

Matching Specialties

This section provides details to Step 5 of the analytic plan. In addition to verifying specialty codes, the specialty category for providers was considered, that is, the specialty category that a provider would be counted under on the Network Adequacy Report. A single category can include multiple specialty codes (e.g., specialty codes 312 and 550 are in the cardiology category), thus verifying specialty category is less strict (sometimes substantially so) than verifying specialty code. Since the specialty category was determined from the specialty code, records that are verified on specialty code are also verified on specialty category. All specialties associated with an NPI were extracted from the State's provider table using the following method:

1. For each NPI, obtain the specialties associated with that NPI from the State's provider table.
2. Using the specialty codes, create a specialty category field based on the categories defined in the crosswalk table provided by the State. This is the *specialties table*.
3. Extract the specialty code from the CE's network provider table, create a specialty category field similar to the previous step, match on the NPI to the specialties table and create a flag to identify records where the specialty code could be verified. Create another flag to identify records where the specialty category could be verified.

The percentage of records verified on specialty code and category were calculated and are presented in the following section.

Activity 5: Communicate Preliminary Findings to Managed Care Plans

The analytic plan described above was implemented for each of the CEs with the objective of validating the counts of providers and locations on the November 2025 Network Adequacy Report. Using the CEs' provider network files, KFMC calculated counts of providers and locations, stratified by specialty category and county.

Documentation submitted by Aetna in October 2025 appeared to apply to the previous reporting template. Based on a comparison of counts from prior reports and the counts generated using the updated template, the methods for counting providers and locations appeared to remain unchanged. The documentation indicated that provider counts were based on the number of provider records within each provider group; however, no definition was provided for what constituted a provider group. Based on the data provided, it appeared that the grouping corresponded to the specialty category assigned to each provider for the Network Adequacy Report. When grouping records by county in addition to provider group, the provider counts calculated by KFMC generally matched those reported by Aetna. After excluding categories in which provider counts were zero, KFMC was unable to reproduce 29 of the 1,699 non-zero reported provider counts. For these mismatches, KFMC's calculated counts were consistently higher than those reported by Aetna. In some categories where Aetna reported zero providers, KFMC identified more than zero. These discrepancies suggest that additional exclusion criteria may have been applied by Aetna that were not documented or available for KFMC's review.

Technical specifications used by Aetna state that provider "location counts are based on distinct latitude and longitude coordinates." However, the provider file submitted did not include latitude and longitude fields. Counts based on distinct address fields should have yielded comparable results, but the counts

reported by Aetna were inconsistent with counts derived from distinct addresses. For example, Aetna reported 1,054 for Adult Mental Health provider locations for Adair County, but 11 distinct addresses remained after cleaning; the reported count was close to a count of provider records (1,068) rather than distinct address fields. These discrepancies indicate that Aetna did not count provider locations as documented, and the basis for the reported counts is unclear. Therefore, KFMC does not consider the location counts reported by Aetna to be valid.

A significant issue that KFMC noted was that Aetna did not include county-level counts of pharmacy providers, despite those counts being required. This issue was also identified with Humana's reported county-level pharmacy counts.

Humana submitted documentation which stated that providers were counted based on distinct NPIs in a given county on the Network Adequacy Report. The documentation did not appear to be relevant for the updated Network Adequacy Reporting template. KFMC attempted to reproduce the reported counts using the methods described. The network provider file submitted by Humana did not include an identifier that clearly linked a provider record to its corresponding category on the Network Adequacy Report. The only potentially relevant column included categories that are not used on the Network Adequacy Report; therefore, KFMC cross walked the Oklahoma specialty code provided by Humana to their corresponding specialty categories using a state-provided crosswalk.

Using the network provider table submitted for the November 2025 Network Adequacy Report, counts of providers were reproduced for some specialty categories, but significant discrepancies were identified for others. For Cleveland County, KFMC was able to reproduce the reported count of locations, but the number of providers reported by Humana (111) far exceeded the number of providers calculated by KFMC (48). Similar discrepancies were observed for counts of PCPs and mental health providers. Counts of locations calculated by KFMC generally matched counts reported by Humana.

Humana's initial submission included a provider network table aligned with the August 2025 Network Adequacy Report, and KFMC was able to reproduce the corresponding reported counts from that file.

Documentation of the process for preparing data and counting providers and locations using standardized mapping software for the Network Adequacy Report was provided by OCH and OCH-CSP. Only providers participating in the OCH or OCH-CSP networks are included on the reports. Reports are submitted separately for OCH and OCH-CSP. Additional data cleaning of provider records includes removing records for hospital-based providers, records for providers that failed credentialing, and records with an invalid address. OCH and OCH-CSP only include providers listed as active on the provider master list sent by OHCA in their reports. The method for determining the ages served variable was described. For providers with a value listed, those that serve only members 21 and older are counted as serving adults, while those that serve only members under 21 are counted as a pediatric provider. Those that serve any overlap of these two ranges and those with no data regarding the ages that the provider serves are counted as serving both adult and pediatric members.

Counts of providers, stratified by specialty code and county, are determined from distinct NPIs. OCH and OCH-CSP stated that practitioners are only to be counted at locations in which they are providing services. This is determined via provider rosters sent to OCH and OCH-CSP by their providers. The documentation stated that location counts are based on "unique locations by specialty and service

area." KFMC attempted to match the number of locations by counting distinct addresses, stratified by specialty and county. Most counts of providers and locations could be reproduced; however, zero providers and locations were reported for Le Flore County, but there were many provider records with this county included in the provider network files that were submitted. There were also small discrepancies in counts of providers and locations for some mental health, therapist, and primary care providers for a few counties.

The documentation submitted by LIBERTY referenced Florida Medicaid, though it was similar to documentation submitted for KFMC's 2024 Network Adequacy Validation. The documentation provided an outline of how member and provider data are prepared prior to being loaded into standardized mapping software used for reporting.

KFMC attempted to use the specialty field, in combination with the NPI and address fields from the provider network table that was submitted, to reproduce counts on LIBERTY's November 2025 Network Adequacy Report. However, there were only three distinct specialties listed, dentist, pediatric dentist, and general practitioner specializing in pediatric dentistry. There are several additional specialties in the Network Adequacy Report for which LIBERTY reported non-zero counts of providers. Several Oklahoma counties which LIBERTY reported had dentists were not represented in the network provider file (e.g., Adair County). Additionally, two specialties (general dentistry oral pathologist and general dentistry prosthodontist) did not have provider or location counts populated on the report. Due to these inconsistencies, KFMC determined that the counts of providers and locations reported by LIBERTY are not valid.

Table B.12 describes the percentage of records from the network provider tables that matched on NPI to at least one record in the State's provider table. Generally, there were very few records for which an NPI could not be found in the State's provider table.

Table B.12. Records that matched on NPI to the State's Provider Table

LIBERTY	**N**	**%**
Records under evaluation	1,119	100%
Minus – No Match on NPI	5	<1%
CE Records that Matched on NPI to State records	**1,114**	**>99%**
Aetna	**N**	**%**
Records under evaluation	1,013,829	100%
Minus – No Match on NPI	1,002	<1%
CE Records that Matched on NPI to State records	**1,012,827**	**>99%**
Humana	**N**	**%**
Records under evaluation	147,130	100%
Minus – No Match on NPI	349	<1%
CE Records that Matched on NPI to State records	**146,781**	**>99%**
OCH	**N**	**%**
Records under evaluation	52,080	100%
Minus – No Match on NPI	37	<1%
CE Records that Matched on NPI to State records	**52,043**	**>99%**
OCH-CSP	**N**	**%**
Records under evaluation	51,967	100%
Minus – No Match on NPI	35	<1%
CE Records that Matched on NPI to State records	**51,932**	**>99%**

Source: CE Provider Network tables for November 2025 submitted December 2025, Oklahoma Provider Network table as of December 2025.

Results for Individual Providers

KFMC stratified the results of matching on provider specialty information and provider address information by whether the NPI for the provider was listed as a business NPI or individual NPI. Results are presented for records of individuals that matched on location information in Table B.13. For Humana, OCH, and OCH-CSP, a substantial number of records matched on address information, but not provider type code. All CEs had a large portion of records that were unable to be matched on the address fields or provider type codes that were checked.

Table B.13. Locations Verified Using NPI – Individuals

LIBERTY	N	%
Records under evaluation	1,114	100%
Minus – No Match on location	745	67%
Minus – Matched on location, not provider type code*		
CE Records Fully Matched to State records	**369**	**33%**
Aetna	**N**	**%**
Records under evaluation	997,892	100%
Minus – No Match on location	848,139	85%
Minus – Matched on location, not provider type code		
CE Records Fully Matched to State records	**149,753**	**15%**
Humana	**N**	**%**
Records under evaluation	107,958	100%
Minus – No Match on location and provider type code	61,126	57%
Minus – Matched on location, not provider type code	5,069	5%
CE Records Fully Matched to State records	**41,763**	**39%**
OCH	**N**	**%**
Records under evaluation	45,712	100%
Minus – No Match on location and provider type code	25,442	56%
Minus – Matched on location, not provider type code	11,243	25%
CE Records Fully Matched to State records	**9,027**	**20%**
OCH-CSP	**N**	**%**
Records under evaluation	45,588	100%
Minus – No Match on location and provider type code	25,383	56%
Minus – Matched on location, not provider type code	11,116	24%
CE Records Fully Matched to State records	**9,089**	**20%**

Source: CE Provider Network tables for November 2025 submitted December 2025 Oklahoma Provider Network table as of December 2025.

*LIBERTY and Aetna did not include provider type codes in the data table that they submitted, so provider type codes for their providers could not be validated. Thus, this aspect of the validation is less rigorous for LIBERTY and Aetna than the other CEs.

Of LIBERTY's records for individual providers, 33% matched on primary address number, city, state, and ZIP code to a State record.

Of Aetna's records for individual providers, 15% matched on primary address number, city, state, and ZIP code to a State record.

Of Humana's records for individual providers, 39% matched on primary address number, city, state, ZIP code, and provider type to a State record.

Of OCH's and OCH-CSP's records for individual providers, 20% matched on primary address number, city, state, ZIP code, and provider type to a State record.

Results for records of individuals that matched on specialty information are shown in Table B.14. Generally, the results indicated alignment between the data from the State's provider table and the CEs' network provider files. It is worth noting that a substantial portion of records for Humana, OCH, and OCH-CSP were only able to be matched on specialty category, not specialty code.

Table B.14. Specialties Verified Using NPI – Individuals

Aetna	N	%
Records with specialties under evaluation	997,892	100%
Minus – Not Matched on Specialty Category	32	<1%
CE Records with Specialties Verified	**997,860**	**>99%**
Verified Specialty Code and Category*		
Verified Specialty Category, not Code	997,860	100%
Humana	**N**	**%**
Records with specialties under evaluation	107,958	100%
Minus – Matched Neither Specialty Code or Category	3,039	3%
CE Records with Specialties Verified	**104,919**	**97%**
Full Matches (Verified Specialty Code and Category)	87,024	83%
Verified Specialty Category, not Code	17,895	17%
OCH	**N**	**%**
Records with specialties under evaluation	45,712	100%
Minus – Matched Neither Specialty Code or Category	901	2%
CE Records with Specialties Verified	**44,811**	**98%**
Full Matches (Verified Specialty Code and Category)	36,733	82%
Verified Specialty Category, not Code	8,081	18%
OCH-CSP	**N**	**%**
Records with specialties under evaluation	45,588	100%
Minus – Matched Neither Specialty Code or Category	896	2%
CE Records with Specialties Verified	**44,692**	**98%**
Full Matches (Verified Specialty Code and Category)	36,720	82%
Verified Specialty Category, not Code	7,972	18%

Source: CE Provider Network tables for November 2025 submitted December 2025, Oklahoma Provider Network table as of December 2025.
*Aetna did not include provider specialty codes in the data table that they submitted, so specialty codes for their providers could not be validated. Thus, this aspect of the validation is less rigorous for Aetna than the other CEs.

Results for Business Providers

Counts of November 2025 Network Adequacy Report records for business providers, stratified by CE, are shown in Table B.15. The number and percentage of those records matched to the State's provider table on address and provider type information are shown.

Table B.15. Locations Verified Using NPI – Businesses		
Aetna	**N**	**%**
Records under evaluation	14,935	100%
Minus – No Match on location	95	<1%
Minus – Matched on location, not provider type code*		
CE Records Fully Matched to State records	**14,840**	**>99%**
Humana	**N**	**%**
Records under evaluation	38,823	100%
Minus – No Match on location and provider type code	10,415	27%
Minus – Matched on location, not provider type code	22,712	59%
CE Records Fully Matched to State records	**5,696**	**15%**
OCH	**N**	**%**
Records under evaluation	6,331	100%
Minus – No Match on location and provider type code	1,813	29%
Minus – Matched on location, not provider type code	534	8%
CE Records Fully Matched to State records	**3,984**	**63%**
OCH-CSP	**N**	**%**
Records under evaluation	6,344	100%
Minus – No Match on location and provider type code	1,787	28%
Minus – Matched on location, not provider type code	536	8%
CE Records Fully Matched to State records	**4,021**	**63%**

Source: CE Provider Network tables for November 2025 submitted December 2025 Oklahoma Provider Network table as of December 2025.
*Aetna did not include provider type codes in the data table that they submitted, so provider type codes for their providers could not be validated. Thus, this aspect of the validation is less rigorous for Aetna than the other CEs.

Of Aetna's records for business providers, over 99% were able to be matched to a record in the State's provider table on primary address number, city, state, and ZIP code. Although most records for Aetna were considered *fully matched*, recall that provider type codes were not validated, so this aspect of the analysis was not as rigorous as intended.

Of Humana's records for business providers, 15% were *fully matched* to a record in the State's provider table on primary address number, city, state, ZIP code, and provider type. An additional 59% of records matched on primary address number, city, state, and ZIP code.

Of OCH's and OCH-CSP's records for business providers, 63% were *fully matched* to a record in the State's provider table. An additional 8% of records matched on primary address number, city, state, and ZIP code.

Results for records of businesses that matched on specialty information are shown in Table B.16. For Aetna, OCH, and OCH-CSP, the results indicated alignment between the data from the State's provider table and the CEs' network provider files. For Humana, a majority of records (71%) were validated.

Table B.16. Specialties Verified Using NPI – Businesses		
Aetna	**N**	**%**
Records with specialties under evaluation	14,935	100%
Minus – Matched Neither Specialty Code or Category	9	<1%
CE Records with Specialties Verified	**14,926**	**>99%**
Full Matches (Verified Specialty Code and Category)*		
Verified Specialty Category, not Code	14,926	100%
Humana	**N**	**%**
Records with specialties under evaluation	38,823	100%
Minus – Matched Neither Specialty Code or Category	11,089	29%
CE Records with Specialties Verified	**27,734**	**71%**
Full Matches (Verified Specialty Code and Category)	3,077	11%
Verified Specialty Category, not Code	24,657	89%
OCH	**N**	**%**
Records with specialties under evaluation	6,331	100%
Minus – Matched Neither Specialty Code or Category	575	9%
CE Records with Specialties Verified	**5,756**	**91%**
Full Matches (Verified Specialty Code and Category)	4,147	72%
Verified Specialty Category, not Code	1,609	28%
OCH-CSP	**N**	**%**
Records with specialties under evaluation	6,344	100%
Minus – Matched Neither Specialty Code or Category	563	9%
CE Records with Specialties Verified	**5,781**	**91%**
Full Matches (Verified Specialty Code and Category)	4,156	72%
Verified Specialty Category, not Code	1,625	28%

Source: CE Provider Network tables for November 2025 submitted December 2025, Oklahoma Provider Network table as of December 2025.
*Aetna did not include provider specialty codes in the data table that they submitted, so specialty codes for their providers could not be validated. Thus, this aspect of the validation is less rigorous for Aetna than the other CEs.

Conclusions

To check for consistency between the State's data and the data maintained by the CEs, KFMC matched CE records to the State's provider table using NPI and found several issues with the provider data used for reporting of network adequacy by each of the CEs.

For LIBERTY, only a small proportion (33%) of records for individuals were able to be matched on address information.

For Aetna, the specialty categories for records (individual and business records combined) that were not matched on address information were commonly for adult and pediatric mental health and adult and pediatric primary care providers.

For Humana, the specialty categories for records (individual and business records combined) that were not matched on address information were commonly for adult and pediatric mental health, adult and pediatric primary care providers, and therapy providers.

For OCH and OCH-CSP, the specialty categories for records (individual and business records combined) that were not matched on address information were commonly for adult and pediatric mental health and adult and pediatric primary care providers.

As stated above, DentaQuest did not provide a network provider file, so their provider data and Network Adequacy Report could not be validated.

Overall, records of provider specialties were usually able to be verified, though there was a substantial portion for each CE that that could only be verified on specialty category, not code. For the purposes of this validation, this was considered acceptable. However, specialty data for these providers should be indicative of what a member would see in an online provider directory; this is concerning as not all specialties in a particular category are interchangeable, so this may mislead members into believing that certain specialty services are available in their area when that may not be the case.

Beyond issues with reproducing counts of providers and locations for several CEs, another potential issue that KFMC highlighted in the 2024 Network Adequacy Validation that has persisted is that the CEs count providers and locations differently. This makes it difficult to compare one CE's provider network to another since different things are being measured. KFMC maintains that consistently counting providers and locations for reporting purposes is important for accurately assessing the adequacy of a CE's network.

The State considers their provider data to be the source of truth. As such, the State and CEs should work together and with the State to resolve the issues identified in this validation and ensure that members have access to the most up to date and accurate provider information through the State's provider data. Due to limitations of matching on NPIs (see Limitations below), the State should consider whether the CEs are to maintain the unique record identifiers used by the State. If so, this would allow for a more accurate assessment of whether the CEs are properly maintaining the State's provider data in their internal systems and KFMC will include those data elements as part of our validation in future years.

Activity 6: Submit Findings to State

Overall Summary of Findings

The overall summary of findings is presented in the Validation of November 2025 Network Adequacy Report Results subsection, in the body of the report.

Conclusions Drawn from the Data

Conclusions drawn from the data are summarized in the Conclusions section in the body of the report.

Limitations

- The street address fields are subject to data cleaning and standardization; thus, they are not suitable for matching to State records. To account for this, records were compared on the primary address number instead of street address fields.
- NPIs are specific to people or businesses, but not to service locations. Therefore, joining provider network records to State records using NPI returned results for multiple service locations. Consequently, issues identified through NPIs may be underrepresented.
- Effective and end dates were not considered when determining whether a record in a CE's network provider table matched a State record.
- KFMC received a modified version of the Provider Master List that is sent to the CEs on a weekly basis. It is possible that not all active provider locations were captured in the file received.
- KFMC's data request was not fulfilled by DentaQuest. As such, KFMC was unable to complete the required validation activities for this CE.

Appendix C

SoonerSelect Program Annual External Quality Review Technical Report

2025-2026 Reporting Cycle

2025 Recommendations

The following EQR Activity recommendations are included in Appendix C:

- PIP Validation
- Compliance Review
- EPSDT Review
- QAPI Review

2025 PIP Recommendations
LIBERTY Dental
Increasing Preventive Services for Children
1. Ensure the data provided aligns with conclusions regarding success of the interventions. 2. Include data from other sources (e.g., national rates, rates from sister plans) when interpreting the strength of utilization rates. 3. Update the Baseline Measurement Period and use consistent language for the goal for Remeasurement Period 1 (i.e., replace “baseline rate” with “Baseline Measurement Period” for clarity). 4. Specify in Activity 5.1.a and 5.2.a whether texts and phone calls (respectively) are sent to all members every month, regardless of receiving services. Also, describe any differences in outreach targeting new members and those considered non-utilizers; include frequencies and turnaround time from identification to outreach. 5. Provide a PDSA of the actions taken for delayed interventions during the activity period in Activity 8.a. and details in Activity 5.1.a regarding delay of implementation of the mailing campaign for the activity period of July 1, 2024-June 30, 2025. 6. Report on all aspects of the planned intervention or provide rationale when deviations to the plan occur. 7. Be sure to communicate significant delays in intervention implementation and other major intervention changes to OHCA during the activity period. In addition, include all relevant details in Activity 8.a in the annual report. 8. Provide numerator and denominator counts for each of the measures presented in Activities 8.b and 9.a in addition to the percentages (for applicable measures). If either are 10 or less, instead report them as suppressed to avoid violating the CMS Cell Suppression Policy. 9. Provide more information regarding steps LIBERTY takes to improve outreach rates of texts and calls and why outreach rates above 25% are considered successful. 10. As stated in the PIP Instructional Guide, ensure that qualifications and responsibilities for all listed staff positions are clearly documented in Activity 10.e. 11. Update the denominator for measures Text Message_1c and Telephonic_3a to exclude members who received any form of outreach, not just text messages. 12. Adjust the ≥ 7 days requirement to only apply to the initial text or call to a member. Specify whether paid and unpaid claims are included when determining if a member has received an applicable service. 13. Ensure that successful outreach is used consistently by using the same terminology in the narrative and the measure descriptions in Activity 5.2.c and in Activity 8.b. Consider removing “live voice” from the measure descriptions. 14. Clarify what defines a region. 15. Explain the discrepancy between the reported counts of members for PIP Outcome Measure M1, M2, and M4 and the outreach campaigns and verify that the measure calculations and descriptions are accurate throughout. 16. Ensure all tables contain descriptive titles and accurately labeled columns and rows. 17. Update the bolded measure abbreviation in the last column in the table for Intervention 3 in Activity 8.b or remove it to avoid confusion. 18. Review the document thoroughly for errors or inconsistencies prior to submission.

2025 PIP Recommendations
Humana Healthy Horizons
Social Needs Screening and Intervention
1. The PIP population should reflect all members that have the potential to be included in the interventions. If members meeting the exclusion criteria are excluded retrospectively during measurement of the PIP outcome, remove the exclusion from the population. Also, remove the "and were screened…" language. Provide an updated estimate of the PIP population, if applicable, after the revisions. 2. Stratifying the HRSNs Referral Follow-up_2c measure numerator into two groups in Activity 5.2.c could help identify potential areas for improvement in future years. The two groups are: Enrollees in the denominator who were successfully outreached and Enrollees in the denominator who received three telephonic outreach attempts without successful contact. 3. Clarify whether all members with a positive HRS during the calendar year that do not receive a referral for HRSNs through the HCN (Humana Community Navigator) had their needs met through Humana's Value-Added Benefits (VAB) program. If not, stratify the measure to assess the proportion of members that screened positive and did not have their needs met through either Humana's VAB program or the HCN. 4. Include detailed information regarding data limitations discovered and process changes made during the activity year in the annual report. 5. Ensure that qualifications for all listed staff are clearly documented in Activity 10.e. 6. In the Study phase, provide more detail related to the factors impacting interventions that prevent goals from being achieved. 7. For each measure in Activities 5.1.c and 5.2.c, provide data cutoff dates (i.e., the deadlines after which no additional data can be included for a reporting period) in Activities 5.1.d and 5.2.d, respectively, and ensure those dates remain consistent across measurement periods. The data cutoff dates may be the same or different across measures. 8. When presenting results of exploratory analyses, include technical specifications for all exploratory measures. 9. Ensure all tables in the report have a distinct label. 10. If Humana is not intervening with members meeting the exclusion criteria, the report needs to address how and when these members are identified to ensure they are excluded prior to outreach. 11. Provide numerator and denominator counts for each of the measures presented in Activities 8.b and 9.a in addition to the percentages (for applicable measures). If either are 10 or less, instead report them as suppressed to avoid violating the CMS Cell Suppression Policy. 12. Ensure the data provided aligns with conclusions regarding success of the interventions. 13. Ensure sufficient data or evidence are provided to support statements made in the annual report. 14. Include follow-up actions taken due to findings from exploratory analysis or other measure results as part of the interpretation of those results in Activity 8 or 9.

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
Subpart F – Grievance and Appeal System Compliance Results	
§ 438.402(c)(1)(ii) General requirements: Filing requirements (Authority to file)	**DentaQuest and LIBERTY** 1. In the *SoonerSelect Member Handbook*, include the following information written at the appropriate member reading level: a. The member's written consent is required for an authorized representative to file a grievance. b. That an authorized representative or a provider, acting on behalf of the member with the member's written consent, may request a State Fair Hearing. (State Contract Section 1.16.7.1 "Authority and Format for Requesting Appeal") (DQ Recommendation 6/LD Recommendation 1)
Appeal Case Review related to § 438.402(c)(1) General requirements: Filing requirements (Authority to file)	**DentaQuest** 2. Provide staff education, refine internal processes, and revise any applicable Standard Operating Procedure to include, that a provider or an authorized representative can request a grievance or appeal on behalf of a member, provided there is written consent from the member and that the written consent should be documented in the CE's appeal system consistently for all applicable cases. (State Contract Section 1.16.1 "Overall Requirements") (Recommendation 7)
	LIBERTY 2. Provide staff education, refine internal processes, and revise applicable Standard Operating Procedures to ensure written consent from the member is received (and documented in the CE's appeal system consistently for all applicable cases) when a provider or other authorized representative files an appeal on behalf of a member. (State Contract Section 1.16.1 "Overall Requirements") (Recommendation 2)
§ 438.404(b)(6) Timely and adequate notice of adverse benefit determination – Content of notice	**DentaQuest** 3. Work with the State to determine the revisions needed for the following documents related to members being billed for services continued during an appeal or state fair hearing: a. Policy and procedure *UM04-INS Notice of Action Letter*, section "B. Denial Notification," number "2. The Notice of Action Letter," letter q (pages 2-3). b. *SoonerSelect Member Handbook*, section "More Information for Appeals," sub-section "Your Care While You Wait for a Decision," third bullet (page 22) c. *ORM,* section "9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals (Policies 200 Series)," (page 25). (State Contract Section 1.16.10 "Contractor Recovery") (Recommendation 9)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.404(b)(6) Timely and adequate notice of adverse benefit determination – Content of notice (Continued)	**LIBERTY** 3. Work with the State to determine the revisions needed to the following related to members being billed for services continued during an appeal or state fair hearing: a. *SoonerSelect Member Handbook*, section "More Information for Appeals," sub-section "Your Care While You Wait for a Decision," first bullet (page 23). b. Policy and procedure *Coverage and Authorization of Services*, section "Process/Procedure," sub-section "B. Authorization of Services," number 2 (pages 4-5). c. Notice of Adverse Determination letter, section "How do I ask for an Appeal?," second paragraph. d. LIBERTY website, appeal form, under the selection for Oklahoma, on the SoonerSelect Appeal Request Form (https://www.libertydentalplan.com/Resources/Documents/OK-Appeal-Request-Form-EN.pdf). (State Contract Section 1.16.10 "Contractor Recovery") (Recommendation 3)
§ 438.406(b)(1) Handling of grievances and appeals (Special requirements – grievance and appeal acknowledgement)	**DentaQuest and LIBERTY** 4. In the *SoonerSelect Member Handbook,* written at the appropriate member reading level, include a statement regarding DentaQuest/LIBERTY sending the member or authorized representative, an acknowledgement letter of receipt of the appeal. (State Contract Section 1.16.1.2 "Receipt of Grievance and Appeal") (DQ Recommendation 10/LD Recommendation 4)
§ 438.406(b)(5) Handling of grievances and appeals: Special requirements (Member's request of case file during appeal)	**DentaQuest and LIBERTY** 5. To the *SoonerSelect Member Handbook*, section "Appeals," third solid bullet (DQ)/second to the last bullet (LD) (page 21), add language, written at the appropriate member reading level, that states the information (member case file, including medical records, other documents, and records) is free of charge/no cost and provided sufficiently in advance of the resolution timeframe for appeals. (State Contract Section 1.16.1.3.2 "Access to SoonerSelect Dental Enrollee Case Files") (DQ Recommendation 18/LD Recommendation 5)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(a) and (b)(1-2) Resolution and notification: Grievances and appeals – Specific timeframes-Standard resolution of grievances	**DentaQuest** 6. To the following, add "calendar" to the specified 30-day timeframe: a. Policy and procedure *CGA01-INS-MCD Member Appeals*, section "Member Appeals Process," number 7. It would read, "The External Appeal Review agent will make a determination within thirty (30) **calendar** days upon receipt of all documentation needed to make the decision for Standard requests." (State Contract Section 1.16.7.3 "Timeframe for Standard Appeal Resolution") b. *SoonerSelect Member Handbook*, in the following: i. Page VI definition "Expedited (Faster) Appeal." ii. Page VIII, section "Key Words Used In This Handbook," definition for "Standard Appeal." iii. Pages 20-21, section "Appeals," fourth bullet. iv. Page 23, section "Requesting a State Fair Hearing," second bullet. v. Pages 24-25, section "How to File A Grievance," subsection "What Happens Next." (i-iv: State Contract Section 1.16.7.3 "Timeframe for Standard Appeal Resolution"/v: State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," first paragraph) c. *ORM*, section "9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals," subsection letter "E. Provider Complaints concerning non-claims issue." It would read, "Allowing providers to file a written complaint for issues that are not about claims at any time; Within three (3) business days of receipt of a complaint, notifying the provider in writing that the complaint has been received and the expected date of resolution; and resolving all complaints within thirty (30) **calendar** days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution." (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," first paragraph and 1.16.7.3 "Timeframe for Standard Appeal Resolution") d. DentaQuest website on the following webpages: i. "Grievances," section "What Happens Next." It would read, "We will let you know in writing that we got your grievance within 10 days of receiving it. We will review your grievance and tell you how we resolved it in writing within 30 **calendar** days from receiving your complaint." State Contract Section 1.16.6.11 "Timeframe for Resolution of Grievance," first paragraph) ii. "Appeals and State Fair Hearings," section "Appeals Process," fourth bullet, first open bullet. It would read, "Standard appeals: If we have all the information we need, we will tell you our decision in writing within 30 **calendar** days from your appeal." (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," first paragraph and 1.16.7.3 "Timeframe for Standard Appeal Resolution") (Recommendation 19)

<table>
<tr><th>Regulatory Area</th><th>2025 Compliance Review Recommendations</th></tr>
<tr><td colspan="2">Common Among the SoonerSelect Dental CEs</td></tr>
<tr><td colspan="2">Subpart F – Grievance and Appeal System Compliance Results (Continued)</td></tr>
<tr><td>§ 438.408(a) and (b)(1-2) Resolution and notification: Grievances and appeals – Specific timeframes-Standard resolution of grievances (Continued)</td><td>LIBERTY
6. To the following, add “calendar” to the specified 30-day timeframe:
a. SoonerSelect Member Handbook in the following:
i. Page 8 (of 57 PDF) definition for “Expedited (faster) Appeal.”
ii. Page 10 (of 57 PDF) definition for “Standard Appeal.”
(Also applies to § 438.408[b][2])
b. LIBERTY website, webpage “Oklahoma: Member Tools” “File A Grievance or Appeal” (https://www.libertydentalplan.com/Oklahoma/SoonerSelect/File-a-Grievance.aspx) in the following:
i. In the fourth paragraph It would read, “We will review your complaint or appeal and send you a letter of our decision within thirty (30) <u>calendar</u> days from the date we received your request.” (Also applies to § 438.408[b][1])
ii. In the fifth paragraph It would read, “If you think waiting thirty (30) <u>calendar</u> days could put your health or life at risk, you can ask for a fast review. If LIBERTY finds a fast review is needed, we will give you an answer within 72 hours from the time we received your request.”
(State Contract Section 1.16.7.3 “Timeframe for Standard Appeal Resolution”) (Recommendation 6)
7. To the Provider Reference Guide, section “Grievances, Appeals, and Provider Claims Disputes,” subsection “Member Appeals,” add the standard appeal resolution timeframe of thirty (30) calendar days. (State Contract section 1.16.7.3 “Timeframe for Standard Appeal Resolution”) (Recommendation 7)</td></tr>
<tr><td rowspan="2">§ 438.408(a) and (b)(1) Resolution and notification: Grievances and appeals – Specific timeframes-Standard resolution of grievances</td><td>DentaQuest
7. To the following documents, add language related to notifying a member of the resolution of a grievance and sending written notification to the SoonerSelect Dental Member within three (3) calendar days of the resolution of the grievance:
a. ORM, section “9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals,” sub-section “F. Member Complaints/Grievances/Appeals.”
b. SoonerSelect Member Handbook, section “What Happens Next,” written at the appropriate member reading level.
c. Policy and procedure CGA06-INS Member Grievances, letter “D. Grievance Resolution.”
(State Contract Section 1.16.6.12 “Grievance Resolution Notice Format, and Content”) (Recommendation 20)</td></tr>
<tr><td>LIBERTY
8. To the following documents, add language related to notifying a member of the resolution of a grievance and sending written notification to the SoonerSelect Dental Member within three (3) calendar days of the resolution of the grievance:
a. Provider Reference Guide, sections “Member Grievances” and “Medicaid and Medicare Member Grievances” (page 73).
b. SoonerSelect Member Handbook, (at the appropriate member reading level), section “What Happens Next.”
(State Contract Section 1.16.6.12 “Grievance Resolution Notice Format, and Content”) (Recommendation 8)</td></tr>
</table>

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
Grievance Case Review related to § 438.408(b)(1) Resolution and notification: Grievances and appeals – Specific timeframes-Standard resolution of grievances	**DentaQuest and LIBERTY** DQ 8/LD 9. Provide staff education and refine internal processes to ensure the following: a. Grievances are resolved, with notice provided, as expeditiously as the member's health condition requires but do not exceed thirty (30) calendar days from the date the CE receives the grievance; and b. Written notice of resolution of a grievance is to be provided to the impacted member within three (3) calendar days of the CE resolving the grievance. (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance" and 1.16.6.12 "Grievance Resolution Notice Format, and Content") (DQ Recommendation 21/LD Recommendation 9)
§ 438.408(b)(2) Resolution and notification: Grievances and appeals – Specific timeframes: Standard resolution of appeals	**DentaQuest** 9. To the *ORM*, section "9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals," letter "E. Provider Complaints concerning non-claims issue," add language related to sending written notice to the affected parties within three (3) calendar days following resolution of the appeal. (State Title 317 of the OAC "317:2-3-5. Member appeals," Subchapter 3 "Member Grievances and Appeals, Provider Complaints, and State Fair Hearings in SoonerSelect," letter g, number 3 "OHCA-established timeframes for appeals decisions.") (Recommendation 22)
	LIBERTY 10. To the following, add language related to sending written notice to the affected parties within three (3) calendar days following resolution of the appeal: a. Policy and procedure *Single Level Enrollee Appeals Process- Oklahoma Medicaid* b. Policy and procedure *Appendix 1- State Timeliness Requirements* c. Policy and procedure *Process for Adverse Determinations* d. LIBERTY website, webpage "SoonerSelect Member Tools" "File A Grievance or Appeal" (https://www.libertydentalplan.com/Oklahoma/SoonerSelect/File-a-Grievance.aspx) e. *SoonerSelect Member Handbook* f. *Provider Reference Guide*, section "Grievances, Appeals, and Provider Claims Disputes," subsection "Member Appeals" (page 72). (State Title 317 of the Oklahoma Administrative Code 317:2-3-5. Member appeals, *Subchapter 3 Member Grievances and Appeals, Provider Complaints, and State Fair Hearings in SoonerSelect*, letter g, number 3 "OHCA-established timeframes for appeals decisions") (Recommendation 10)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes	**DentaQuest** 10. To the following, add "calendar" to the specified 14-day timeframe and language, written at the appropriate member reading level, that details DentaQuest may extend the timeframe by up to 14 calendar days if DentaQuest shows (to the satisfaction of OHCA, upon request) that there is a need for additional information: a. *SoonerSelect Member Handbook*, section "More Information for Appeals" b. DentaQuest website, webpage "Appeals and State Fair Hearings," section "More Information for Appeals." (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph and 1.16.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 26)
	LIBERTY 11. To the *SoonerSelect Member Handbook*, written at the appropriate member reading level, address the following: a. Section "More Information for Appeals," add "calendar" to the specified 14-day timeframe and language that details LIBERTY may extend the timeframe by up to 14 calendar days if LIBERTY shows (to the satisfaction of OHCA, upon request) there is a need for additional information. b. Section "If You Have Problems with Your Dental Plan," add language that details LIBERTY may extend the timeframes by up to 14 calendar days if – i. The member or Provider as Authorized Representative requests the extension; or ii. LIBERTY shows (to the satisfaction of OHCA, upon its request) there is need for additional information and how the delay is in the member's interest. (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph and "1.16.7.3 Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 12) 12. To the *Provider Reference Guide*, section "Grievances, Appeals, and Provider Claim Disputes," sub-sections "Member Grievances," "Medicaid and Medicare Member Grievances," "Member Appeals," and "Medicaid and Medicare Member Appeals" (pages 72-75), add language that details LIBERTY may extend the timeframes by up to 14 calendar days if – a. The member or Provider as Authorized Representative requests the extension; or b. LIBERTY shows (to the satisfaction of OHCA, upon its request) there is need for additional information and how the delay is in the member's interest. (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph and "1.16.7.3 Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 13)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes	**DentaQuest** 11. To the following documents, include language that DentaQuest may extend the timeframe by 14 calendar days if the member or provider as authorized representative requests the extension; or DentaQuest shows (to the satisfaction of OHCA, upon request) there is need for additional information and how the delay is in the member's interest. a. Policy and procedure *CGA06-INS Member Grievances*, section "Procedure," letter "D. Grievance Resolution," number 2 (page 5). b. *ORM*, section "9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals," sub-section "F. Member Complaints/Grievances/Appeals," (page 26). c. *SoonerSelect Member Handbook*, section "If You Have Problems with Your Dental Plan," written at the appropriate member reading level. (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph and 1.16.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 29)
	LIBERTY 13. To the following, add language that states the timeframe may extended by up to 14 calendar days if the member or Provider as Authorized Representative requests the extension: a. Policy and procedure *Single Level Enrollee Appeals Process- Oklahoma Medicaid*, section "VII. Extension(s)." b. Policy and procedure *Medicaid Member Grievance Process – Oklahoma*, section "VI. Extension(s)." (State Contract Sections 1.16.7.3 "Timeframe for Standard Appeal Resolution," third paragraph and 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph) (Recommendation 11) 14. To the LIBERTY website, add "calendar" to the specified 14-day timeframe. Additionally, include language, written at the appropriate member reading level, making clear LIBERTY may extend the timeframe by up to 14 calendar days if the member or Provider as Authorized Representative requests the extension. (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph and "1.16.7.3 Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 14)
Grievance Case Review related to § 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes	**DentaQuest** 12. Provide staff education and refine internal processes to ensure rationale for extending the timeframes for grievance resolution is clearly documented in the case notes of the grievance record. (State Contract Section 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph) (Recommendation 30)
	LIBERTY 15. Provide staff education and refine internal processes to ensure rationale for extending the timeframes for grievance resolution is clearly documented in the case notes of the grievance record. (State Contract Section 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph) (Recommendation 15)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension	**DentaQuest** 13. In the *SoonerSelect Member Handbook*, written at the appropriate member reading level, address the following: a. In the section "More Information for Appeals" (page 22): i. Revise the language to indicate that verbal notice is given in all instances the timeframe of an appeal is extended. ii. Include the 2-calendar day timeframe for written notice to the member of the reason for the decision to extend the timeframe and specify that the member will be informed of the right to file a grievance is he or she disagrees with that decision. b. In section "If You Have Problems with Your Dental Plan," include the extension requirements for grievances. (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," third paragraph and 1.16.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 32) 14. To the following documents, add language that details if DentaQuest extends the timeframes not at the request of the member, DentaQuest will make reasonable efforts to give the member prompt verbal notice of the delay, and within 2 calendar days, will give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. a. Policy and procedure *CGA06-INS Member Grievances*, section "Procedure," letter "C. Grievance Resolution," number 2 (page 5). b. *ORM*, section "9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals," sub-section "F. Member Compliant/Grievances/Appeals," (page 26). (a: § 438.408[c][2][i-iii] and State Contract Section 1.16.6.11 "Timeframe for Resolution of Grievance," third paragraph, letters a and b; b: State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph and 1.16.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 35)
	LIBERTY 16. In the *SoonerSelect Member Handbook*, written at the appropriate member reading level, address the following: a. In the section "More Information for Appeals" (page 22): i. Revise the language to indicate that verbal notice is given in all instances the timeframe of an appeal is extended. ii. Include the 2-calendar day timeframe for written notice to the member of the reason for the decision to extend the timeframe and specify that the member will be informed of the right to file a grievance if he or she disagrees with that decision. b. In the section "If You Have Problems with Your Dental Plan," include the extension requirements for grievances. (State Contract sections 1.16.6.11 "Timeframe for Resolution of Grievance," third paragraph and 1.16.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 16) 17. To the *Provider Reference Guide*, section "Grievances, Appeals, and Provider Claim Disputes," sub-sections "Member Grievances," "Medicaid and Medicare Member Grievances," "Member Appeals," and "Medicaid and Medicare Member Appeals," add language that details if LIBERTY extends the timeframes not at the request of the member, LIBERTY must complete all of the following: a. Make reasonable efforts to give the member prompt verbal notice of the delay.

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension (Continued)	b. Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires." (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," third paragraph and 1.16.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 17)
Grievance Case Review related to § 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension	**DentaQuest** 15. Provide staff education and refine internal processes to ensure the requirement that reasonable efforts to provide prompt verbal notification to the member of a delay in the resolution of the grievance are made when the required timeframes for resolution of the grievance is extended. Any outreach attempt to the enrollee should be documented in the CE's system. (State Contract Section 1.16.6.11 "Timeframe for Resolution of Grievance," third paragraph) (Recommendation 36) 16. Provide staff education and refine internal processes to ensure the requirement that written notice of the reason for the decision to extend the timeframe of the grievance resolution is sent within two (2) calendar days and the notice shall include the member's right to file a grievance if they disagree with the decision to extend. (State Contract Section 1.16.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 37)
	LIBERTY 18. Provide staff education and refine internal processes to ensure the requirement that reasonable efforts to provide prompt verbal notification to the member of a delay in the resolution of the grievance are made when the required timeframes for resolution of the grievance are extended. Any outreach attempt to the enrollee should be documented in the CE's system. (State Contract Section 1.16.6.11 "Timeframe for Resolution of Grievance," third paragraph) (Recommendation 18) 19. Provide staff education and refine internal processes to ensure the requirement that written notice of the reason for the decision to extend the timeframe of the grievance resolution is sent within two (2) calendar days and the notice shall include the member's right to file a grievance if they disagree with the decision to extend. (State Contract Section 1.16.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 19)
Appeal Case Review related to § 438.408(d)(2)(ii) Resolution and notification: Grievances and appeals – Format of notice-Appeals	**DentaQuest** 17. Provide staff education and refine internal processes to ensure staff are aware of the policy that details reasonable efforts to verbally notify the member of the expedited appeal resolution are made and the outreach attempts are documented within the appeal record. (State Contract Section 1.16.7.5 "Appeal Resolution Notice Format and Content," second paragraph) (Recommendation 44)
	LIBERTY 20. Provide staff education and refine internal processes to ensure staff are aware of the policy that details that any delay in expedited appeal resolution is communicated promptly to the member and outreach attempts documented within the appeal record. (State Contract Section 1.16.7.5 "Appeal Resolution Notice Format and Content," second paragraph) (Recommendation 21)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
Appeal Case Review related to § 438.408(e)(1) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution	**DentaQuest and LIBERTY** DQ 18/LD 21. Provide staff education and refine internal processes to ensure staff are aware of the policy that details all notices of appeal resolution are to clearly indicate the date the CE made the appeal decision. (DQ: Also, see § 438.408[b][2] for the recommendation made; DQ and LD: State Contract Section 1.16.7.5 "Appeal Resolution Notice Format and Content," third paragraph) (DQ Recommendation 45/LD Recommendation 22)
§ 438.408(e)(2)(iii) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution	**DentaQuest** 19. Work with the State to determine any necessary revisions to policy and procedure *CGA01-INS-MCD Member* Appeals, section "Procedure," letter "C. Member Appeals Resolution," number 6, letter c, roman numeral iii, related to the member not being held liable for the cost of services continued during an appeal or state fair hearing. (State Contract Section 1.16.10 "Contractor Recovery" and related State Guidance) (Recommendation 49) 20. For all appeals not resolved wholly in favor of the member, work with the State to determine how to revise the *Appeal Resolution*, to include that the member may not be billed for such services continued during an appeal or state fair hearing, regardless of the outcome. (Also, see § 438.408[b][2] for the recommendation made; State Contract Section 1.16.7.5 "Appeal Resolution Notice Format and Content," third paragraph) (Recommendation 50)
	LIBERTY 22. Work with the State to determine any necessary revisions to policy and procedure *Single Level Enrollee Appeals Process-Oklahoma Medicaid*, section "The G&A Analyst prepares a formal written appeal response letter" (pages 6-7), related to the member's responsibility for payment of services continued during an appeal or state fair hearing. (State Contract Section 1.16.10 "Contractor Recovery") (Recommendation 23)
§ 438.410(b) Expedited resolution of appeals: Punitive Action	**DentaQuest and LIBERTY** DQ 21/LD 23. In the following documents, add information that punitive action will not be taken on a provider who requests an expedited resolution or supports a member's appeal: a. *Participating Practice Agreement*, including single case agreements. b. *ORM* (DQ), section "9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals (Policies 200 Series)/*Provider Reference Guide* (LD)." (State Contract Section 1.12.2.3 "Network Provider Agreement Limitations/Restrictions and Assurance," letter c) (DQ Recommendation 52/LD Recommendation 25)
§ 438.410(c)(1-2) Expedited resolution of appeals: Action following denial of a request for expedited resolution	**DentaQuest and LIBERTY** DQ 22/LD 24. In the *SoonerSelect Member Handbook*, written at the appropriate member reading level, include language that if the member's request for expedited resolution of an appeal is denied, the appeal will be transferred to the timeframe for standard resolution. (State Contract Section 1.16.7.4 "Timeframe for Expedited Resolution") (DQ Recommendation 53/LD Recommendation 26)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
Appeal (DentaQuest) and Grievance (LIBERTY) Case Review related to § 438.416(b) Recordkeeping requirements	**DentaQuest and LIBERTY** DQ23/LD 25. Provide staff education and refine internal processes to clearly document, in the grievance and appeal system, all decisions made during the appeal process, including the dates of the decision(s). (§ 438.416[b][3 and 5]; State Contract Section 1.16.2 "Recordkeeping," letters c and e) (DQ Recommendation 56 DQ/LD Recommendation 27)
§ 438.416(c) Recordkeeping requirements	**DentaQuest** 24. To policy and procedure *CGA06-INS Member Grievances,* add language that details DentaQuest will produce records to OHCA staff no later than three (3) business days after the date of request, in a format (electronic or hard copy) requested. (State Contract Section 1.16.2 "Recordkeeping") (Recommendation 57)
	LIBERTY 26.To the following policies and procedures, add language that details, LIBERTY will produce records to OHCA staff no later than three (3) business days after the date of request, in a format (electronic or hard copy) requested: a. *Single Level Enrollee Appeals Process – Oklahoma Medicaid*, section "Process/Procedure," sub-section "I Retention." b. *Medicaid Member Grievance Process – Oklahoma*, section "Process/Procedure," sub-section "VII. Retention." (State Contract Section 1.16.2 "Recordkeeping") (Recommendation 28)
§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending-Definition	**DentaQuest** 25. In the *SoonerSelect Member Handbook,* written at the appropriate member reading level, section "Part III: Plan Procedures," address the following: a. Page 22, sub-section "Your Care While You Wait for a Decision," revise the second bullet, as it includes information on the 10-day timely filing. (§ 438.420[a] and related State Guidance) b. Page 23, sub-section "State Fair Hearings," in the following, remove the language related to the 10-day timely filing: i. Second paragraph. (§ 438.420[a]) and related State Guidance ii. Subsection "Your Care While You Wait for a Decision," first bullet. (§ 438.420[c]; State Contract Section 1.16.9.2 "Duration of Continued or Reinstated Benefits," letter c) (Recommendation 58)
	LIBERTY 27. In the *SoonerSelect Member Handbook,* written at the appropriate member reading level, section "Part III: Plan Procedures," subsection "Your Care While You Wait for a Decision," revise the second bullet (page 35), to remove the information on the 10-day timely filing. (§ 438.420[a] and related State Guidance) (Recommendation 29)

<table>
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<tr><td colspan="2">Subpart F – Grievance and Appeal System Compliance Results (Continued)</td></tr>
<tr><td rowspan="2">§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending-Definition</td><td>DentaQuest
26. Related to the State's policy continuation of benefits, work with the State to determine any needed revisions in the ORM, section "9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals (Policies 200 Series)." (§ 438.420[a] and related State Guidance) (Recommendation 59)</td></tr>
<tr><td>LIBERTY
28. To the policy and procedure Appendix 1 – State Timeliness Requirements GA PP – OK Medicaid, section "Process/Procedure," column "Oklahoma Medicaid Enrollee," column "Expedited Appeals and Standard Appeals," Topic "Continuation of Benefits Filing Limitation" (page 3), remove or revise the language related to the 10-day timely filing. (State Contract Section 1.16.9.1 "When the Contractor Shall Continue Benefits," letter e, roman numerals i and ii) (Recommendation 30)
29. To the Provider Reference Guide, section "13. Quality Management," sub-section "Medicaid and Medicare Member Appeals," second paragraph (page 74 of 85), remove or revise the language related to the 10-day timely filing, add the language "on or before the later of the following," and correct the typographic error "as." (State Contract Section 1.16.9.1 "When the Contractor Shall Continue Benefits," letter e, roman numerals i and ii) (Recommendation 31)</td></tr>
<tr><td rowspan="2">§ 438.420(d) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending – Enrollee responsibility for services furnished while the appeal or state fair hearing is pending</td><td>DentaQuest
27. Work with the State to determine any needed revision to the following, and any other applicable documents, regarding the State's policy on member's liability of payment of services continued during an appeal or state fair hearing:
a. Policy and procedure CGA01-INS-MCD Member Appeals, section "Procedure," letter "F. Continuation of Benefits during the Internal Appeal and Fair Hearing," number 3, letter d.
b. SoonerSelect Member Handbook, section "Part III: Plan Procedures," sub-section "State Fair Hearings," sub-section "Your Care While You Wait for a Decision," third bullet (page 23).
(State policy "OAC 317:2-3-7. Obligation to pay costs of services" and State Contract Section 1.16.10 "Contractor Recovery") (Recommendation 60)</td></tr>
<tr><td>LIBERTY
30. Work with the State to determine any needed revision to the following, and any other applicable documents, regarding the State's policy on member's liability of payment of services continued during an appeal or state fair hearing:
a. SoonerSelect Member Handbook, section "State Fair Hearings," sub-section "Your Care While You Wait for a Decision," fourth bullet (page 23).
b. SoonerSelect Appeal Request Form found on the LIBERTY website (https://www.libertydentalplan.com/Resources/Documents/OK-Appeal-Request-Form-EN.pdf)
(State Contract Section 1.16.10 "Contractor Recovery") (Recommendation 32)</td></tr>
</table>

Regulatory Area	***2025 Compliance Review Recommendations***
DentaQuest	
Subpart F – Grievance and Appeal System Compliance Results	
Grievance and Appeal issues not related to an element on the grievance and appeal case review tool for the Compliance Review	28. Revise or establish a formal process for the CE to conduct quality assurance reviews and implement corrective actions for all written communications related to appeals and grievances. This process should ensure that all letters consistently include the required information and are free from grammatical errors. (Recommendation 1)
Appeal issues not related to an element on the grievance and appeal case review tool for the Compliance Review	29. Provide staff education and refine internal processes to ensure that the correct letter templates are used for member appeals. (Recommendation 2)
	30. For appeals, when adding a recipient to the "cc" line of an appeal letter, instead of putting "Requesting Provider," put the name of the provider. (Recommendation 3)
Appeal issues not related to an element on the grievance and appeal case review tool for the Compliance Review	31. For the Appeal Resolutions Letters, in the section "Why am I getting this notice?," update the templates and/or provide staff education to ensure the correct date and verbiage is used. (Recommendation 4)
	32. Provide staff education and refine internal processes to ensure that all dates included in the appeal letters are accurate. (Recommendation 5)
§ 438.402(c)(2)(ii) General requirements: Filing requirements – Timing-Appeal	33. In the following, add "calendar" to the specified timeframe: a. *SoonerSelect Member Handbook*, section "Appeals," first bullet. It would read, "If you are not satisfied with an action we took or what we decided about your prior authorization request (see pages 19-20) about prior authorizations and actions), you can file an appeal. An appeal is a request for us to review the decision. You have 60 **calendar** days after you get a written notice of adverse benefit determination from us to file an appeal." b. DentaQuest webpage "Appeal Process," first paragraph, first bullet. It would read, "If you are not satisfied with an action we took or what we decided about your prior authorization request (see pages 19-20) about prior authorizations and actions), you can file an appeal. An appeal is a request for us to review the decision. You have 60 **calendar** days after you get a written notice of adverse benefit determination from us to file an appeal." (State Contract Section 1.16.7.2 "Timeframe for Requesting Appeal") (Recommendation 8)
§ 438.406(b)(1) Handling of grievances and appeals: Special requirements (Grievance and appeal acknowledgement)	34. In the *ORM,* section "9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals" include a statement regarding DentaQuest sending the member, authorized representative, and/or provider (when applicable) an acknowledgement of receipt grievances and appeals. (State Contract Section 1.16.1.2 "Receipt of Grievance and Appeal") (Recommendation 11)

Regulatory Area	***2025 Compliance Review Recommendations***
DentaQuest	
	Subpart F – Grievance and Appeal System Compliance Results (Continued)
Grievance and Appeal Case Review related to § 438.406 (b)(1) Handling of grievances and appeals: Special requirements (Grievance and appeal acknowledgement)	35. Provide staff education and refine internal processes to ensure an acknowledgement letter is sent, upon the receipt of a grievance, to the member or the member's authorized representative within ten (10) calendar days. (State Contract Section 1.16.1.2 "Receipt of Grievance and Appeal") (Recommendation 12)
	36. Provide staff education and refine internal processes to ensure an acknowledgement letter is sent, upon the receipt of an appeal, to the member or the member's authorized representative within five (5) calendar days. (State Contract Section 1.16.1.2 "Receipt of Grievance and Appeal") (Recommendation 13)
§ 438.406(b)(2) Handling of grievances and appeals: Special requirements (Requirements for individuals make decisions on grievances and appeals)	37. To policy and procedure *CGA01-INS-MCD Member Appeals*, section "Procedure," letter "B. Member Appeals Review," add language that states, "Ensure that the individuals who make decisions on grievances and appeals are individuals— Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease. (A) An appeal of a denial that is based on lack of medical necessity." (State Contract Section 1.16.1.3 "Decision Makers on Grievance or Appeal") (Recommendation 14)
§ 438.406(b)(2) Handling of grievances and appeals: Special requirements (Requirements for individuals make decisions on grievances and appeals)	38. To policy and procedure *CGA06-INS Member Grievances*, section "Procedure," letter "C. Member Grievance Process," add the missing language (bold and underlined, "Ensure that the individuals who make decisions on grievances and appeals are individuals— (i) Who were neither involved in any **<u>previous level of review</u>** or decision-making nor **<u>a subordinate of any such individual</u>**. (ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease. (A) **<u>An appeal of a denial that is based on lack of medical necessity</u>**. (State Contract Section 1.16.1.3 "Decision Makers on Grievance or Appeal") (Recommendation 15)
§ 438.406(b)(4) Handling of grievances and appeals: Special requirements (Member's opportunity to present evidence and testimony and make legal and factual arguments)	39. To policy and procedure *CGA01-INS-MCD Member Appeals*, add language that states, "Provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in § 438.408(b) and (c) in the case of expedited resolution." (State Contract Section 1.16.1.3.1 "Presentation of Evidence") (Recommendation 16)
§ 438.406(b)(5) Handling of grievances and appeals: Special requirements (Member's request of case file during appeal)	40. To policy and procedure *CGA01-INS-MCD Member Appeals*, section "Procedure," number 2, letter c, add language that states the information must be provided "sufficiently in advance of the resolution timeframe for appeals as specified in § 438.408(b) and (c)." (State Contract Section 1.16.1.3.2 "Access to SoonerSelect Dental Enrollee Case Files") (Recommendation 17)

Regulatory Area	2025 Compliance Review Recommendations
DentaQuest	
	Subpart F – Grievance and Appeal System Compliance Results (Continued)
Appeal Case Review related to § 438.408(b)(2) Resolution and notification: Grievances and appeals – Specific timeframes-Standard resolution of appeals	41. Provide staff education and refine internal processes to ensure the following: a. The written notice of appeal resolution is sent to all affected parties, including the member, and case documentation (e.g., letters, coversheets, and/or case notes) is to reflect who the written notification was sent to. b. Standard appeals are to be resolved, with notice provided, as expeditiously as the member's health condition requires but do not exceed thirty (30) calendar days from the date the CE receives the appeal and three (3) calendar days following the CE's resolution decision. (State Contract Section 1.16.7.3 "Timeframe for Standard Appeal Resolution") (Recommendation 23)
§ 438.408(b)(3) Resolution and notification: Grievances and appeals – Specific timeframes - Expedited resolution of appeals	42. To the *ORM*, section "9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals," letters "E. Provider Complaints concerning non-claims issue" and/or "F. Member Complaints/Grievances/Appeals," add language that details the CE will resolve each expedited appeal and provide notice, as expeditiously as the SoonerSelect Dental Member's health condition requires, and will be within seventy-two (72) hours from the date the CE receives the expedited Appeal. (State Contract Section 1.16.7.4 Timeframe for Expedited Resolution, second paragraph) (Recommendation 24)
Appeal Case Review related to § 438.408(b)(3) Resolution and notification: Grievances and appeals – Specific timeframes-Expedited resolution of appeals	43. Provide staff education and refine internal processes to ensure expedited appeals are resolved, with notice to the affected parties, as expeditiously as the member's health condition requires but do not exceed seventy-two (72) hours from the date the CE receives the expedited appeal; and written notice provided within three (3) calendar days following the CE's resolution decision. (Also, see § 438.408(b)(2) for the recommendations made; State Contract Section 1.16.7.4 "Timeframe for Expedited Resolution," second paragraph) (Recommendation 25)
§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes	44. In the document *Complaints, Grievances, and Appeals Client Requirements Document and Process Notes*, table section "Member Appeals Process," case type "Appeal," add language that details DentaQuest may extend the timeframe by up to 14 calendar days if DentaQuest shows (to the satisfaction of OHCA, upon request) there is a need for additional information and how the delay is in the member's interest. (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph and 1.16.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 27) 45. To policy and procedure *CGA01-INS-MCD Member Appeals*, section "Member Appeals Process," number 5, add "calendar" days to the specified 14-day timeframe. It would read, "Resolution for an appeal can be extended for up to fourteen (14) **calendar** days if…" (State Contract Sections 1.16.6.11 "Timeframe for Resolution of Grievance," second paragraph and 1.16.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 28)

Regulatory Area	2025 Compliance Review Recommendations
DentaQuest	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
Appeal Case Review related to § 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes	46. Provide staff education and refine internal processes to ensure rationale for extending the timeframes for appeal resolution is clearly documented in the case notes of the appeal record. (State Contract Section 1.16.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 31)
§ 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension	47. To the DentaQuest document *Complaints, Grievances, and Appeals Client Requirements Document and Process Notes*, table section "Member Appeals Process," case type "Appeal" (pages 1-2), add the timeframe of "2 calendar days" and language that states, "inform the member of the right to file a grievance if he or she disagrees with that decision." It would read, "Extension Process: A 14-calendar day internal extension may be granted if DentaQuest is unable to obtain documentation needed in the required timeframe; reasonable effort of oral notification regarding the delay **within 2 calendar days and inform the member of the right to file a grievance if he or she disagrees with that decision**." (§ 438.408[c][2][ii] and State Contract Section 1.16.6.11 "Timeframe for Resolution of Grievance," third paragraph, letter b) (Recommendation 33)
§ 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension	48. To policy and procedure *CGA01-INS-MCD Member Appeals*, section "Member Appeals Process," number 5, add language that details DentaQuest will resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. (§ 438.408[c][2][iii]; State Contract Section 1.16.7.3 "Timeframe for Resolution of Grievance," fourth paragraph, letter c) (Recommendation 34)
Appeal Case Review related to § 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension	49. Provide staff education and refine internal processes to ensure the requirement that reasonable efforts to provide prompt verbal notification to the member of a delay in the resolution of the appeal are made when the required timeframes for resolution of the appeal is extended. Any outreach attempt to the member should be documented in the CE's system. (State Contract Section 1.16.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 38)
	50. Provide staff education and refine internal processes to ensure the requirement that written notice of the reason for the decision to extend the timeframe of the appeal resolution is sent within two (2) calendar days and the notice shall include the member's right to file a grievance if they disagree with the decision to extend. (State Contract Section 1.16.6.11 "Timeframe for Resolution of Grievance," third paragraph) (Recommendation 39)
§ 438.408(c)(3) Resolution and notification: Grievances and appeals – Deemed exhaustion of appeal process	51. To the *ORM*, section "9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals," sub-section "F. Member Complaints/Grievances/Appeals," add language that details if DentaQuest fails to adhere to the notice and timing requirements, the member is deemed to have exhausted DentaQuest's appeals process and may initiate a State fair hearing. (State Contract Section 1.16.8. "Deemed Exhaustion of Appeals Process") (Recommendation 40)

Regulatory Area	2025 Compliance Review Recommendations
DentaQuest	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(d)(1) Resolution and notification: Grievances and appeals – Format of notice-Grievances	52. To policy and procedure *CGA06-INS Member Grievances*, letter "D. Grievance Resolution," add language that details the notice will be in a format and language that, at a minimum, meet the requirements of 42 C.F.R. § 438.10, including large print explaining the availability of written translations or verbal interpretation to understand the information provided and the toll-free and TTY/TDD telephone number for member services. (State Contract Section 1.16.6.12 "Grievance Resolution Notice Format, and Content") (Recommendation 41)
Grievance Case Review related to § 438.408(d)(1) Resolution and notification: Grievances and appeals – Format of notice-Grievances	53. Provide staff education and refine internal processes to ensure the contractual requirement that all notices of grievance resolution include taglines in each State-established prevalent non-English language as well as large print explaining the availability of written translations or verbal interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service. (State Contract Section 1.16.6.12 "Grievance Resolution Notice Format, and Content") (Recommendation 42)
Appeal Case Review related to § 438.408(d)(2)(i) Resolution and notification: Grievances and appeals – Format of Notice-Appeals	54. Provide staff education and refine internal processes to ensure the contractual requirement that all notices of appeal resolution include taglines in each State-established prevalent non-English language as well as large print explaining the availability of written translations or verbal interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service. (Also, see § 438.408[b][2] for the recommendation made; State Contract Section 1.16.7.5 "Appeal Resolution Notice Format and Content") (Recommendation 43)
Appeal Case Review related to § 438.408(e)(2)(i) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution	55. For all appeals not resolved in the member's favor, provide staff education and refine internal processes to ensure the requirement that the written notice of appeal resolution includes the member's right to request a State fair hearing, and how to do so. (Also, see § 438.408[b][2] for the recommendation made; State Contract Section 1.16.7.5 "Appeal Resolution Notice Format and Content," third paragraph) (Recommendation 46)
§438.408(e)(2)(ii) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution	56. To policy and procedure *CGA01-INS-MCD Member* Appeals, section "Procedure," letter "C. Member Appeals Resolution," number 6, letter c, roman numeral iii (page 7), add language that details the written notice of the appeal resolution must include language that details, for appeals not resolved in the members favor, the right to request and receive benefits while the hearing is pending, and how to make the request. (State Contract Section 1.16.7.5 "Appeal Resolution Notice Format and Content," letter d) (Recommendation 47)
Appeal Case Review related to § 438.408(e)(2)(ii) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution	57. For all appeals not resolved in the member's favor, provide staff education and refine internal processes to ensure the requirement that members must be notified, through the written notice of appeal resolution, of their right to request and receive benefits while the hearing is pending and how to make the request. (Also, see § 438.408[b][2] for the recommendation made; State Contract Section 1.16.7.5 "Appeal Resolution Notice Format and Content," third paragraph) (Recommendation 48)

Regulatory Area	2025 Compliance Review Recommendations
DentaQuest	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.410(a) Expedited resolution of appeals: Punitive action	58. To the *ORM,* section "9.00 "Member & Provider Inquiries, Complaints, Grievances & Appeals (Policies 200 series)," add language that details DentaQuest must establish and maintain an expedited review process for appeals, when DentaQuest determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (State Contract Section 1.16.7.4 "Timeframe for Expedited Resolution") (Recommendation 51)
§ 438.416(b) Recordkeeping requirements	59. To policy and procedure *CGA01-INS-MCD Member Appeals*, section "Procedure," letter "B. Member Appeals Review," number 1, letters a through f, add language that the record of each appeal will include a general description of the reason for the appeal (nature of appeal) and the date of resolution. (§ 438.416[b][1 and 5]; State Contract Section 1.16.2 "Recordkeeping," letters a and d) (Recommendation 54)
	60. To policy and procedure *CGA06-INS Member Grievances*, section "Procedure" letter "C. Member Grievance Process," number 1, letter a, roman numerals i-vi, add language that the record of each grievance will include the date of resolution, at each level, if applicable. (§ 438.416[b][5]; State Contract Section 1.16.2 "Recordkeeping," letter e). (Recommendation 55)
LIBERTY	
Subpart F – Grievance and Appeal System Compliance Results	
§ 438.408(d)(2)(ii) Resolution and notification: Grievances and appeals – Format of notice-Appeals	31. To the *Provider Reference Guide*, section "Medicaid and Medicare Member Appeals," last paragraph (page 74), add language that LIBERTY will make reasonable efforts to provide verbal notice of an expedited appeal resolution. (State Contract Section 1.16.7.5 "Appeal Resolution Notice Format and Content," second paragraph) (Recommendation 20)
§438.408(e)(2)(ii-iii) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution, also applies to Appeal Case Review	32. For appeals not resolved wholly in favor of the member, work with the State to determine how to revise the *Appeal Resolution* template letter to include that the member may not be billed for services continued during an appeal or state fair hearing, regardless of the outcome. (State Contract Section 1.16.10 "Contractor Recovery") (Recommendation 24)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart D – MCO, PIHP and PAHP Standards Compliance Results	
Case Review related to § 438.208(b)(3) Coordination and continuity of care: Care and coordination of services for all MCO, PIHP, and PAHP enrollees	**Aetna and Humana** 1. Provide staff education and refine internal processes to ensure that at least three (3) outreach attempts, and other methods to maximize contact with members, should be made to contact every member to complete a health risk screen within thirty (30) days from date of enrollment for new members. (State Contract Section 1.9.2 "Health Risk Screening") (ABH and Humana Recommendation 1)
	OCH 1. Provide staff education and refine internal processes to ensure the following. a. At least three (3) outreach attempts, and other methods to maximize contact with members, are made to contact every member to complete a health risk screen within thirty (30) days from date of enrollment for new members. b. If a member has not completed an HRS, HRS completion is offered to the member at any successful contact, regardless of the reason for the contact or what department is completing the contact. (Recommendation 1)
Case Review related to § 438.208(c)(2) Coordination and continuity of care: Additional services for enrollees with special health care needs	**Aetna and Humana** 2. Provide staff education and refine internal processes to complete outreach to members within 30 days of the member indicating they would like help with a PH, BH, and/or Social Determinant of Health need as indicated in the HRS. (State Contract Section 1.9.3 "Comprehensive Assessment) (ABH and Humana Recommendation 2)
	OCH 2. Provide staff education and refine internal processes to ensure the following. a. Outreach to members is completed within 30 days of the member indicating they would like help with a PH, BH, and/or Social Determinant of Health need as indicated in the HRS (PH T19 Members 5 and 8). b. With any change in health status, including hospitalizations, the CMA is reviewed and updated, as needed. If no updates are needed, a note in the member's record is to be included to indicate that it was reviewed, and no changes were necessary. (Recommendation 3)
Case Review related to § 438.208(c)(2) Coordination and continuity of care: Additional services for enrollees with special health care needs	**Aetna, Humana, and OCH** 3. Provide staff education and refine internal processes to ensure every member in care coordination is provided written notice of their care manager assignment. The notice should include the following. a. The assigned Care Manager's name and contact information, b. Procedures to contact the assigned Care Manager if any issues or needs arise, and c. Information on when the member can expect to be contacted by the Care Manager based on the Risk Stratification Level Framework assigned to the member. (State Contract Section 1.9.5.2 "Care Manager Assignment") (ABH and Humana Recommendation 3/OCH Recommendation 5)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results	
§ 438.402(c)(1) General requirements: Filing requirements – Authority to file	**Aetna** 4. In the *SoonerSelect Member Handbook*, written at the appropriate member reading level, include the following: a. Information that the member's written consent is required for an authorized representative to file a grievance b. An authorized representative or a provider, acting on behalf of the member with the member's written consent, may request a State Fair Hearing. (§ 438.402[c][1][ii]; State Contract Section 1.18.1 "Enrollee Grievance and Appeal Overall Requirements") (Recommendation 11)
	Humana 4. Revise the *Member Handbook* to include language that the member's written consent is required for an authorized representative to file a grievance. (State Contract Section 1.18.1 "Enrollee Grievance and Appeal Overall Requirements") (Recommendation 5)
	OCH 4. Revise the *SoonerSelect* and *Sooner Select Children's Specialty Program Member Handbooks*, written at the appropriate member reading level, to include information that the member's written consent is required for an authorized representative to file a grievance. (Recommendation 10)
§ 438.404(b)(6) Timely and adequate notice of adverse benefit determination: Content of notice	**Aetna** 5. Work with the State to determine the revisions needed to the following documents related to members not being billed for services continued during an appeal or state fair hearing: a. *SoonerSelect Member Handbook* in the following: i. Section "More Information for Appeals," subsection "Your Care While You Wait for a Decision on Your Appeal," third bullet (page 55). ii. Section "State Fair Hearings," subsection "Your Care While You Wait for a Decision on Your State Fair Hearing," first bullet. b. Policy *7200.03 Utilization Management (UM) Timeliness Standards and Decision Notification*, section "E. Notice of Action Requirements," third paragraph (pages 8-9). c. Notice of Adverse Determination letters, section "Continuation of services during the appeal process" fourth paragraph. d. Aetna website, webpage "Grievances and appeals," section "Continuing benefits during an appeal," subsection "The appeal decision," first bullet. (State Contract Section 1.18.10 "Contractor Recovery") (Recommendation 16)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.404(b)(6) Timely and adequate notice of adverse benefit determination: Content of notice (Continued)	**Humana** 5. Work with the State to determine the revisions needed to the following documents related to members not being billed for services continued during an appeal or state fair hearing: a. Procedure *OK.CLI.014 Authorization Decision Notification* section "Adverse Notification Process," sixth bullet (page 2). b. Procedure *OK.CLI.015 Medical Management Program Description*, section "Notice and Content," sixth bullet (page 17). c. Procedure *OK.CLI.016 Authorization Denial and Peer-to-Peer Review*, section "Procedures," second paragraph number 1, number 1.6 (page 2). d. *Provider Manual*, section "Continuation of benefits," second paragraph (page 59). e. *Member Handbook*, section "Your Care While You Wait for a Decision," (page 62) last bullet. f. Notice of Adverse Determination letters, section "Appeals," second paragraph (page 5). g. Humana website, webpage "Oklahoma SoonerSelect: Grievances and Appeals," section "Continuation of benefit during the appeal process, last sentence. (State Contract Section 1.18.10 "Contractor Recovery") (Recommendation 6)
	OCH 5. Work with the State to determine the revisions needed to the following documents related to members not being billed for services continued during an appeal or state fair hearing: a. *SoonerSelect Member Handbooks*, section "More Information for Appeals," subsection "Your Care While You Wait for a Decision on Your Appeal," fourth paragraph (page 53 [SSP]/page 51 [CSP]). b. Policy and procedure *OK.UM.08 Adverse Benefit Determination (Denial)* Notices, section "Policy," third paragraph. (State Contract Section 1.18.10 "Contractor Recovery") (Recommendation 15)
§ 438.406(b)(1) Handling of grievances and appeals (Special requirements)	**Aetna, Humana, and OCH** 6. In the *SoonerSelect Member Handbook,* written at the appropriate member reading level, include a statement regarding Aetna/Humana/OCH sending the member, authorized representative, or provider (when applicable) an acknowledgement letter of receipt of the appeal. (OCA section 317:2-3-4 "Member grievances," letter f, number 4, letter B; State Contract Section 1.18.1.2 "Receipt of Grievance and Appeal") (ABH Recommendation 18/Humana Recommendation 9/OCH Recommendation 16)
§ 438.406(b)(5) Handling of grievances and appeals (Special requirements)	**Aetna, Humana, and OCH** 7. To the *SoonerSelect Member Handbook*, section "Appeals," second bullet (page 54) [ABH]/ seventh paragraph (page 61) [Humana]/ fifth paragraph (page 52 [SSP]/page 50 [CSP]) [OCH], add language, written at the appropriate member reading level, that states the information (member case file, including medical records, other documents, and records) is free of charge/no cost and provided sufficiently in advance of the resolution timeframe for appeals. (State Contract Section 1.18.1.3.2 "Access to Enrollee Case Files") (ABH Recommendation 23/Humana Recommendation 11/OCH Recommendation 18)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(a) Resolution and notification: Grievances and appeals – Basic rule	**Aetna** 8. To the *SoonerSelect Member Handbook*, add "calendar" to the specified 30-day timeframe in the following: a. Section "Key Words Used in This Handbook," definitions for "Expedited (faster) Appeal" and "Standard Appeal" (pages v and viii, respectively) b. Section "Appeals," third to the last bullet (page 53) c. Section "Requesting a State Fair Hearing," second bullet (page 56) d. Section "What Happens Next?" second bullet (page 57) (Also applies to § 438.408[b][1-2]; State Contract Sections 1.18.7.3 "Timeframe for Standard Appeal Resolution" and 1.18.6.11 "Timeframe for Resolution of Grievance," first paragraph) (Recommendation 25)
	Humana 8. To the following documents, add "calendar" to the specified 30-day timeframe: a. *RT-POL-MCD RNS-10 Oklahoma Medicaid Grievance and Appeal Policy*, section "Appeals," subsection "Timeframes" (page 6). b. *SoonerSelect Member Handbook* in the following: i. Section "Key Words Used in This Handbook," definitions for "Expedited (faster) Appeal" and "Standard Appeal" (pages 8 and 11, respectively) ii. Section "Appeals" (page 61) iii. Section "Requesting a State Fair Hearing," second paragraph (page 63) iv. Section "If you are unhappy with Your Plan: How to File a Grievance," fourth paragraph, second bullet (page 65). (Also applies to § 438.408[b][1-2]; State Contract Sections 1.18.7.3 "Timeframe for Standard Appeal Resolution" and 1.18.6.11 "Timeframe for Resolution of Grievance," first paragraph) (Recommendation 13)
	OCH 8. To the following documents, add "calendar" to the specified 30-day timeframe: a. Policy and procedure *OK.GRV.01 Enrollee Grievance System* in the following: i. Section "Grievance Resolution and Notification," number 3 (page 6) ii. Section "Written Grievance," number 1, fourth sentence (page 7) b. *SoonerSelect Member Handbooks* in the following: i. Section "Words/Phrases," definitions for "Expedited (faster) Appeal" (page viii) and "Standard Appeal" (page xii) ii. Section "Appeals," second paragraph (page 52 [SSP]/page 50 [CSP]) iii. Section "Requesting a State Fair Hearing," second paragraph (page 54 [SSP]/page 52 [CSP]) iv. Section "What Happens Next?" second bullet (page 55 [SSP]/page 53 [CSP]) (Also applies to § 438.408[b][2]; State Contract Sections 1.18.7.3 "Timeframe for Standard Appeal Resolution" [letter b above] and 1.18.6.11 "Timeframe for Resolution of Grievance," first paragraph [letter a above]) (Recommendation 20)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(b)(1) Resolution and notification: Grievances and appeals – Specific timeframes- Standard resolution of grievances	**Aetna** 9. To the following documents, add language related to notifying a member of the resolution of a grievance and sending written notification to the member within three (3) calendar days of the resolution of the grievance: a. *Provider Manual*, "Chapter 16: Appeal and grievance system," section "Standard grievance," fourth paragraph (page 111). b. *SoonerSelect Member Handbook* (written at the appropriate member reading level), section "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next," third bullet (page 57). c. Aetna website, webpage "Grievances and appeals," section "What happens next?," subsection "Grievances," second paragraph. (Also applies to § 438.408[d][1]; State Contract Section 1.18.6.12 "Grievance Resolution Notice Format, and Content") (Recommendation 26)
	Humana 9. To the *SoonerSelect Member Handbook*, section "If You Are Unhappy with Your Plan: How to File a Grievance," fourth paragraph, third bullet (page 65), add the word "calendar" to the 3-day timeframe. It would read, "We will tell you how we resolved it in writing within 3 **calendar** days after we resolve the grievance." (Also applies to § 438.408[d][1]; State Contract Section 1.18.6.12 "Grievance Resolution Notice Format and Content") (Recommendation 14) 10. To the following documents, add language related to notifying a member of the resolution of a grievance and sending written notification to the member within three (3) calendar days of the resolution of the grievance: a. *Provider Manual*, section "Grievance," fourth sentence (page 57). b. Humana website, webpage "Oklahoma SoonerSelect: Grievances and Appeals," section "Grievances." (Also applies to § 438.408[d][1]; State Contract Section 1.18.6.12 "Grievance Resolution Notice Format, and Content") (Recommendation 15)
	OCH 9. To the following documents, add language related to notifying a member of the resolution of a grievance and sending written notification to the member within three (3) calendar days of the resolution of the grievance: a. *Provider Manual*, section "Member Grievance and Appeals Process," subsection "Grievances" (page 106). b. *SoonerSelect Member Handbooks*, (written at the appropriate member reading level), section "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next," third bullet (page 55 [SSP]/page 53 [CSP]). c. Policy and procedure *OK.GRV.01 Enrollee Grievance System*, section "Grievance Department Handling," number 7 (page 5), change the timeframe from "three business days" to "three (3) calendar days." It would read, "For all grievances the plan shall provide written notice to enrollee of the resolution within **three calendar days** of the resolution and ensure that such notification methods meet the written enrollee material guidelines of the contract." (Also applies to § 438.408[d][1]; State Contract Section 1.18.6.12 "Grievance Resolution Notice Format, and Content") (Recommendation 21)

<table>
<tr><th>Regulatory Area</th><th>2025 Compliance Review Recommendations</th></tr>
<tr><td colspan="2">Common Among the SoonerSelect Medical CEs</td></tr>
<tr><td colspan="2">Subpart F – Grievance and Appeal System Compliance Results (Continued)</td></tr>
<tr><td rowspan="3">§ 438.408(b)(2) Resolution and notification: Grievances and appeals – Specific timeframes: Standard resolution of appeals</td><td>Aetna
10. To the following, add language related to sending written notice to the affected parties within three (3) calendar days following resolution of the appeal:
a. SoonerSelect Member Handbook (written at the appropriate member reading level)
b. Provider Manual, “Chapter 16: Appeal and grievance system,” section “Standard appeal”
c. Aetna website, webpage “Grievances and appeals,” section “What happens next?,” subsection “Appeals,” second paragraph
(State Title 317 of the OAC “317:2-3-5. Member appeals,” “Subchapter 3 Member Grievances and Appeals, Provider Complaints, and State Fair Hearings in SoonerSelect,” letter g, number 3 “OHCA-established timeframes for appeals decisions.”) (Recommendation 28)</td></tr>
<tr><td>Humana
11. To the following documents, add language related to sending written notice to the affected parties within three (3) calendar days following resolution of the appeal:
a. SoonerSelect Member Handbook, section “Appeals,” first paragraph (page 61; written at the appropriate member reading level)
b. Provider Manual, section “Appeal” first paragraph (page 57).
(State Title 317 of the OAC “317:2-3-5. Member appeals,” “Subchapter 3 Member Grievances and Appeals, Provider Complaints, and State Fair Hearings in SoonerSelect,” letter g, number 3) (Recommendation 17)</td></tr>
<tr><td>OCH
10. To the following documents, add language related to sending written notice to the affected parties within three (3) calendar days following resolution of the appeal”:
a. SoonerSelect and SoonerSelect Children’s Specialty Program Member Handbooks (written at the appropriate member reading level)
b. Provider Manual
(Recommendation 22)</td></tr>
<tr><td>§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes</td><td>Aetna
11. In the Provider Manual, “Chapter 16: Appeal and grievance system” and the Aetna website, add language that states Aetna may extend the appeal/grievance resolution timeframes by up to 14 calendar days if:
a. The member or provider as authorized representative requests an extension; or,
b. Aetna shows to the satisfaction of OHCA, upon request, there is a need for additional information and how the delay is in the member’s interest.
(State Contract Sections 1.18.7.3 “Timeframe for Standard Appeal Resolution,” third paragraph and 1.18.6.11 “Timeframe for Resolution of Grievance,” second paragraph) (Recommendation 30)</td></tr>
</table>

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes (Continued)	**Humana** 12. In the *Provider Manual*, address the following: a. In the sections "Appeal," second paragraph (page 55) and "Expedited appeal process," third paragraph (page 58), add language that states Humana may extend the appeal resolution timeframes by up to 14 calendar days if Humana shows to the satisfaction of OHCA, upon request, that there is a need for additional information and how the delay is in the member's interest. (State Contract Section 1.18.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) b. In the section "Grievances" (page 57), add language that states Humana may extend the grievance resolution timeframe by up to 14 calendar days if: i. The member or Provider as Authorized Representative requests an extension; or, ii. Humana shows to the satisfaction of OHCA, upon request, that there is a need for additional information and how the delay is in the member's interest." (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 21)
	OCH 11. In the *Provider Manual*, sections "Grievances" and "How to File an Appeal," or in the paragraphs in the section "Member Grievance and Appeals Processes," add language that states OCH may extend the grievance/appeal resolution timeframe by up to 14 calendar days if: a. The member or Provider as Authorized Representative requests an extension; or, b. OCH shows to the satisfaction of OHCA, upon request, that there is a need for additional information and how the delay is in the member's interest. (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 24)
§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes	**Aetna** 12. In the *SoonerSelect Member Handbook,* written at the appropriate member reading level, complete the following: a. Section "More Information for Appeals" (page 54). i. Add "calendar" to the 14-day timeframe. ii. Add language that the timeframe may be extended if Aetna shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the member's interest. (State Contract Section 1.18.7.3 "Timeframe for Standard Appeal Resolution," third paragraph, letter a) b. Section "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next," (page 57). i. Add language that Aetna may extend the timeframe by up to 14 calendar days if Aetna shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the member's interest. ii. If the grievance is extended, Aetna will tell the member within two calendar days and mail a written notification letter. iii. Add language that the member or provider as authorized representative may also request the extension. (State Contract Section 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph, letter a) (Recommendation 31)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes (Continued)	**Humana** 13. In the *SoonerSelect Member Handbook,* written at the appropriate member reading level, address the following: a. Section "More Information for Appeals" (page 61): i. Add "calendar" to the 14-day timeframe. ii. Add language that the timeframe may be extended if Humana shows (to the satisfaction of OHCA, upon request) that there is a need for additional information and how the delay is in the member's interest. b. Section "If You Are Unhappy with Your Plan: How to File a Grievance," fourth paragraph (page 65): i. Add language that Humana may extend the timeframe by up to 14 calendar days if Humana shows (to the satisfaction of OHCA, upon request) that there is a need for additional information and how the delay is in the member's interest. ii. If the grievance is extended, Humana will tell the member within two calendar days and mail a written notification letter. iii. Add language that the member or provider as authorized representative may also request the extension. (State Contract Sections 1.18.7.3 "Timeframe for Standard Appeal Resolution," third paragraph, letter a, and 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph, letter a) (Recommendation 22)
	OCH 12. In the *SoonerSelect Member Handbook,* section "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next," written at the appropriate member reading level, address the following: a. Add "calendar" to the 14-day timeframe. b. Add language that the time frame may be extended if OCH shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the member's interest. c. Add language that the member or provider as authorized representative may also request an extension. d. Add "calendar" to the 2-day timeframe grievance extension notification to the member. (State Contract section 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph) (Recommendation 25) 13. In the *SoonerSelect Children's Specialty Program Member Handbook,* section "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next," (page 53) written at the appropriate member reading level, add language that: a. OCH-CSP may extend the timeframe by up to 14 calendar days if OCH-CSP shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the member's interest. b. If the grievance is extended, OCH-CSP will tell the member within two calendar days and mail a written notification letter. (State Contract Section 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph) (Recommendation 26)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes (Continued)	**OCH (Continued)** 14. In the *SoonerSelect* and *SoonerSelect Children's Specialty Program Member Handbooks,* address the following at the appropriate member reading level: a. Section "More Information for Appeals" (page 52 [SSP]/page 50 [CSP]): i. Add "calendar" to the 14-day timeframe. ii. Add language that the timeframe may be extended if OCH/OCH-CSP shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the member's interest. b. Section "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next," add language that the member or provider as authorized representative may also request an extension. (State Contract Section 1.18.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 27)
§ 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes*:* Requirements following extension	**Aetna** 13. To the *Provider Manual*, "Chapter 16: Appeal and grievance system" (page 110) and Aetna website, webpage "Grievances and appeals," related to extension of the appeal and grievance timeframes, add language that if Aetna extends the timeframes not at the request of the member, Aetna must complete all of the following: a. Provide members with prompt verbal notice of the delay. b. Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," third paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 32) **Humana** 14. To the *Provider Manual*, section "Grievance" (page 55) related to extension of the appeal and grievance timeframes, add language that if Humana extends the timeframes not at the request of the member, Humana must complete all of the following: a. Provide members with prompt oral notice of the delay. b. Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph) (Recommendation 26)

Regulatory Area	2025 Compliance Review Recommendations
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Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes*:* Requirements following extension (Continued)	**OCH** 15. To the *Provider Manual*, sections "Grievances" and "How to File an Appeal," add language that if OCH extends the grievance/appeal timeframes not at the request of the member, OCH must complete all of the following: a. Provide members with prompt verbal notice of the delay. b. Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 28)
§ 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension	**Aetna** 14. In the *SoonerSelect Member Handbook*, written at the appropriate member reading level, address the following: a. In the section "More Information for Appeals" (page 53): i. Revise the language to state Aetna will give the member prompt verbal notice of the delay. ii. Include the 2-calendar day timeframe for written notice to the member of the reason for the decision to extend the timeframe and that the member will be informed of the right to file a grievance if he or she disagrees with that decision. iii. Add language related to resolution of the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. b. In the section "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next" (page 57), include language related to the extension timeframe to include if Aetna extends the timeframes, not at the request of the member, Aetna will complete all of the following: i. Make reasonable efforts to give the enrollee prompt verbal notice of the delay. ii. Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. (State Contract sections 1.18.6.11 "Timeframe for Resolution of Grievance," third paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 33)

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Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension (Continued)	**Humana** 15. In the *SoonerSelect Member Handbook*, written at the appropriate member reading level, address the following: a. In the section "More Information for Appeals" (page 61): i. Revise the language to state Humana will give the member prompt verbal notice of the delay. ii. Include the 2-calendar day timeframe for written notice to the member of the reason for the decision to extend the timeframe. iii. Add language related to resolution of the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. b. In the section "If You Are Unhappy with Your Plan: How to File a Grievance," fourth paragraph (page 65), add the following: i. Information on making reasonable efforts to give the member prompt verbal notice of the delay. ii. Add the word "calendar" to the 2-day timeframe for written notice to the member of the reason for the decision to extend the timeframe. c. In the sections "More Information for Appeals" and "If You Are Unhappy with Your Plan: How to File a Grievance," fourth paragraph, specify that the member will be informed of the right to file a grievance is he or she disagrees with that decision. (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," third paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 27) **OCH** 16. In the *SoonerSelect* and *SoonerSelect Children's Specialty Program Member Handbooks*, written at the appropriate member reading level, address the following: a. In the section "More Information for Appeals" (page 52 [SSP]/page 50 [CSP]): i. Revise the language to state OCH/OCH-CSP will give the member prompt verbal notice of the delay. ii. Add language that the appeal will be resolved as expeditiously as the member's health condition requires and no later than the date the extension expires. b. In the sections "More Information for Appeals" (page 52 [SSP]/page 50 [CSP]) and "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next" (page 55 [SSP]/page 53 [CSP]), specify that the member will be informed of the right to file a grievance is he or she disagrees with that decision. (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," third paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 30) 17. In the *SoonerSelect Member Handbook*, address the following: a. In the section "More Information for Appeals" (page 52), include the 2-calendar day timeframe for written notice to the member of the reason for the decision to extend the timeframe. b. In the section "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next" (page 55), include "calendar" in the specified 2-day timeframe for written notice to the member of the reason for the decision to extend the timeframe.

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Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension (Continued)	(State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," third paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 31) 18. In the *SoonerSelect Children's Specialty Program Member Handbook*, written at the appropriate member reading level, address the following: a. In the section "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next?" (page 53), add language that if OCH-CSP extends the timeframes not at the request of the member, the member will receive prompt verbal notice of the delay. b. In the sections "More Information for Appeals" (page 50) and "If You Are Unhappy with Your Plan: How to File a Grievance," subsection "What Happens Next," (page 53) add language related to the two (2) calendar day timeframe for written notice to the member of the reason for the decision to extend the timeframe. (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," third paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 32)
§ 438.408(e)(2)(iii) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution	**Aetna** 15. Work with the State to determine any necessary revisions to the policy *3100.70 Member Appeal System*, section "Focus/Disposition," subsection "Written Appeal Decision Letter (Pre-Service, Expedited, Post-Service)," fifth bullet (page 18) regarding the member's responsibility for payment services continued during an appeal or state fair hearing. (State Contract Section 1.18.10 "Contractor Recovery") (Recommendation 39)
	Humana 16. Work with the State to determine any necessary revisions to the *RT-POL-MCD RNS-10 Oklahoma Medicaid Grievance and Appeal Policy*, sections "Contract Recovery" (page 13) and "Effectuation of Reversed Enrollee Appeal Resolutions," second bullet (page 14) regarding the member's responsibility for payment of services continued during an appeal or state fair hearing. See § 438.404(b)(6) for the recommendation related to the Humana website and *Member Handbook*. (State Contract Section 1.18.10 "Contractor Recovery") (Recommendation 36)
	OCH 19. Work with the State to determine any necessary revisions to the following documents regarding the member's responsibility for payment of services continued during an appeal or state fair hearing: a. Policy and procedure *OK.AP.01 Member Appeal System*, section "B. Appeal process," number "4. Written Notice of Resolution," letter b, fifth bullet (page 5). b. The *Notice of* [Adverse] *Appeal Decision OCH* template letter, page 3. (State Contract Section 1.18.10 "Contractor Recovery") (Recommendation 34)

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<tr><th>Regulatory Area</th><th>2025 Compliance Review Recommendations</th></tr>
<tr><td colspan="2">Common Among the SoonerSelect Medical CEs</td></tr>
<tr><td colspan="2">Subpart F – Grievance and Appeal System Compliance Results (Continued)</td></tr>
<tr><td rowspan="3">§ 438.408(f)(2) Resolution and notification: Grievance and appeals – Requirements for State fair hearings-State fair hearing</td><td>Aetna
16. Add the word “calendar” to the 120-day timeframe in the following sections of the SoonerSelect Member Handbook:
a. “Your Care While You Wait for a Decision on Your Appeal,” last paragraph (page 55).
b. “Requesting a State Fair Hearing,” last paragraph (page 56).
(State Contract Section 1.18.8.1 “Authority and Timeline for State Fair Hearing Request”) (Recommendation 41)</td></tr>
<tr><td>Humana
17. Add to the SoonerSelect Member Handbook, section “Requesting a State Fair Hearing” third paragraph (page 64) the word “calendar.” It would read, “You can ask for a State Fair Hearing at any time within 120 <u>calendar</u> days from the date on the notice of adverse resolution (denial) letter.” (State Contract Section 1.18.8.1 “Authority and Timeline for State Fair Hearing Request”) (Recommendation 39)</td></tr>
<tr><td>OCH
20. Add the word “calendar” to the 120-day timeframe in the following documents:
a. Policy and procedure OK.AP.01 Member Appeal System, section “F. Continuation of Benefits Pending Appeal and State Fair Hearing,” number 4 (page 8). It would read, “The Plan will continue or reinstate benefits if the member: Files a request for a State Fair Hearing within 120 <u>calendar</u> days of the adverse resolution notice.”
b. SoonerSelect Member Handbooks, section “Requesting a State Fair Hearing,” fourth paragraph [SSP]/ seventh paragraph [CSP] (page 54 [SSP/page 52 [CSP]). It would read, “You can ask for a State Fair Hearing at any time within 120 <u>calendar</u> days from the day we send you notice of adverse resolution.”
c. Notice of Appeal Decision OCH letter template, section “You Have the Right to Ask for a State Fair Hearing” second and third paragraphs. It would read, “You must ask for a State Fair Hearing within 120 <u>calendar</u> days from the date of this letter.

If your services qualify for continued benefits you may ask for your services to be continued during the State Fair Hearing. You must request a hearing within 120 <u>calendar</u> days from when your appeal decision was made. We will automatically continue your benefits for you even if you do not ask for this. You may be held liable for the cost of those benefits if the State Fair Hearing Decision is to uphold the decision to deny the service.”
(State Contract Section 1.18.8.1 “Authority and Timeline for State Fair Hearing Request”) (Recommendation 35)</td></tr>
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Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.410(c)(1-2) Expedited resolution of appeals: Action following denial of a request for expedited resolution	**Aetna** 17. To the following, add language that if the member's request for expedited resolution of an appeal is denied, the appeal will be transferred to the timeframe for standard resolution: a. *SoonerSelect Member Handbook*, section "More Information for Appeals," first paragraph (page 54), written at the appropriate member reading level. b. *Provider Manual*, section "Expedited Appeals" (page 112) (State Contract Section 1.18.7.4 "Timeframe for Expedited Resolution") (Recommendation 42)
	Humana 18. To the *SoonerSelect Member Handbook*, section "More Information for Appeals," first paragraph (page 61), written at the appropriate member reading level, add language that if the member's request for expedited resolution of an appeal is denied, the appeal will be transferred to the timeframe for standard resolution. (State Contract Section 1.18.7.4 "Timeframe for Expedited Resolution") (Recommendation 41)
	OCH 21. To the *SoonerSelect Member Handbooks*, written at the appropriate member reading level, add language that if the member's request for expedited resolution of an appeal is denied, the appeal will be transferred to the timeframe for standard resolution. (State Contract Section 1.18.7.4 "Timeframe for Expedited Resolution") (Recommendation 36)
§ 438.416(a-c) Recordkeeping requirements	**Aetna** 18. In the policy *3100.90 Member Complaint/Grievance*, address the following: a. To the section "Grievance Committee," third paragraph, first bullet and the section "Investigation and Documentation," fourth paragraph, first bullet (page 11), add to the list of the requirements what must be in the record for each appeal/grievance the date of resolution at each level, if applicable. b. To the section "Operating Protocol," subsection "Systems" (page 13), add: i. The grievance record must be available upon request to CMS. ii. Language regarding Aetna completing review of grievances for updates and revisions to OHCA's quality strategy. iii. Language that Aetna will produce records to OHCA staff no later than three (3) business days after the date of request, in the format (electronic or hard copy) requested. (State Contract Section 1.18.2 "Recordkeeping," letter e) (Recommendation 44)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.416(a-c) Recordkeeping requirements (Continued)	**Humana** 19. Add the following to the *RT-POL-MCD RMS-10 Medicaid Grievance and Appeal Policy*: a. Humana and subcontractors must retain member grievance and appeal records for a period of no less than ten (10) years. b. Humana must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. c. The record must be accurately maintained in a manner accessible to OHCA and available upon request to CMS and Humana will produce records to OHCA staff no later than three (3) Business Days after the date of request, in the format (electronic or hard copy) requested. (§ 438.416[a]; State Contract Sections 1.2.13 "Record Retention" and 1.18.2 "Recordkeeping," respectively) (Recommendation 42)
	OCH 22. To policy and procedure *Member Appeal System OK.AP.01*, section "G. Recordkeeping," add language that OCH/OCH-CSP shall produce records to OHCA staff no later than three (3) business days after the date of request, in a format (electronic or hard copy) requested." (State Contract Section 1.18.2 "Recordkeeping") (Recommendation 37)
§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending	**Aetna** 19. In the *SoonerSelect Member Handbook,* written at the appropriate member reading level, complete the following: a. In the section "Appeals," sixth paragraph, add the word "calendar" to the 60-day timeframe. It would read, "If you are not satisfied with an action we took or what we decided about your prior authorization (PA) request (see page 50 about prior authorizations and actions), you can file an appeal within 60 **calendar** days (about 2 months) from the time you receive the denial notification letter. An appeal is a request for us to review the decision." (§ 438.420[b][1]; State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letter a) b. In the section "Appeals," subsection "Your Care While You Wait for a Decision on Your Appeal," first bullet (page 55) add language that Aetna must continue the member's benefits if all of the following occur: i. The request for an appeal is filed within the required timeframe; ii. The appeal involves the termination, suspension, or reduction of previously authorized services; and iii. The period covered by the original authorization has not expired." (§ 438.420[b][1-4]; State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letter a) c. In the subsection "Your Care While You wait for a Decision on your State Fair Hearing," add language that if Aetna continues or reinstates the member's benefits, at the member's request, while the appeal or state fair hearing is pending, the benefits must be continued until the member fails to request a state fair hearing after Aetna sends the notice of an adverse resolution to the member's appeal. (§ 438.420[c][2]; State Contract Section 1.18.9.2 "Duration of Continued or Reinstated Benefits," letter b) (Recommendation 45)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending (Continued)	**Humana** 20. In the *SoonerSelect Member Handbook,* written at the appropriate member reading level, section "Part III: Plan Procedures": a. Sub-section "Appeals," subsection "Your Care While You Wait for a Decision on Your Appeal," (page 62) address the following: i. Remove the fourth bullet, as it includes information on the 10-day timely filing. (§ 438.420[a] and related State Guidance). ii. Add to the list of conditions, the member files the request for an appeal within sixty (60) calendar days following the date on the Adverse Benefit Determination notice. (§ 438.420[b][1]) b. In the section "State Fair Hearings," subsection "Your Care While You wait for a Decision on your State Fair Hearing," first paragraph, add language that if Humana continues or reinstates the member's benefits, at the member's request, while the appeal or state fair hearing is pending, the benefits must be continued until the member fails to request a state fair hearing after Humana sends the notice of an adverse resolution to the member's appeal. (§ 438.420[c][2] and related State Guidance) (Recommendation 44)
	OCH 23. In the *SoonerSelect Member Handbooks*, section "Part III: Plan Procedures," subsection "Appeals," in the sixth paragraph (page 51 [SSP]/page 49 [CSP), add the word "calendar" to the 60-day timeframe. It would read, "If you are not satisfied with an action we took or what we decided about your prior-authorization request (PA) (see page 49 about prior authorizations and actions), you can file an appeal at any time. An appeal is a request for us to review the decision. You have 60 **calendar** days after we send you a denial notice (adverse benefit determination) to file an appeal." (§ 438.420[b][1]; State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letter a) (Recommendation 40)
§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending	**Aetna** 20. On the Aetna website, webpage "Grievances and appeals," section "More help with grievances and appeals," dropdown "Continuing benefits during and appeal," complete the following: a. Remove the language related to the 10-day timely filing. (§ 438.420[a]; State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letter e) b. Revise the first through third paragraphs to include the following reasons that Aetna must continue the members benefits: i. The member files the request for an appeal timely; ii. The appeal involves the termination, suspension, or reduction of previously authorized services; iii. The services were ordered by an authorized provider; and iv. The period covered by the original authorization has not expired (§ 438.420[b][1-4]; State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letter a-e) c. In the third paragraph related to the reasons Aetna can discontinue the member's benefits, add the following reasons. i. The member fails to request a state fair hearing after receiving the notice of an adverse resolution to the appeal. (§ 438.420[c][2] ii. A State fair hearing officer issues a hearing decision adverse to the member. (§ 438.420[c][3]) (§ 438.420[c][2-3]; State Contract Section 1.18.9.2 "Duration of Continued or Reinstated Benefits," letter b-c) (Recommendation 46)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending (Continued)	**Humana** 21. On the Humana website, webpage "Oklahoma SoonerSelect: Grievances and Appeals," section "Grievances and Appeals," subsection "Continuation of benefits during the appeal process," address the following: a. Remove language related to the 10-day timely filing. (§ 438.420[a]; State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letter e, roman numeral I; and related State Guidance) b. Revise the information to include the following reasons for which Humana must continue member benefits: i. The member files the request for an appeal within sixty (60) calendar days following the date on the Adverse Benefit Determination notice. ii. The services were ordered by an authorized provider. (§ 438.420[b][1 and 3]; State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letters a and c) (Recommendation 45)
	OCH 24. On the OCH and OCH – CSP websites, webpage "Grievances, Appeals and State Fair Hearing," section "State Fair Hearing," third paragraph, first bullet, and the *SoonerSelect Member Handbooks* (SSP and CSP), section "Part III. Plan Procedures," subsection "Appeals," (page 53/page 52, respectively), subsection "Your Care While You Wait for a Decision on your State Fair Hearing," add to the statement that OCH must continue providing the services until the member fails to request a state fair hearing after OCH sends the notice of adverse resolution to the member's appeal. (§ 438.420[c][2]; State Contract Section 1.18.9.2 "Duration of Continued or Reinstated Benefits," letter b) (Recommendation 42)
§ 438.420(d) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending: Enrollee responsibility for services furnished while the appeal or state fair hearing is pending	**Aetna** 21. Work with the State to determine any needed revisions to the following, and any other applicable documents, regarding the State's policy on member's liability of payment of services continued during an appeal or state fair hearing. a. *SoonerSelect Member Handbook*, section "Appeals," subsection "Your Care While You wait for a Decision on your State Fair Hearing," fourth bullet (pages 55-56). b. *Provider Manual*, section "Notice of action (NOA) requirements," second paragraph, last bullet (pages 82-83) c. Policy *3100.70 Member Appeal System*, section "Request for Continued Benefits During Appeals Process," third paragraph (page 12). See § 438.404(b)(6) for the recommendation related to the *Member Handbook* and the Aetna website. (Recommendation 48)

Regulatory Area	2025 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.420(d) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending: Enrollee responsibility for services furnished while the appeal or state fair hearing is pending (Continued)	**Humana** 22. Work with the State to determine any needed revision to the Humana website, link to "Filling out Grievance/Appeal Request form," pdf "Appeal Request Form," section "Important notice for members of SoonerSelect whose benefits or service were stopped or reduced," last sentence, and any other applicable documents, regarding the State's policy on member's liability of payment of services continued during an appeal or state fair hearing. See § 438.404(b)(6) for the recommendation related to the Humana website and Member Handbook and § 438.408(e)(2)(iii) for the recommendation related to *RT-POL-MCD RNS-10 Oklahoma Medicaid Grievance and Appeal Policy.* (State Contract Section 1.18.10 "Contractor Recovery") (Recommendation 47) **OCH** 25. Work with the State to determine any needed revision to the following, and any other applicable documents, regarding the State's policy on member's liability of payment of services continued during an appeal or state fair hearing: a. *SoonerSelect* and *Sooner Select Children's Specialty Program Member Handbooks*, section "Part III. Plan Procedures," subsection "Appeals," subsection "Your Care While You wait for a Decision on your Appeal," third and fourth paragraphs (page 53). b. Policy and procedure *OK.AP.01 Member Appeal System*, section "Procedure" in the following: i. Letter "A. General Requirements," second paragraph, fifth bullet (page 2). ii. Letter "B. Appeal Process," number 4, letter b, fifth bullet. c. Policy and Procedure *OK.GRV.01 Enrollee Grievance System,* section "Procedure," letter "A. General Requirements," number eight, letter e (page 3). See § 438.404(b)(6) for the recommendation related to the *Member Handbook* and § 438.408(e)(2)(iii) for the recommendation related to policy and procedure *OK.AP.01 Member Appeal System.* (State Contract Section 1.18.10 "Contractor Recovery") (Recommendation 43)
Aetna	
Subpart D – MCO, PIHP and PAHP Standards Compliance Results	
Case Review related to § 438.208(c)(3) Coordination and continuity of care: Additional services for enrollees with special health care needs or who need LTSS – Treatment/service plans	22. Provide staff education and refine internal processes to ensure the following: a. Care plans are completed within 15 days of the comprehensive assessment for members in care coordination that need a course of treatment or regular care monitoring. b. Document outreach attempts for care plan completion in the health plan's EHR. (Recommendation 4)

Regulatory Area	2025 Compliance Review Recommendations
Aetna	
Subpart D – MCO, PIHP and PAHP Standards Compliance Results (Continued)	
§ 438.242(b) Health information systems: Basic elements of a health information system and related provision § 431.60(b) Beneficiary access to and exchange of data: Accessible content	23. In policy *2400.05 Encounter Data Submission*, section "FOCUS/DISPOSITION," fourth paragraph (page 2), add language related to making information and data available at the request of CMS. It would read, "Aetna will make all information and data collected by the Contractor's information system available (in usable format specified) to OHCA **and, upon request, to the CMS, in accordance with 42 C.F.R. § 438.242(b)(4)**." (§ 438.242[b][4]; State Contract Section 1.21.1 "General Requirements," second paragraph, second sentence) (Recommendation 5)
§ 438.242(b) Health information systems: Basic elements of a health information system and related provision § 431.60(b) Beneficiary access to and exchange of data: Accessible content	24. In the 2026 review, in the follow-up to prior recommendations, submit the revised and approved policy *A-OK 7000.69 My Member Care Information Portals*. (§ 438.242[b][5] and § 431.60[b][1-4]; State Contract Section 1.21.7.1 "Encounter Data Detail and Format," fourth paragraph) (Recommendation 6)
Subpart F – Grievance and Appeal System Compliance Results	
Grievance issues not related to an element on the grievance and appeal case review tool for the Compliance Review	25. For grievances that are closed due to not receiving the provider record, provide staff education and refine internal processes for the following. a. Refer the provider to the provider relations team for education and remediation on contractual requirements to submit to the health plan the requested record for grievances. b. Keep cases open to continue the investigation if in the member's interest and, if needed, request extensions as outlined in § 438.408(c)(1)(ii). c. Avoid categorizing grievances closed due to the absence of a provider record as "unsubstantiated." (Recommendation 7)
Grievance issues not related to an element on the grievance and appeal case review tool for the Compliance Review	26. For grievances that are closed due to the submitter not responding to outreach to obtain further information, provide staff education that the resolution letter should include information on how to resubmit the grievance and provide the requested information. (Recommendation 8)

Regulatory Area	2025 Compliance Review Recommendations
Aetna	
	Subpart F – Grievance and Appeal System Compliance Results (Continued)
Grievance issues not related to an element on the grievance and appeal case review tool for the Compliance Review	27. Revise grievance resolution letters to provide clear instructions and information to the member, such as stating whether the member was responsible for payment, or information on how the issue can or will be resolved. (Recommendation 9)
§ 438.402(c)(1) General requirements: Filing requirements – Authority to file	28. Revise the following documents and any additional applicable documents to remove language that states member consent is not required for expedited appeals submitted by a provider: a. Policy *3100.70 Member Appeals*, section "Timeframe for Resolving- Expedited Appeals" first paragraph second sentence (page 15). b. *Provider Manual*, "Chapter 16: Appeal and grievance system," section "Expedited Appeal," second paragraph (page 112). (§ 438.402[c][1][ii]; State Contract Section 1.18.1 "Enrollee Grievance and Appeal Overall Requirements") (Recommendation 10)
§ 438.402(c)(1) General requirements: Filing requirements – Authority to file	29. Add to policy *3100.90 Member Complaint/Grievance*, section "Focus/Disposition," subsection "Scope," first paragraph (page 4), information that written consent of the member is needed to file a grievance. (§ 438.402[c][1][ii]; State Contract Section 1.18.1 "Enrollee Grievance and Appeal Overall Requirements") (Recommendation 12)
Appeal Case Review related to § 438.402(c)(1) General requirements: Filing requirements – Authority to file	30. Provide staff education, refine internal processes, and revise applicable Standard Operating Procedures, to ensure written consent from the member is received (and documented in the CE's appeal system consistently for all applicable cases) when a provider or other authorized representative files an appeal on behalf of a member. (State Contract Section 1.18.1 "Overall Requirements") (Recommendation 13)
§ 438.402(c)(2) General requirements: Filing requirements – Timing	31. To the *SoonerSelect Member Handbook*, section "Appeals," written at the appropriate member reading level, add the specified timeframe of "calendar" days. It would read, "If you are not satisfied with an action we took or what we decided about your prior authorization (PA) request (see page 50 about prior authorizations and actions), you can file an appeal within 60 **calendar** days (about 2 months) from the time you receive the denial notification letter. An appeal is a request for us to review the decision." (State Contract Section 1.18.7.2 "Timeframe for Requesting Appeal") (Recommendation 14)
§ 438.402(c)(2) General requirements: Filing requirements – Timing	32. To the *Provider Manual*, section "Standard appeal" second paragraph, add the specified timeframe of "calendar" days. It would read, "Members or their designated representatives including a provider can file an appeal directly with us either in writing or verbally by calling into member services, provider services, or by calling any other health plan staff. Providers can also advise and advocate on behalf of member. The date of the verbal appeal establishes the filing date for the appeal. Members have 60 **calendar** days from the date of the notice of adverse benefit determination letter to file an appeal." (State Contract Section 1.18.7.2 "Timeframe for Requesting Appeal") (Recommendation 15)

Regulatory Area	2025 Compliance Review Recommendations
Aetna	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.406(b)(1) Handling of grievances and appeals: Special requirements	33. Revise policy *3100.90 Member Complaint/Grievance*, section "Acknowledgement of Grievances," second bullet (page 10) to state, "All member grievances are acknowledged in writing within ten (10) calendar days." (OCA section 317:2-3-4 "Member grievances," letter f, number 4, letter B) (Recommendation 17)
§ 438.406(b)(1) Handling of grievances and appeals: Special requirements	34. In the *Provider Manual*, "Chapter 16: Appeal and grievance system," subsection "Member appeal and grievance system overview," subsection "Appeals" (pages 111-112), include a statement regarding Aetna sending the member, authorized representative, or provider (when applicable) an acknowledgement letter of receipt of the appeal. (OCA section 317:2-3-4 "Member grievances," letter f, number 4, letter B) (Recommendation 19)
Grievance and Appeal Case Review related to § 438.406(b)(1) Handling of grievances and appeals: Special requirements (Grievance and appeal acknowledgement)	35. Provide staff education and refine internal processes to ensure an acknowledgement letter is sent, upon the receipt of a grievance, to the member or the member's authorized representative within ten (10) calendar days. (Recommendation 20)
Grievance and Appeal Case Review related to § 438.406(b)(1) Handling of grievances and appeals: Special requirements (Grievance and appeal acknowledgement)	36. Provide staff education and refine internal processes to ensure an acknowledgement letter is sent, upon the receipt of an appeal, to the member or the member's authorized representative within five (5) calendar days. (Recommendation 21)
§ 438.406(b)(2) Handling of grievances and appeals: Special requirements	37. In policy *3100.90 Member Complaint/Grievance*, section "Focus/Disposition," subsection "Scope," (pages 4-5) include language that Aetna ensures that the individuals who make decisions on grievances and appeals are individuals – Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. (§ 438.406[b][2][iii]; State Contract Section 1.18.1.3 "Decision Makers on Grievance or Appeals") (Recommendation 22)
§ 438.406(b)(5) Handling of grievances and appeals: Special requirements	38. To the *Provider Manual*, section "Standard Appeal," fourth paragraph (page 111), add language that states the information related to presenting supporting evidence will be provided to the member or their designated representative sufficiently in advance of the resolution timeframe for appeals. (State Contract Section 1.18.1.3.2 "Access to Enrollee Case Files") (Recommendation 24)

Regulatory Area	2025 Compliance Review Recommendations
Aetna	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
Grievance Case Review related to § 438.408(b)(1) Resolution and notification: Grievances and appeals – Specific timeframes-Standard resolution of grievances	39. Provide staff education and refine internal processes to ensure grievance withdrawal letters are sent to the member when the case is withdrawn, regardless of who submitted the grievance. The notice letter is to be sent within the required timeframes, of no later than thirty (30) calendar days from the date the CE receives the grievance and within three (3) calendar days of the grievance being withdrawn. (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance" and 1.18.6.12 "Grievance Resolution Notice Format, and Content") (Recommendation 27)
§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes	40. To the following, add the State Contract specification that the provider as authorized representative may also request the extension. a. Policy *3100.70 Member Appeal System*, section "Focus/Disposition," section "Appeal Extension," first bullet. It would read, "Aetna Better Health of Oklahoma may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the member **or provider as authorized representative** requests the extension; or" (State Contract Section 1.18.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) b. Policy *3100.90 Member Complaint/Grievance*, section "Focus/Disposition," section "Extensions" (page 13). It would read, "Grievances will be resolved within thirty (30) calendar days from receipt and notified within three calendar days of resolution unless an extension of time is warranted. The resolution time period may be extended up to fourteen (14) calendar days if: • The member **or provider as authorized representative** requests the extension • Aetna demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest." (State Contract Section 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph) (Recommendation 29)
§ 438.408(c)(3) Resolution and notification: Grievances and appeals – Extension of timeframes: Deemed exhaustion of appeals processes	41. To the Aetna website, webpage "Grievances and appeals," add language that details if Aetna fails to adhere to the notice and timing requirements, the member is deemed to have exhausted Aetna's appeals process and may initiate a State fair hearing. (State Contract Section 1.18.8 "Deemed Exhaustion of Appeals Process") (Recommendation 34)
Grievance Case Review related to § 438.408(d)(1) Resolution and notification: Grievances and appeals – Format of notice-Grievances	42. Provide staff education and refine internal processes to ensure all grievance resolution letters: a. Are written in easily understood language that is no higher than sixth grade using the Flesch-Kincaid readability test. b. Include the plan's findings of the grievance and identify next steps, if any, for the member and/or the health plan. (State Contract Section 1.18.6.12 "Grievance Resolution Notice Format, and Content") (Recommendation 35)

Regulatory Area	2025 Compliance Review Recommendations
Aetna	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
Grievance Case Review related to § 438.408(d)(1) Resolution and notification: Grievances and appeals – Format of notice-Grievances	43. Revise the letter attachment templates to ensure all communication with members includes "a large-print tagline, in minimum eighteen-point (18-point) font, and information on how to request auxiliary aids and services, including the provision of materials in alternative formats." (OAC "317:2-3-8. Grievances and appeals notice") (Recommendation 36)
§ 438.408(d)(2)(ii) Resolution and notification: Grievances and appeals – Format of notice-Appeals	44. In the *Provider Manual*, "Chapter 16: Appeal and grievance system," add language that Aetna will make reasonable efforts to provide verbal notice of an expedited appeal resolution. (State Contract Section 1.18.7.5 "Appeal Resolution Notice Format and Content," second paragraph) (Recommendation 37)
Appeal Case Review related to § 438.408(e)(2)(iii) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution	45. Provide staff education and refine internal processes to ensure all notices of appeal resolution clearly indicate the date the CE made the appeal decision. (Recommendation 38) Also, see § 438.408(b)(2) for the recommendation made.
Appeal Case Review related to § 438.408(e)(2)(iii) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution	46. For appeals not resolved wholly in favor of the member, work with the State to determine how to revise the *Appeal Resolution* template letter to include that the member may not be billed for such services continued during an appeal or state fair hearing, regardless of the outcome. (Recommendation 40)
§ 438.416(a-c) Recordkeeping requirements	47. In the policy *3100.70 Member Appeals*, complete the following: a. To the section "Appeal Summary," second paragraph, first bullet "File content," add to the list of the requirements of what must be in the record for each appeal the date of resolution at each level, if applicable. b. To the section "Operating Protocol," subsection "Systems" (page 20), add: i. The appeal record must be available upon request to CMS. ii. Language regarding Aetna completing review of appeals as part of its ongoing monitoring procedures, as well as for updates and revisions to OHCA's quality strategy. iii. Language that Aetna will produce records to OHCA staff no later than three (3) business days after the date of request, in the format (electronic or hard copy) requested. (State Contract Section 1.18.2 "Recordkeeping," letter e) (Recommendation 43)

Regulatory Area	2025 Compliance Review Recommendations
Aetna	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.420(c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending – Duration of continued or reinstated benefits	48. In the *Provider Manual*, "Chapter 12: Prior Authorization," section "Continuation of benefits," second paragraph, bullets one through three, related to the reasons Aetna can discontinue the member's benefits (page 83), include the reason if the member fails to request a state fair hearing after Aetna sends the notice of an adverse resolution to the member's appeal. (§ 438.420[c][2]; State Contract Section 1.18.9.2 "Duration of Continued or Reinstated Benefits," letter b) (Recommendation 47)
Humana	
Subpart F – Grievance and Appeal System Compliance Results	
§ 438.402(c)(1)(i)(B) General requirements: Filing requirements – Authority to file-External medical review	23. In *RT-POL-MCD RMS-10 Oklahoma Medicaid Grievance and Appeal Policy*, section "External Medical Review" (page 3), remove the language related to OHCA having the authority to offer and arrange for external medical reviews under certain circumstances. (OAC "317:2-3-6. External medical review and clinical expertise," letter a "External medical review") (Recommendation 4)
§ 438.404(c) Timely and adequate notice of adverse benefit determination: Timing of notice	24. In the *SoonerSelect Member Handbook,* section "Prior Authorization and Timeframes," third paragraph (page 59), add the word "calendar" to the 10-day timeframe. It would read, "In most cases, if you are receiving a service and a new request is made to keep receiving a service, we must tell you at least 10 **calendar** days before we change the service if we decide to reduce, stop, or restrict the service." (State Contract Section 1.18.6.4 "Termination, Suspension, or Reduction of Previously Authorized Covered Services") (Recommendation 7)
§ 438.404(c)(4-5) Timely and adequate notice of adverse benefit determination: Timing of notice	25. In the *SoonerSelect Member Handbook,* section "Prior Authorization and Timeframes," second paragraph (page 59), add information, at the appropriate reading level for members, that Humana provides the member written notice of the reason for the decision to extend the timeframe, includes the members right to file a grievance if he or she disagrees with that decision, and that the determination is issued and carried out as expeditiously as the member's health condition requires and no later than the date the extension expires. (Recommendation 8)
Appeal Case Review related to § 438.406(b)(1) Handling of grievances and appeals: Special requirements (Grievance and appeal acknowledgement)	26. Provide staff education related to sending an acknowledgement letter, upon the receipt of an appeal, to the member or the member's authorized representative within five (5) calendar days. (Recommendation 10)

Regulatory Area	2025 Compliance Review Recommendations
Humana	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.406(b)(5) Handling of grievances and appeals (Special requirements)	27. To the *Provider Manual*, "Chapter 12: Member grievances, appeals and state fair hearing requests" (page 57), add language that states Humana will provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Humana (or at the direction of the Humana) in connection with the appeal of the adverse benefit determination. The information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. (State Contract Section 1.18.1.3.2 "Access to Enrollee Case Files") (Recommendation 12)
Grievance Case Review related to § 438.408(b)(1) Resolution and notification: Grievances and appeals – Specific timeframes: Standard resolution of grievances	28. Provide staff education and refine internal processes to ensure that written notice of resolution of a grievance is to be provided to the impacted member within three (3) calendar days of the CE resolving the grievance. (Recommendation 16)
Appeal Case Review related to § 438.408(b)(2) Resolution and notification: Grievances and appeals – Specific timeframes- Standard resolution of appeals	29. Provide staff education and refine internal processes to ensure written resolution of appeals are sent to all affected parties, including the member, within the three (3) calendar days following the CE's resolution decision. (Recommendation 18)
Appeal Case Review related to § 438.408(b)(3) Resolution and notification: Grievances and appeals – Specific timeframes- Expedited resolution of appeals	30. Provide staff education and refine internal processes to ensure expedited appeals are resolved, with notice to the affected parties, as expeditiously as the member's health condition requires but not to exceed seventy-two (72) hours from the date the CE receives the expedited appeal; written notice should be provided within three (3) calendar days following the CE's resolution decision. (Recommendation 19)
§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes	31. To the *RT-POL-MCD RNS-10 Oklahoma Medicaid Grievance and Appeal Policy,* section "Grievances," sub section "Extensions," add the language, "to OHCA's satisfaction upon request." It would read, "Humana justifies **to OHCA's satisfaction upon request**, the necessity for additional information and documents that it is in the best interest of the enrollee." (State Contract Section 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph) (Recommendation 20)

Regulatory Area	2025 Compliance Review Recommendations
Humana	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes	32. To the Humana website, webpage "Oklahoma SoonerSelect: Grievances and Appeals," address the following: a. In the section "Grievances," third from the last paragraph, add language that Humana may extend the grievance resolution timeframe by up to 14 calendar days if Humana shows (to the satisfaction of OHCA, upon request) that there is a need for additional information and how the delay is in the member's interest. b. In the section "Appeals," add language that states Humana may extend the appeal resolution timeframe by up to 14 calendar days if: i. The member requests the extension; or ii. Humana shows to the satisfaction of OHCA, upon request, there is need for additional information and how the delay is in the member's interest. (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," second paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution") (Recommendation 23)
	33. In the document *Oklahoma Medicaid Standard Appeal*, section "Is An Extension of the Decision Timeframe Permitted?" add the language "(including provider as the authorized representative)." It would read, "If the member or authorized rep **(including provider as the authorized representative)** requests the extension." (State Contract Section 1.18.7.3 "Timeframe for Standard Appeal Resolution," third paragraph) (Recommendation 24)
Appeal Case Review related to § 438.408(c)(1) Resolution and notification: Grievances and appeals – Extension of timeframes	34. Provide staff education or refine internal processes to ensure rationale for extending the timeframes for appeal resolution is clearly documented in the case notes of the appeal record. (Recommendation 25)
§ 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes: Requirements following extension	35. On the Humana website, webpage "Oklahoma SoonerSelect: Grievances and Appeals," address the following: a. In section "Grievances," fourth paragraph, add language that states: i. Humana will make reasonable efforts to give the member prompt verbal notice of the delay and provide the member written notice of the reason for the decision to extend the timeframe within two (2) calendar days. ii. Inform the member of the right to file a grievance if the member disagrees with that decision. b. In section "After you submit your appeal," third paragraph, add language the notice will include the right to file a grievance if the member disagrees with the extension. (State Contract Sections 1.18.6.11 "Timeframe for Resolution of Grievance," third paragraph and 1.18.7.3 "Timeframe for Standard Appeal Resolution," fourth paragraph) (Recommendation 28)

Regulatory Area	2025 Compliance Review Recommendations
Humana	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
Appeal Case Review related to § 438.408(c)(2) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension	36. Provide staff education and refine internal processes to ensure the requirement that reasonable efforts to provide prompt verbal notification to the member of a delay in the resolution of the appeal are be made when the required timeframes for resolution of the appeal is extended. Any outreach attempt to the member should be documented in the CE's system. (Recommendation 29) 37. Provide staff education and refine internal processes to ensure the requirement that written notice of the reason for the decision to extend the timeframe of the appeal resolution is sent within two (2) calendar days and the notice shall include the member's right to file a grievance if they disagree with the decision to extend. (Recommendation 30)
Grievance and Appeal Case Review related to § 438.408(d)(1) and (d)(2)(i) Resolution and notification: Grievances and appeals – Format of notice	38. Revise the taglines for all applicable template documents to include a large-print tagline in minimum eighteen-point (18-point) font. (State Title 317 of the OAC 317:2-3-8. "Grievances and appeals notice") (Recommendation 31)
§ 438.408(d)(2)(i) Resolution and notification: Grievances and appeals – Format of Notice-Appeals	39. To the Humana website, webpage "Oklahoma SoonerSelect: Grievances and Appeals," section "After you submit your appeal," first sentence, for notification following resolution of the appeal, revised the "5 business day" timeframe to "3 calendar days." (State Contract Section 1.18.6.12 "Grievance Resolution Notice Format and Content") (Recommendation 32)
Appeal Case Review related to § 438.408(d)(2)(i) Resolution and notification: Grievances and appeals – Format of notice-Appeals	40. Provide staff education and refine internal processes to ensure the contractual requirement that all notices of appeal resolution include taglines in each State-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDD [Teletypewriter/ Telecommunications Devise for the Deaf] telephone number of the entity providing customer service. Also, see § 438.408(d)(1) for the recommendation made. (Recommendation 33)
§ 438.408(d)(2)(ii) Resolution and notification: Grievances and appeals – Format of notice-Appeals	41. In the following, add language that Humana will make reasonable efforts to provide verbal notice of an expedited appeal resolution: a. *RT-POL-MCDRNS-10 Oklahoma Medicaid Grievance and Appeal Policy*, section "Expedited Appeals and Standard Pre-Service Step Therapy Requests" (page 9). b. Document *Oklahoma Medicaid – Expedited Appeal*, section "Decision Timeframe," second paragraph. c. Humana website, webpage "Oklahoma SoonerSelect: Grievances and Appeals," section "Appeals." (State Contract Section 1.18.7.5 "Appeal Resolution Notice Format and Content," second paragraph) (Recommendation 34)

Regulatory Area	2025 Compliance Review Recommendations
Humana	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
Appeal Case Review related to § 438.408(e)(1) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution	42. Provide staff education and refine internal processes to ensure staff are aware of the policy that details all notices of appeal resolution are to clearly indicate the date the CE made the appeal decision. (Recommendation 35)
Appeal Case Review related to § 438.408(e)(2)(iii) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution	43. For appeals not resolved wholly in favor of the member, work with the State to determine how to revise the Appeal Resolution template letter to include that the member may not be billed for such services continued during an appeal or state fair hearing, regardless of the outcome. (Recommendation 37)
§ 438.408(f)(1)(ii) Resolution and notification: Grievance and appeals – Requirements for State fair hearings: Availability-External medical review	44. Language, related to OHCA having the authority to offer and arrange for external medical reviews, needs to be removed in the following: a. Humana *RT-POL-MCD RNS-10 Oklahoma Medicaid Grievance and Appeal Policy*, section "External Medical Reviews" (page 3). b. *Provider Manual*, section "Appeal," second paragraph (page 57). (OAC "317:2-3-6. External medical review and clinical expertise," letter a "External medical review") (Recommendation 38)
§ 438.408(f)(2) Resolution and notification: Grievance and appeals – Requirements for State fair hearings: State fair hearing	45. On the Humana website, webpage "Oklahoma SoonerSelect: Grievances and Appeals," section "State fair hearing," second to last paragraph, revise the time frame from 30 calendar days to 120 calendar days. It would read, "If you file a State fair hearing request, you must do it within **<u>120</u>** calendar days after the date on the denial letter." (State Contract Section 1.18.8.1 "Authority and Timeline for State Fair Hearing Request") (Recommendation 40)
§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending	46. To the *Provider Manual*, "Chapter 12: Member grievances, appeals and state fair hearing requests," section "Continuation of benefits" (pages 58-59), address the following: a. In the first paragraph, to the list of conditions that Humana will continue paying the members benefits while the state fair hearing or appeal is pending, add the member files the request for an appeal within sixty (60) calendar days following the date on the Adverse Benefit Determination notice (§ 438.420[b][1]; State Guidance related to State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letter a) b. In the second paragraph, to the list of reasons members benefits will be continued, add the reason, the member fails to request a State Fair Hearing after Humana sends the notice of an Adverse Resolution to the member's appeal. (§ 438.402[c][2]; and related State Guidance) (Recommendation 43)

Regulatory Area	2025 Compliance Review Recommendations
Humana	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending	47. To the *RT-POL-MCD RMS-10 Oklahoma Medicaid Grievance and Appeal Policy*, section "Procedure," include the language, if Humana continues or reinstates the member's benefits, at the member's request, while the appeal or state fair hearing is pending, the benefits must be continued until the member fails to request a state fair hearing after Humana sends the notice of an adverse appeal resolution to the member. (State Guidance related to § 438.420[c][2]) (Recommendation 46)
§ 438.424(b) Effectuation of reversed appeal resolutions: Services furnished while the appeal is pending	48. Revise the language in the *RT-POL-MCD RMS-10 Oklahoma Medicaid Grievance and Appeal Policy*, section "Effectuation of Reversed Enrollee Appeal Resolutions," first bullet (page 14) to remove the sentence, **"**The enrollee may be held liable for the cost of these benefits if Humana or the state fair hearing officer reverses the initial decision to deny authorization of the services." (State Contract Section 1.18.10 "Contractor Recovery") (Recommendation 48)
OCH/OCH – CSP	
Subpart D – MCO, PIHP and PAHP Standards Compliance Results	
Care Coordination issues not related to an element on the care coordination case review tool for the Compliance Review	26. Provide staff education and refine internal processes to ensure the following. a. Correct information is documented in all communication to members and their providers. b. All contact with the member is documented in the health plan's Electronic Health Record (EHR), to include the date of outreach and a note of what was discussed with the member or authorized representative. c. Tasks, such as calling a member at a different time or sending a letter via mail, are to be adequately documented in the health plan's EHR, assigned to a staff member with a reasonable due date, and tracked for timely completion. (Recommendation 2)
Case Review related to § 438.208(c)(2) Coordination and continuity of care: Additional services for enrollees with special health care needs	27. Provide staff education and refine internal processes to ensure the following: a. Every member in CSP is assigned a care manager, regardless of risk stratification tier. b. Outreach attempts are to be completed at a minimum of once every six (6) months, and each attempt is to be documented within the health plan's EHR. (Recommendation 4)
Case Review related to § 438.208(c)(3) Coordination and continuity of care: Additional services for enrollees with special health care needs or who need LTSS: Treatment/service plans	28. Provide staff education and refine internal processes to ensure the following. a. Care plans are completed within 15 days of the comprehensive assessment for members in care coordination that need a course of treatment or regular care monitoring. b. Document in the health plan's EHR, outreach attempts for care plan completion. (Recommendation 6)

Regulatory Area	2025 Compliance Review Recommendations
OCH/OCH – CSP	
Subpart F – Grievance and Appeal System Compliance Results	
§ 438.228(a-b) Grievance and appeal systems	29. On the OCH website, webpage "Grievances, Appeals, and State Fair Hearing," update the linked *SoonerSelect Member Handbook* to be the current version (May 2025). (Recommendation 7)
Grievance and Appeal issues not related to an element on the grievance and appeal case review tool for the Compliance Review	30. Provide staff education and revise internal processes to ensure members are able to file appeals verbally as well as in writing. (Recommendation 8)
§ 438.402(c)(1) General requirements: Filing requirements – Authority to file	31. In policy and procedure *OK.AP.01 Member Appeal System*, section "B. Appeal Process," number "2. Timeframe for Standard Appeal Resolution," letter b, revise the language related to "OHCA may offer and arrange for an external medical review for the Plan's adverse benefit determination," as OHCA does not offer external medical review for the purpose of grievances and appeals. (Oklahoma Administrative Code "317:2-3-6. External medical review and clinical expertise," letter a "External medical review"; also applies to § 438.408(f)(1)(ii) Resolution and notification: Grievance and appeals – Requirements for State fair hearings: Availability-External medical review) (Recommendation 9)
§ 438.402(c)(1)(ii) General requirements: Filing requirements – Authority to file	32. On the OCH website, webpage "Grievances, Appeals and State Fair Hearing," and the Children's Specialty Program website, webpage "Grievances and Appeals," include information that the member's written consent. (Recommendation 11) is required for an authorized representative to file a grievance or request a State Fair hearing
Appeal Case Review related to § 438.402(c)(1) General requirements: Filing requirements – Authority to file	33. Provide staff education, refine internal processes, and revise applicable Standard Operating Procedures, to ensure written consent from the member is received, and adequately documented in the CE's appeal system consistently, when a provider or other authorized representative files an appeal on behalf of a member. (Recommendation 12)
§ 438.402(c)(2) General requirements: Filing requirements – Timing	34. Address the following, written at the appropriate member reading level, in both the *SoonerSelect Member Handbook* and the *SoonerSelect Children's Specialty Program Member Handbook*. a. In the *SoonerSelect Member Handbook*, section "Appeals," second to last paragraph, add the specified timeframe of "calendar" days. It would read, "If you are not satisfied with an action we took or what we decided about your prior-authorization request (PA) (see page 44 about prior authorizations and actions), you can file an appeal. An appeal is a request for us to review the decision. You have 60 **calendar** days after we send you a denial notice (adverse benefit determination notice) to file an appeal." b. In the *SoonerSelect Children's Specialty Program Member Handbook*, section "Appeals," second to last paragraph, add the sentence, "You have 60 calendar days after we send you a denial notice (adverse benefit determination notice) to file an appeal." (State Contract Section 1.18.7.2 "Timeframe for Requesting Appeal") (Recommendation 13)

Regulatory Area	2025 Compliance Review Recommendations
OCH/OCH – CSP	
Subpart F – Grievance and Appeal System Compliance Results	
§ 438.402(c)(2) General requirements: Filing requirements – Timing	35. Update the link, on the OCH-CSP website, webpage "Grievances and Appeals," section "State Fair Hearings," last sentence, "You can find detailed information about grievances and appeals in our Member Handbook," to include the most current version of the *SoonerSelect Member Handbook*. (Also see § 438.228(a-b) for the recommendation made related to the OCH website, webpage "Grievances, Appeals and State Fair Hearings," section "State Fair Hearings," as it applies here. Recommendation 14)
Appeal Case Review related to § 438.406(b)(1) Handling of grievances and appeals: Special requirements (Grievance and appeal acknowledgement)	36. Provide staff education, refine internal processes, and revise applicable Standard Operating Procedures, to ensure written acknowledgement of appeal receipt is sent to the member. (Recommendation 17)
§ 438.406(b)(5) Handling of grievances and appeals: Special requirements (Member's request of case file during appeal)	37. To the *Provider Manual*, section "Appeals," add language that states the information will be provided sufficiently in advance of the resolution timeframe for appeals. (State Contract Section 1.18.1.3.2 "Access to Enrollee Case Files") (Recommendation 19)
Appeal Case Review related to § 438.408(b)(2) Resolution and notification: Grievances and appeals – Specific timeframes-Standard resolution of appeals	38. Provide staff education and refine internal processes to ensure written resolution of appeals is sent to all affected parties, including the member, within three (3) calendar days following the CE's resolution decision. (Recommendation 23)
§ 438.408(c)(2)(ii) Resolution and notification: Grievances and appeals – Extension of timeframes-Requirements following extension	39. In the policy and procedure *OK.GRV.01 Enrollee Grievance System*, related to giving the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision, in section "Grievance Department Handling," number 6, second bullet (page 5) and section "Grievance Resolution and Notification," number 6, second bullet (page 6), change the specified "three calendar days" to "two calendar days." (State Contract Section 1.18.6.11 "Timeframe for Resolution of Grievance," third paragraph) (Recommendation 29)
Appeal Case Review related to § 438.408(d)(2)(ii) Resolution and notification: Grievances and appeals – Format of notice-Appeals	40. Provide staff education and refine internal processes to ensure any delay in expedited appeal resolution is communicated promptly to the member and outreach attempts are documented within the appeal record. (Recommendation 33)

Regulatory Area	2025 Compliance Review Recommendations
OCH/OCH – CSP	
Subpart F – Grievance and Appeal System Compliance Results (Continued)	
§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending	41. To the policy and procedure *OK.AP.01 Member Appeal System*, section "Procedure," letter "F. Continuation of Benefits Pending Appeal and State fair Hearing," (pages 7-9), number 2, (page 7) add language related to timely filing, on or before the later of the following: The intended effective date of the CE's proposed adverse benefit determination. (§ 438.420[a] and [b][1]; State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letter e, roman numeral ii, and related State Guidance) (Recommendation 38)
§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending	42. In the *Provider Manual,* section "Member Grievance and Appeals Process," subsection "Continuation of Benefits during the Appeal Process," (page 107) revise the following: a. Remove language related to the 10-day timely filing. (§ 438.420[a]; State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letter e) b. Add language that the member's benefits will continue if all of the following occur: i. The member files the request for an appeal timely; ii. The appeal involves the termination, suspension, or reduction of previously authorized services; iii. The services were ordered by an authorized provider; iv. The period covered by the original authorization has not expired; and (§ 438.420[b]; State Contract Section 1.18.9.1 "When the Contractor Shall Continue Benefits," letters a-d) c. Add language, if OCH continues or reinstates the member's benefits, at the member's request, while the appeal or state fair hearing is pending, the benefits must be continued until one of the three specified occurrences happen: i. The enrollee withdraws the appeal or request for state fair hearing. ii. The enrollee fails to request a state fair hearing after OCH sends the notice of an adverse resolution to the member's appeal. iii. A State fair hearing office issues a hearing decision adverse to the enrollee. (§ 438.420[c]; State Contract Section 1.18.9.2 "Duration of Continued or Reinstated Benefits," letters a-c) (Recommendation 39)
§ 438.420(a-c) Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State Fair Hearing are pending	43. Address the following on the OCH-CSP website: a. Webpage "Member Handbooks and Forms," section "Forms," fourth bullet "Grievance/Appeal Form (PDF)," link the grievance/appeal from to the webpage. b. Webpage "Grievances and Appeals," section "Grievances, Appeals, and State Fair Hearings," in the first paragraph, update the link to the most current version of the *SoonerSelect Member Handbook*. (§ 438.420[a] and [b]) (Recommendation 41)

Review Area	2025 EPSDT Recommendations
Common Among the SoonerSelect Dental CEs	
Education and Outreach to Enrollees: Identification and Communication (42 CFR 441.56)	1. With the next annual evaluation, submit evidence that members are informed of EPSDT benefits within 60 days of enrollment.
Related to the Prior Authorization Case Review	2. Ensure all denied prior authorization requests are reviewed and documented by a licensed dentist.
Education and Outreach to Enrollees: Education and Communication (SoonerSelect Dental Contract Section 1.7.4)	3. Make the following updates the *Member Handbook*: a. Provide more explanation of EPSDT dental benefits. b. In the EPSDT section, provide a direct link to the DentaQuest/LIBERTY Dental SoonerSelect webpage. c. Add information in the list of covered services to indicate which are EPSDT services. d. Consider adding a schedule of preventative care by age.
	4. Expand the EPSDT information available on the DentaQuest/LIBERTY SoonerSelect webpage. Consider adding links to EPSDT resources.
DentaQuest	
Education and Outreach to Enrollees: Education and Communication (SoonerSelect Dental Contract Section 1.7.4)	5. Clarify the EPSDT eligibility age range in the *Office Reference Manual* by using a single, consistent definition. The State standard of "under 21 years of age" should be used throughout the section to prevent confusion and ensure alignment with EPSDT requirements.
Related to the Prior Authorization Case Review	6. Evaluate internal workflows to confirm all PA requests are processed within required timeframes.
LIBERTY	
Education and Outreach to Enrollees: Identification and Communication	5. Provide examples of member outreach material for the next annual evaluation
Related to the Prior Authorization Case Review	6. Consider all medical record documentation when making determinations of medical necessity.

Review Area	2025 EPSDT Recommendations
Aetna	
Education and Outreach to Enrollees: Identification and Communication (42 CFR 441.56)	1. With the next annual evaluation, submit evidence that members receive information about EPSDT services within 60 days of enrollment.
Related to the Prior Authorization Case Review	2. When reviewing prior authorizations, ensure the requests for EPSDT eligible services are evaluated beyond plan limitations, including age restrictions.
Related to the Prior Authorization and Appeal Case Reviews	3. Appropriate medical necessity criteria should be selected when making prior authorization and appeal determinations. If a Milliman or other pediatric criterion is not available, Aetna should consider if the service meets current clinical standards or has support from pediatric literature.
Related to the Appeal Case Review	4. Providers with appropriate experience and specialty should evaluate appeals.
	5. Aetna should consider all documentation, including that provided with the initial authorization request, when making an appeal determination.
Education and Outreach to Enrollees: Education and Communication (SoonerSelect Contract Section 1.7.11)	6. With the next version of the *Member Handbook*, ensure direct access to EPSDT information and resources. Consider making the following changes: a. Provide more robust and visible EPSDT information on Aetna's website or replace the link to Aetna's website with a link to the member-facing EPSDT webpage on OCHA's website (https://oklahoma.gov/ohca/individuals/programs/child-health.html). b. Provide a direct link to the Family-Centered Page on the Bright Futures website (https://www.aap.org/en/practice-management/bright-futures/bright-futures-family-centered-care/).
Humana	
Related to the Appeal Case Review	1. Humana should ensure that EPSDT-covered services are not denied based solely on the absence of corresponding codes in the Medicaid Fee Schedule.
OCH & CSP	
EPSDT Program Structure: Operational Oversight (42 CFR § 438.206)	1. With the next annual evaluation, submit evidence that wait time standards for EPSDT services are met.
Related to the Prior Authorization Case Review	2. All denied prior authorizations should be reviewed by a physician, and appropriate medical necessity criteria applied.

Review Area	2025 EPSDT Recommendations
OCH & CSP (Continued)	
Related to the CSP Prior Authorization Case Review	3. Ensure that all denials for EPSDT-eligible services, including administrative denials, are reviewed for medical necessity and that determinations consistently apply appropriate medical necessity criteria. 4. Ensure that all physician reviewers making EPSDT-related determinations possess appropriate qualifications, including experience in pediatrics and/or EPSDT. 5. With the next annual review, include copies of the medical necessity criteria applied in each determination to enable full assessment of decision appropriateness.
Related to the Appeal Case Review	6. All appeals should undergo review by appropriately qualified clinical reviewers, with determinations based on medical necessity rather than administrative policy alone.
Related to the CSP Appeal Case Review	7. Review internal processes to ensure that all appeal requests are routed and completed in a timely manner.
Education and Outreach to Enrollees: Education and Communication (SoonerSelect Contract Section 1.7.11)	8. Ensure that EPSDT information on the OCH website is straightforward, intuitive to navigate, and written at a reading level appropriate for the member population. 9. With the next version of the *Member Handbook*, ensure direct access to EPSDT information and resources. Consider making the following changes: a. Provide a direct link to the EPSDT page on the OCH website. b. Replace the OHCA link with a link to the member-facing EPSDT webpage on OHCA's website (https://oklahoma.gov/ohca/individuals/programs/child-health.html). c. Provide a direct link to the Family-Centered Page on the Bright Futures website (https://www.aap.org/en/practice-management/bright-futures/bright-futures-family-centered-care/).

Contract Area	2025 QAPI Recommendations
1.10.3/1.11.3 Quality Assessment and Performance Improvement (QAPI) Program	
Common Among the SoonerSelect CEs	
1.10.3.1/1.11.3.1 QAPI Program	1. Ensure all performance measures include complete baseline and benchmark information, including associated rates, benchmark sources, historical performance (when available), and timelines for when pending data (e.g., HEDIS, CAHPS, or internal metrics) will be incorporated.
1.10.3.3/1.11.3.3 QAPI Documentation, *letter j*	2. Develop and document standardized, systematic methodologies for provider profiling and performance measure selection, including clear criteria for determining which and how many providers to profile, how measures are chosen, and how these processes align with QAPI program objectives
1.10.3.3/1.11.3.3 QAPI Documentation, *letter l*	3. Provide greater specificity regarding data management and performance monitoring processes, including detailed descriptions of how data are collected, validated, trended, and used to inform QAPI decision making, rather than high level or general descriptions of data aggregation activities.
1.10.3.3/1.11.3.3 QAPI Documentation, *letter m*	4. Expand documentation to clearly describe day to day operationalization of the QAPI program, including CE specific initiatives (e.g., PIPs), cross departmental roles, routine quality monitoring activities, and mechanisms used to ensure QAPI processes are implemented consistently across the organization.
1.10.3 Quality Assessment and Performance Improvement (QAPI) Program	
DentaQuest	
1.10.3.3 QAPI Documentation	1. Clearly identify all LOPO representatives serving on the QIC, including each member's name, position, organizational affiliation, and committee role. Specify which LOPO member(s) serve(s) as the QIC chair or co-chair.
LIBERTY	
1.10.3.1 QAPI Program	1. Describe the mechanisms to assess the quality and appropriateness of care provided to enrollees with special health care needs in the Program Description.
1.10.3.2 Oversight of QAPI Program	2. Discuss the series of actions, activities, or steps taken to select and direct task forces or subcommittees in the Program Description. 3. Clarify and document the stakeholder groups that receive QIC findings and define the processes and communication methods the QIC uses to disseminate this information. 4. Describe the process for reporting findings to the executive management team in the Program Description, including the communication pathways, frequency of reporting, and responsible roles.

Contract Area	2025 QAPI Recommendations
1.10.3 Quality Assessment and Performance Improvement (QAPI) Program	
LIBERTY (Continued)	
1.10.3.3 QAPI Documentation	5. Revise the Program Description to include detailed, Oklahoma Medicaid-specific information regarding LIBERTY's QAPI structure, processes, and operational activities. 6. In the QAPI Program Description, explain the QAPI program's guiding philosophy and strategic direction. 7. Define the communication process between the QIC and the executive management team in the Program Description. 8. Identify the committee representatives of each subcommittee and describe the criteria or rationale used to select them in the Program Description. 9. Define the process for reporting QAPI findings to relevant stakeholders, including participating providers, in the Program Description. Include the communication methods, frequency of reporting, and the personnel responsible for timely dissemination of information. 10. In the Program Description, describe the methodology for determining which and how many participating providers to profile and how profiling measures will be selected. 11. Describe the specific criteria, and activities used to select evaluation and study design procedures in the Program Description. 12. Describe the data-collection and data-use processes in greater detail, such as the specific data sources, methods, and workflows used to gather, validate, and integrate information into QAPI activities in the Program Description. 13. In the Program Description, explain how LIBERTY ensures that QAPI program activities are implemented throughout the organization and how results are documented. 14. Update the Program Description to identify the specific Health Management Information systems in use, describe their key functionalities, and explain how each system supports QAPI activities beyond basic data aggregation. 15. Clearly document the procedures, timelines, and communication channels used to report QAPI findings to all participating providers and enrollees. 16. In the Program Description, describe how LIBERTY will evaluate the effectiveness of the QAPI program and what information (e.g., performance measures, PIPs) will be included in the annual QAPI Program Evaluation. 17. Provide complete performance data for all referenced metrics, including clearly sourced benchmarks. Include CAHPS, HEDIS, and any other standardized measure results to demonstrate how these data informed the annual QAPI Program Evaluation.
Aetna	
1.11.3.1 QAPI Program	1. Provide descriptions of the tools and resources used to assess the quality and appropriateness of care.
1.11.3.3 QAPI Documentation	2. Specify the methodology used for selecting participating provider profiles to ensure transparency and reproducibility of the process.

Contract Area	2025 QAPI Recommendations
1.11.3 Quality Assessment and Performance Improvement (QAPI) Program	
OCH and OCH-CSP	
1.11.3.1 QAPI Program	1. Include specific data indicators and associated performance rates in the Program Description.
1.11.3.3 QAPI Documentation	2. Specify the methodology used for selecting participating provider profiles to ensure transparency and reproducibility of the process.

Appendix D

KanCare Program Annual External Quality Review Technical Report

2025-2026 Reporting Cycle

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Based on documentation provided for review, the completion status of previous recommendations was scored using the following scale:

- Fully Addressed – Documentation clearly indicated all aspects of the recommendation were applied.
- Partially Addressed – Some parts of the recommendation were applied; issues remain.
- Not Addressed – Documentation did not indicate any part of the recommendation was applied.
- In Progress – Review indicated efforts to meet the recommendation are active or the recommendation is on hold.
- No Longer Applicable – Changing circumstances rendered the recommendation not applicable.
- Unable to Address – CE is not able to obtain and provide documentation to address the recommendation.
- Unable to Assess – KFMC is not able to assess the recommendation.

Performance Improvement Project Validation

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the CEs		
1.	Increase the detail provided in the PIP methodologies to decrease the amount of follow-up questions. **KFMC 2025 Update:** KFMC provided review, feedback, and technical assistance throughout the methodology development and approval process. Each PIP underwent multiple cycles of draft submission, review, and feedback meetings before OHCA granted approval for implementation. During these cycles, the CEs incorporated additional detail and clarification into their methodologies.	Fully Addressed
2.	Use the PIP Instructional Guide and lessons learned from PIP feedback meetings while writing PIP methodology proposals and PIP reports going forward, to reduce needed revisions. **KFMC 2025 Update:** KFMC provided review, feedback, and technical assistance throughout the methodology development and approval process. Each PIP underwent multiple cycles of draft submission, review, and feedback meetings before OHCA granted approval for implementation. The CEs applied the PIP Instructional Guide and incorporated lessons learned from previous feedback discussions into subsequent methodology submissions.	Fully Addressed
3.	Consider the potential impact on the PIP outcome when determining PIP and intervention population sizes, and designing interventions. **KFMC 2025 Update:** KFMC provided review, feedback, and technical assistance throughout the methodology development and approval process. Each PIP underwent multiple cycles of draft submission, review, and feedback meetings before OHCA granted approval for implementation. The CEs incorporated these considerations into subsequent methodology submissions.	Fully Addressed

Compliance Review

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Dental CEs		
	Subpart B – State Responsibilities	
§ 438.10(c)(6)(v) Information requirements – Basic rules	**DentaQuest** 1. Revise section "E. Other Distribution Methods," first paragraph, page 5 of policy and procedure *MKT03-INS Member Communications Distribution* to add the timeframe to provide printed copies of member-facing communication within "five (5) business days." (State Contract Section 1.11.3.5 "Distribution Guidelines," letter e) (2024 Recommendation 3) **KFMC 2025 Update:** In the policy and procedure *MKT03-INS Member Communications Distribution*, section "Exhibit E – Oklahoma Medicaid," letter "A. Enrollee materials available in paper form," DentaQuest revised the timeframe to "five (5) business days." However, DentaQuest advised the policy and procedure has been submitted to "approving internal party" and is awaiting review and approval. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, DentaQuest needs to submit the approved policy and procedure.	In Progress
	LIBERTY 1. To the LIBERTY policy and procedure, *Development of Member Facing Materials*, section "Communication/Delivery Method" number 3, letter e, add the timeframe of "five (5) business days." It would read, "e. LIBERTY informs the members that the information is available in paper form at no cost upon request and will be provided within **five (5) business days**." (State Contract Section 1.11.3.5 "Distribution Guidelines," letter e) (2024 Recommendation 3) **KFMC 2025 Update:** To the policy and procedure *Development of Member Facing Materials*, section "Communication/Delivery Method" number 3, letter e, LIBERTY added the timeframe of "five (5) business days." However, LIBERTY advised, the policy and procedure is still in review with OHCA. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress
§ 438.10(f)(1) Information requirements – Information for all enrollees of MCOs, PIHPs, and PAHPs, and PCCM entities: General requirements	**DentaQuest** 2. In the *SoonerSelect Member Handbook*, section "Your Care When You Change Dental Plans or Dentists," change the timeframe of "15 days" to "15 calendar days" and "30 days" to "30 calendar days." It would read, "If your provider leaves DentaQuest, we will tell you in writing within 15 **calendar** days from when we know about this. We will tell you how you can choose a new PCD or choose one for you if you do not make a choice within 30 **calendar** days." (State Contract Section 1.11.14.3 "SoonerSelect Dental Enrollee-initiated PCD Changes") (2024 Recommendation 4) **KFMC 2025 Update:** In the *SoonerSelect Member Handbook,* to the section "Your Care When You Change Dental Plans or Dentists," DentaQuest added "calendar" to the 15-day and 30-day timeframes. The recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Dental CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(f)(1) Information requirements – Information for all enrollees of MCOs, PIHPs, and PAHPs, and PCCM entities: General requirements (Continued)	**LIBERTY** 2. In the *Member Handbook*, sections "How to Choose Your PCD" and "Your Care When You Change Dental Plans or Dentists," revise the timeframe of "15 days" to "15 **calendar** days." It would read, "If your provider leaves LIBERTY, we will tell you within 15 **calendar** days from when we know about this." (State Contract Section 1.11.14.3 "Notification of PCD Termination") (2024 Recommendation 7) **KFMC 2025 Update:** To the *SoonerSelect Member Handbook*, LIBERTY revised the timeframe of "15 days" to "15 **calendar** days." The recommendation is fully addressed.	Fully Addressed
	3. In the *Provider Reference Guide*, section "Voluntary Termination of the Provider Contract," include the timeframe of providing notice by the "later of 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." (State Contract Section 1.11.14.3 "Notification of PCD Termination") (2024 Recommendation 8) **KFMC 2025 Update:** To the *Provider Reference Guide*, section "Voluntary Termination of the Provider Contract," LIBERTY added the recommended language. However, LIBERTY advised, it is still awaiting OHCA approval on the benefits schedule so the PRG can be sent for approval. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved *Provider Reference Guide*.	In Progress
	4. In the LIBERTY policy and procedure *Member Transfer Notification - (Provider Termination)*, section "Process/Procedure," sixth bullet (page 2), change the timeframe of "fifteen (15) days" to "fifteen (15) **calendar** days." It would read, "In case of the immediate termination of a contracting general dentist due to potential of imminent harm to a member, notification of the transfer should be given to members immediately and no later than fifteen (15) **calendar** days upon such termination." (State Contract Section 1.11.14.3 "Notification of PCD Termination") (2024 Recommendation 9) **KFMC 2025 Update:** To the policy and procedure *Member Transfer Notification - (Provider Termination)*, in a new section, LIBERTY added "calendar" to the specified timeframe. However, LIBERTY advised, the policy and procedure is still in review with OHCA. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Dental CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(g)(2)(ii)(A-B) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	**DentaQuest** 3. In the *SoonerSelect Member Handbook*, include information to inform enrollees how they can obtain information from OHCA about how to access services DentaQuest does not cover because of moral or religious objections. (State Contract Section 1.7.8 "Moral Objections") (2024 Recommendation 5) **KFMC 2025 Update:** In the *SoonerSelect Member Handbook,* DentaQuest added the information to sections "Services NOT Covered" and "Disenrollment Options." The recommendation is fully addressed.	Fully Addressed
	LIBERTY 5. When the *Member Handbook* is next revised, include language that LIBERTY does not deny medically necessary services for moral or religious objections. (State Contract Section 1.7.8 "Moral Objections") (2024 Recommendation 10) **KFMC 2025 Update:** To the *SoonerSelect Member Handbook*, LIBERTY added the recommended language. The recommendation is fully addressed.	Fully Addressed
§ 438.10(g)(2)(ix) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	**DentaQuest** 4. In the *SoonerSelect Member Handbook*, section "Member Rights and Responsibilities," sub-section "Your Responsibilities" (pages 26-27), add "OHCA/" to the member responsibility that states, "Checking DentaQuest information; correcting inaccuracies; and allowing government agencies, employers, and providers to release records to OHCA or DentaQuest." It would read, "Checking **OHCA/**DentaQuest information; correcting inaccuracies; and allowing government agencies, employers, and providers to release records to OHCA or DentaQuest." (State Contract Section 1.11.5.4 "SoonerSelect Dental Enrollee Handbook Content," second paragraph, letter a) (2024 Recommendation 6) **KFMC 2025 Update:** In the *SoonerSelect Member Handbook,* to the section "Member Rights and Responsibilities," sub-section "Your Responsibilities," DentaQuest added "OHCA" to the statement. The recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Dental CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(g)(2)(ix) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook (Continued)	**DentaQuest (Continued)** 5. In the *SoonerSelect Member Handbook*, section "Member Rights and Responsibilities," sub-section "Your Responsibilities" (pages 26-27), Change the verbiage "Work on" to "Respond to" and add "OHS" [Oklahoma Human Services] to the member responsibility that states, "Work on requests for assistance from the Office of Child Support Services," It would read, "Respond to requests for assistance from the OHS Office of Child Support Services. (State Contract Section 1.11.5.4 "SoonerSelect Dental Enrollee Handbook Content," second paragraph, letter d) (2024 Recommendation 7) **KFMC 2025 Update:** In the *SoonerSelect Member Handbook,* to the section "Member Rights and Responsibilities," sub-section "Your Responsibilities," DentaQuest revised the language to change the verbiage "Work on" to "Respond to" and added "OHS" to the member responsibility. The recommendation is fully addressed.	Fully Addressed
	6. In the DentaQuest policy and procedure *MKT01-INS Marketing Safeguards*, section "Enrollee's rights and responsibilities," add the enrollee's responsibilities and ensure they are consistent with the *SoonerSelect Member Handbook*, *ORM* [*Office Reference Manual*], and any additional applicable documents. (2024 Recommendation 8) **KFMC 2025 Update:** DentaQuest advised the recommended changes were made to the *Member Handbook*, *ORM*, and policy and procedure *MKT01-INS Marketing Safeguards*. DentaQuest submitted the handbook to OHCA, and it was approved on May 13, 2025. Policy revisions were submitted to "approving internal party" and are awaiting review and approval. The *ORM* was submitted to OHCA on June 10, 2025, is under OHCA review, and has not yet been approved. Currently, KFMC is not able to review the documents for consistency. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, DentaQuest needs to submit the approved policy and procedure and *ORM*.	In Progress
	7. Review and revise the member rights listed in the *SoonerSelect Member Handbook*, policy and procedure *MKT01-INS Marketing Safeguards*, and *ORM* (and any additional applicable documents) to be consistent. (Also applies to § 438.100[a]) (2024 Recommendation 9) **KFMC 2025 Update:** DentaQuest advised the recommended changes were made to the *Member Handbook*, *ORM*, and policy and procedure *MKT01-INS Marketing Safeguards*. DentaQuest submitted the handbook to OHCA, and it was approved on May 13, 2025. Policy revisions were submitted to "approving internal party" and are awaiting review and approval. The *ORM* was submitted to OHCA on June 10, 2025, is under OHCA review, and has not yet been approved. Currently, KFMC is not able to review the documents for consistency. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, DentaQuest needs to submit the approved policy and procedure and *ORM*.	In Progress

Regulatory Area	*Follow-Up to Previous Recommendations (2024)*	*2025 Completion Status*
*Common Among the SoonerSelect **Dental** CEs (Continued)*		
Subpart B – State Responsibilities (Continued)		
§ 438.10(g)(2)(ix) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook (Continued)	**DentaQuest (Continued)** 8. Review and revise the member responsibilities listed in the *SoonerSelect Member Handbook* and *ORM* (and any additional applicable documents) to be consistent. (2024 Recommendation 10) **KFMC 2025 Update:** DentaQuest advised the recommended changes were made to the *Member Handbook* and *ORM*. DentaQuest submitted the handbook to OHCA, and it was approved on May 13, 2025. The *ORM* was submitted to OHCA on June 10, 2025, is under OHCA review, and has not yet been approved. Currently, KFMC is not able to review the documents for consistency. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, DentaQuest needs to submit the approved *ORM*.	In Progress
	LIBERTY 6. To the *Member Handbook*, section "Member Rights and Responsibilities," add the language "State laws and regulations." It would read, "Have access to, and where legally appropriately, receive copies of, amend, or correct your dental records as specified by federal **and State** laws **and regulations**." (State Contract Section 1.11.5.4 "SoonerSelect Dental Enrollee Handbook Content," letter q, roman numeral vi) (2024 Recommendation 11) **KFMC 2025 Update:** To the *SoonerSelect Member Handbook*, LIBERTY added the recommended language. The recommendation is fully addressed.	Fully Addressed
	7. Review and revise the "Member Rights and Responsibilities" listed in the *Member Handbook*, policy and procedure *Member Rights and Responsibilities*, and *Provider Reference Guide* (and any additional applicable documents) to be consistent. (Also applies to § 438.100[a]) (2024 Recommendation 12) **KFMC 2025 Update:** LIBERTY advised the changes were made to the *Member Handbook*, *Provider Reference Guide*, and policy and procedure. However, the policy and procedure is still in review with OHCA. Therefore, this recommendation is still in progress. For this recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure for KFMC to compare the documents for consistency.	In Progress

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Dental CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.100 Enrollee rights	**DentaQuest** 9. For consistency among DentaQuest documents, in the *ORM*, section "3.01 Plan Eligibility," (or most appropriate section) include federal regulatory and State Contract language that the member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, PCCM or PCCM entity and its network providers or the State agency treat the enrollee. (State Contract Section 1.11.9 "SoonerSelect Dental Enrollee Rights," § 438.100[c]) (2024 Recommendation 13) **KFMC 2025 Update:** DentaQuest advised that the recommended changes were made to the *ORM*. The *ORM* was submitted to OHCA on June 10, 2025, is currently under OHCA review, and has not yet been approved. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, DentaQuest needs to submit the approved *ORM*.	In Progress
	LIBERTY 8. In the *Provider Reference Guide*, section "Member Rights and Responsibilities," sub-section "As a SoonerCare Member, Everyone is Entitled to the Following Rights," include the following member rights: a. Right to "be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion." b. Right to "request and receive a copy of his or her medical records, and request that they be amended or corrected." (§ 438.100[b][2][v-vi] and [b][3]) (2024 Recommendation 14) **KFMC 2025 Update:** To the *Provider Reference Guide*, section "Member Rights and Responsibilities," sub-section "As a SoonerCare Member, Everyone is Entitled to the Following Rights," LIBERTY added the recommended language. Letter a is the sixth bullet and letter b is the nineteenth bullet (page 36).	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Dental CEs (Continued)		
Subpart D – MCO, PIHP, and PAHP Standards		
§ 438.210(c) Coverage and authorization of services – Notice of adverse benefit determination and related provisions § 438.404(b) and (c)(1-4) Timely and adequate notice of adverse benefit determination	**DentaQuest** 10. In the *SoonerSelect Member Handbook*, section "Prior Authorization and Timeframes," first bullet (page 20), change the reference of "10 days before" to "10 calendar days before." It would read, "In most cases, if you are receiving a service and a new request is made to keep receiving a service, we must tell you at least 10 **calendar** days before we change the service if we decide to reduce, stop or restrict the service." (§ 438.404[b][1-6]) (2024 Recommendation 14) **KFMC 2025 Update:** In the *SoonerSelect Member Handbook,* DentaQuest added "calendar" to the 10-day timeframe. The recommendation is fully addressed.	Fully Addressed
	11. In DentaQuest policy and procedure *UM08-INS Authorization Review*, in the identified sections below, change the reference of "ten (10) days before" to include "calendar." a. Page 7, section "C. Reduction, Suspension, or Termination of Previously Approved Services," number 3 would read, "3. If previously authorized services are retrospectively reduced, suspended, or terminated, DentaQuest will provide notice at least 10 **calendar** days prior to the effective date of the adverse benefit determination." b. Page 15, section "Exhibit AE – Medicaid," first bullet would read, "For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) **calendar** days before the adverse benefit determination is to take effect." (State Contract Section 1.16.6.4 "Termination, Suspension, or Reduction of Previously Authorized Covered Services"; § 438.404[b] and [c][1-3]) (2024 Recommendation 15) **KFMC 2025 Update:** In the policy and procedure, DentaQuest added the word "calendar" to the 10-day timeframe. The recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Dental CEs (Continued)		
Subpart D – MCO, PIHP, and PAHP Standards (Continued)		
§ 438.210(c) Coverage and authorization of services – Notice of adverse benefit determination and related provisions § 438.404(b) and (c)(1-4) Timely and adequate notice of adverse benefit determination (Continued)	**LIBERTY** 9. In the LIBERTY policy and procedure *Appendix A to Coverage and Authorization of Services,* in the section "Timeframes," change the reference of "at least ten days before" to "at least 10 calendar days before." It would read, "LIBERTY shall send the written notice at least ten **calendar** days before the date of action, in accordance with 42 C.F.R. §§ 431.211 and 438.404(c)(1). LIBERTY shall also send the written notice of an Adverse Benefit Determination at least ten **calendar** days before the date of action when the Members (includes enrollee and subscriber) location and address is unknown based on returned mail with no forwarding address, in accordance with OAC 317:35-5-67." (State Contract Section 1.16.6.4 "Termination, Suspension, or Reduction of Previously Authorized Covered Services"; § 438.404[c][1]) (2024 Recommendation 15) **KFMC 2025 Update:** To the policy and procedure *Appendix A to Coverage and Authorization of Services,* section "Timeframes," LIBERTY added "calendar" to the specified timeframe. However, LIBERTY advised, it is still awaiting OHCA approval. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress
	10. In the LIBERTY policy and procedure *Appendix A to Coverage and Authorization of Services,* in the section "Exceptions" (page 1), add to the bulleted list the federal regulatory requirements § 431.213(d and f): "d. The beneficiary's whereabouts are unknown, and the post office returns mail directed to him indicating no forwarding address." "f. A change in the level of medical care is prescribed by the beneficiary's physician." (§ 438.404[c][1]) (2024 Recommendation 16) **KFMC 2025 Update:** To the policy and procedure *Appendix A to Coverage and Authorization of Services,* section "Timeframes," LIBERTY added the federal regulatory requirements. However, LIBERTY advised, it is still awaiting OHCA approval. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Dental CEs (Continued)		
	Subpart D – MCO, PIHP, and PAHP Standards (Continued)	
§ 438.210(c) Coverage and authorization of services – Notice of adverse benefit determination and related provisions § 438.404(b) and (c)(1-4) Timely and adequate notice of adverse benefit determination (Continued)	**LIBERTY (Continued)** 11. In the LIBERTY policy and procedure *Coverage and Authorization of Services,* section "Process/Procedure," sub-section "B. Authorization of Services," number 2 (page 4), add the timeframe of "at least 10 calendar days before the date of action." (State Contract Section 1.16.6.4 "Termination, Suspension, or Reduction of Previously Authorized Covered Services") (2024 Recommendation 17) **KFMC 2025 Update:** To the policy and procedure *Coverage and Authorization of Services,* section "Process/Procedure," sub-section "B. Authorization of Services," number 2 (page 4), LIBERTY added the timeframe of "at least 10 calendar days before the date of action." However, LIBERTY advised, it is still awaiting OHCA approval. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress
	12. In the *Member Handbook,* section "Prior Authorization and Timeframes," second paragraph, first solid bullet (page 29), change the reference of "10 days before" to "10 calendar days before." It would read, "In most cases, if you are receiving a service and a new request is made to keep receiving a service, we must tell you at least 10 **calendar** days before we change the service if we decide to reduce, stop, or restrict the service." (State Contract Section 1.16.6.4 "Termination, Suspension, or Reduction of Previously Authorized Covered Services"; § 438.404[c][1]) (2024 Recommendation 18) **KFMC 2025 Update:** To the *SoonerSelect Member Handbook*, LIBERTY added "calendar" to the specified timeframe. The recommendation is fully addressed.	Fully Addressed
	13. Add to LIBERTY policy and procedure *Coverage and Authorization of Services*, section "Process/Procedure," letter "B. Authorization of Services," the language, "If the MCO, PIHP, or PAHP meets the criteria for extending the timeframe for standard service authorization decisions consistent with § 438.210(d)(1)(ii), it must— (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires." (State Contract Section 1.16.6.6 "Prior Authorization Denial or Limitation"; § 438.404[c][1]) (2024 Recommendation 19) **KFMC 2025 Update:** To the policy and procedure *Coverage and Authorization of Services*, section "Process/Procedure," letter "B. Authorization of Services," LIBERTY added the recommended language. However, LIBERTY advised, it is still awaiting OHCA approval. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Dental CEs (Continued)		
Subpart D – MCO, PIHP, and PAHP Standards (Continued)		
§ 438.210(d)(1)(i-ii) Coverage and authorization of services – Timeframe for decisions: Standard authorization decisions	**DentaQuest** 12. In DentaQuest policy and procedure *UM08-INS Authorization Review*, section "Procedure," sub-section "A. Prior Authorization Review," number 4.c, add the federal regulatory language "(to the State agency upon request)." (2024 Recommendation 16) **KFMC 2025 Update:** In the policy and procedure, section "Exhibit Y – Oklahoma Sooner Select Medicaid," DentaQuest added the language, "DentaQuest will also provide justification to the State agency upon request." The recommendation is fully addressed.	Fully Addressed
	13. In the *SoonerSelect Member Handbook*, section "Prior Authorization and Timeframes," add the federal regulatory language that details the timeframe for the decisions may be extended if "the enrollee or the provider requests the extension; or the CE justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." (2024 Recommendation 17) **KFMC 2025 Update:** In the *SoonerSelect Member Handbook,* section "Prior Authorization and Timeframes," DentaQuest added language that states, "The timeframe for the decision may be extended if you or your provider request an extension, or DentaQuest proves the need for more information and that extension is in your best interest." The recommendation is fully addressed.	Fully Addressed
	LIBERTY 14. To the LIBERTY policy and procedure *Coverage and Authorization of Services*, section "Process/Procedure," letter "B. Authorization of Services," number 2, add the federal regulatory and State Contract language that for standard authorization decisions, notice will be provided as expeditiously as the enrollee's health condition requires and is not to exceed fourteen (14) calendar days following receipt of the request for service. Also, that the Contractor may extend the fourteen (14) calendar day prior authorization notice timeframe up to an additional fourteen (14) calendar days when requested by the SoonerSelect Dental Enrollee or Provider as Authorized Representative or if the CE justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. (Also applies to 438.404[c][3]; State Contract Section 1.16.6.6 "Prior Authorization Denial or Limitation") (2024 Recommendation 20) **KFMC 2025 Update:** To the policy and procedure *Coverage and Authorization of Services*, section "Process/Procedure," letter "B. Authorization of Services," number 2, LIBERTY added the recommended language. However, LIBERTY advised, it is still awaiting OHCA approval. Therefore, the recommendation is in progress. To be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Dental CEs (Continued)		
Subpart D – MCO, PIHP, and PAHP Standards (Continued)		
§ 438.210(d)(1)(i-ii) Coverage and authorization of services – Timeframe for decisions: Standard authorization decisions (Continued)	**LIBERTY (Continued)** 15. In the *Member Handbook*, section "Prior Authorization and Timeframes," add the federal regulatory language that details the timeframe for the decisions may be extended if "the enrollee or the provider requests the extension; or the CE justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." (2024 Recommendation 21) **KFMC 2025 Update:** To the *Member Handbook*, section "Prior Authorization and Timeframes," LIBERTY added the recommended language.	Fully Addressed
DentaQuest		
Subpart B – State Responsibilities		
§ 438.56(d)(2)(i) Disenrollment: Requirements and limitations – Procedures for disenrollment-Cause for disenrollment	14. To the *SoonerSelect Member Handbook*, section "Disenrollment Options," sub-section "If You Want to Leave the Plan," (page 27), add "SoonerSelect Dental Enrollee moves out of the Contractor's service area" as a good reason (good cause) for disenrollment. (State Contract Section 1.6.7.2 "SoonerSelect Dental Enrollee Request," letter a) (2024 Recommendation 1) **KFMC 2025 Update:** DentaQuest added the language to the *SoonerSelect Member Handbook,* section "Disenrollment Options," sub-section "If You Want to Leave the Plan." The recommendation is fully addressed.	Fully Addressed
§ 438.10(c)(4) Information requirements – Basic rules	15. To the *SoonerSelect Member Handbook*, section "Key Words Used In This Handbook," add the State Contract identified term "copayment" and the definition. (State Contract Section 1.11.3.10 "Defined Terms," letter b) (2024 Recommendation 2) **KFMC 2025 Update:** In the *SoonerSelect Member Handbook,* section "Key words Used In This Handbook," DentaQuest added the term "copayment" and included the definition. The recommendation is fully addressed.	Fully Addressed
§ 438.10(g)(2)(xi)(A) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	16. In the *SoonerSelect Member Handbook*, section "Member Rights and Responsibilities," add to the list of member rights "The right to file a grievance, appeal, and state fair hearing." (2024 Recommendation 11) **KFMC 2025 Update:** In the *SoonerSelect Member Handbook,* section "Member Rights and Responsibilities," DentaQuest added the member right, "The right to file a grievance, appeal and State Fair Hearing." The recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
DentaQuest (Continued)		
	Subpart B – State Responsibilities (Continued)	
§ 438.10(g)(4) Information Requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	17. Revise the DentaQuest policy and procedure *MKT03-INS Member Communications Distribution*, section "C. Communication of Benefit Changes to Members" to include the federal and State Contract requirement of "at least 30 days before the intended effective date of the change." (State Contract Section 1.11.5.1 "Distribution Timeframe") (2024 Recommendation 12) **KFMC 2025 Update:** In the policy and procedure, section "Exhibit E – Oklahoma Medicaid," letter "B. Age Transition Outreach," DentaQuest added the recommended language. However, DentaQuest advised the policy has been submitted to "approving internal party" and is awaiting review and approval. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, DentaQuest needs to submit the approved policy and procedure.	In Progress
LIBERTY		
	Subpart B – State Responsibilities	
§ 438.56(b)(3) Disenrollment: Requirements and limitations – Disenrollment requested by the MCO, PIHP, PAHP, PCCM, or PCCM entity	16. To the LIBERTY policy and procedure *ENROLLMENT AND DISENROLLMENT PROCESS - OKLAHOMA*, section "Process/Procedure," sub-section "IV. Disenrollment," number 2, add the State good cause action for the CE to request disenrollment that states, "SoonerSelect Dental Enrollee has been enrolled in error, as determined by OHCA." (State Contract Section 1.6.7.1 "Contractor Request," letter a) (2024 Recommendation 1) **KFMC 2025 Update:** To the policy and procedure *ENROLLMENT AND DISENROLLMENT PROCESS - OKLAHOMA*, section "Process/Procedure," sub-section "IV. Disenrollment," number 2, LIBERTY added the recommended language. However, LIBERTY advised, the policy and procedure is still in review with OHCA. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress
§ 438.56(c)(1-2) Disenrollment – Requirements and limitations: Disenrollment requested by the enrollee	17. To the LIBERTY policy and procedure *DISENROLLMENT PROCESS – MEDICAID*, section "PROCESS/PROCEDURE," number 2, letter a, roman numeral ii, add the federal regulatory and State Contract language "or during the ninety (90) Days following the date OHCA sends the SoonerSelect Dental Enrollees notice of that Enrollment, whichever is later" and the State Contract language, "upon automatic reenrollment" to numbers 1 and 2. They would read as follows: a. Number 1: "Within 90 days after initial enrollment, **<u>or during the ninety (90) days following the date OHCA sends the SoonerSelect Dental Enrollees notice of that Enrollment, whichever is later</u>**." b. Number 2: "At least once every 12 months, **<u>during the Open Enrollment Period</u>**." (State Contract Section 1.6.4 "Enrollment Lock-In Period") (2024 Recommendation 2) **KFMC 2025 Update:** To the policy and procedure *DISENROLLMENT PROCESS – MEDICAID*, section "PROCESS/PROCEDURE," number 2, letter a, roman numeral ii, LIBERTY added the recommended language. However, LIBERTY advised, the policy and procedure is still in review with OHCA. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
LIBERTY (Continued)		
	Subpart B – State Responsibilities (Continued)	
§ 438.10(d)(4) Information requirements – Language and format	18. In the *Member Handbook*, revise the following: a. In the second paragraph on page 2, add language stating interpreter services are available free of charge/at no cost. b. In the section "Help from Member Services," third and fourth solid bullets on page 14, add language stating the services are available free of charge/at no cost. (State Contract Section 1.11.1.2 "Interpretation Services") (2024 Recommendation 4) **KFMC 2025 Update:** To the *SoonerSelect Member Handbook*, LIBERTY made the recommended revisions. The recommendation is fully addressed.	Fully Addressed
§ 438.10(d)(4) Information requirements – Language and format	19. To the LIBERTY policy and procedure *Member Rights and Responsibilities*, section "Process/Procedure," sub-section "Member Rights," in the twelfth bullet (page 2), add language stating that written member informing materials in alternative formats (including Braille, large size print, and audio format) are available free of charge/at no cost. (State Contract Section 1.11.1.2 "Interpretation Services") (2024 Recommendation 5) **KFMC 2025 Update:** To the policy and procedure *Member Rights and Responsibilities*, section "Process/Procedure," sub-section "Member Rights," twelfth bullet, LIBERTY added the language "no-cost." However, LIBERTY advised, the policy and procedure is still in review with OHCA. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress
	20. To the LIBERTY policy and procedure *Single Level Member Appeals Process – Oklahoma Medicaid*, section "Policy," roman numeral III (page 3), add language stating the services are available free of charge/at no cost. (State Contract Section 1.11.1.2 "Interpretation Services") (2024 Recommendation 6) **KFMC 2025 Update:** To the policy and procedure *Single Level Member Appeals Process – Oklahoma Medicaid*, section "Policy," roman numeral III, LIBERTY added the language stating, "All services are available free of charge/at no cost to members." However, LIBERTY advised, the policy and procedure is still in review with OHCA. Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress

Regulatory Area	***Follow-Up to Previous Recommendations (2024)***	***2025 Completion Status***
LIBERTY (Continued)		
	Subpart B – State Responsibilities (Continued)	
§ 438.10(h)(3)(i)(B) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Provider Directory	21. Include in LIBERTY policy and procedure that LIBERTY updates paper provider directories quarterly. (2024 Recommendation 13) **KFMC 2025 Update:** To the policy and procedure *Maintaining Provider Directories*, sub-section "Updating Provider Directories," number 5 (page 3), language was added that LIBERTY updates paper provider directories quarterly.	Fully Addressed
	Subpart D – MCO, PIHP, and PAHP Standards	
§ 438.210(d)(2)(i-ii) Coverage and authorization of services – Timeframe for decisions: Expedited authorization decisions	22. In the LIBERTY policy and procedure *Emergency Dental Services/Expedited Dental Services*, in the section "Time Frames For Expedited Initial Determinations," second paragraph, add the language that states, the CE "justifies (to the State agency upon request) a need for additional information." It would read, "LIBERTY may extend the 72-hour time frame by up to 14 calendar days if the member requests an extension or if LIBERTY Dental **justifies (to the State agency upon request)** the need for additional information and an extension is verified to be in the member's best interest." (2024 Recommendation 22) **KFMC 2025 Update:** To the policy and procedure *Emergency Dental Services/Expedited Dental Services*, LIBERTY added the recommended language. However, LIBERTY advised, it is still awaiting OHCA approval. Therefore, the recommendation is in progress. To be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress
	23. In the LIBERTY policy and procedure *Emergency Dental Services/Expedited Dental Services*, in the section "Process/Procedure," sub-section "Time Frames for Expedited Initial Determinations," second paragraph, last sentence, add language that details the "Provider as Authorized Representative requests an extension." It would read, "LIBERTY may extend the 72-hour time frame by up to 14 calendar days if the member **or provider as Authorized Representative** requests an extension or if the need for additional information and an extension is verified to be in the member's best interest." (Also applies to § 438.210[c] and related provision § 438.404[c][6]) (2024 Recommendation 23) **KFMC 2025 Update:** To the policy and procedure *Emergency Dental Services/Expedited Dental Services*, section "Process/Procedure," sub-section "Time Frames for Expedited Initial Determinations," LIBERTY added the recommended language. However, LIBERTY advised, the policy and procedure is "still in review with OHCA." Therefore, the recommendation is in progress. For the recommendation to be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
LIBERTY (Continued)		
	Subpart D – MCO, PIHP, and PAHP Standards (Continued)	
§ 438.210(d)(2)(i-ii) Coverage and authorization of services – Timeframe for decisions: Expedited authorization decisions (Continued)	24. In the LIBERTY policy and procedure *Prospective, Retrospective, and Concurrent Review Process*, section "IV. Urgent Review," change the time period from "(14) business days" to "(14) **calendar** days." (2024 Recommendation 24) **KFMC 2025 Update:** To the policy and procedure *Prospective, Retrospective and Concurrent Review Process*, in a newly added section "V. Non-Urgent Review," LIBERTY added "calendar" to the specified timeframe. However, LIBERTY advised, it is still awaiting OHCA approval. Therefore, the recommendation is in progress. To be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress
	25. In the LIBERTY policy and procedure *Prospective, Retrospective, and Concurrent Review Process*, section "IV. Urgent Review," add the federal regulatory and State Contract language that details the time period may be extended by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. (2024 Recommendation 25) **KFMC 2025 Update:** To the policy and procedure *Prospective, Retrospective and Concurrent Review Process*, section "IV. Urgent Review," LIBERTY added the recommended language. However, LIBERTY advised, it is still awaiting OHCA approval. Therefore, the recommendation is in progress. To be fully addressed, LIBERTY needs to submit the approved policy and procedure.	In Progress

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs		
	Subpart B – State Responsibilities	
§ 438.10(c)(6)(v) Information requirements – Basic rules	**Aetna** 1. To the *Member Welcome Notice*, in the blue box, add the federal regulatory and State Contract required timeframe of "five (5) Business Days." It would read, "Want a printed copy? Just call Member Services at 1-844-365-4385 (TTY:711). We'll mail a member handbook or provider directory to you at no cost **within 5 business days**." (State Contract Section 1.12.3.5 "Distribution Guidelines," letter e) (2024 Recommendation 2) **KFMC 2025 Update:** Aetna submitted the revised *Member Welcome Email* with the addition of the federal regulatory and State Contract language. This recommendation is fully addressed.	Fully Addressed
	2. To the most appropriate section(s) of Aetna's policy and procedure *4500.15 New, Existing and Reinstated Member Information*, add clarification that if the original enrollee material is provided electronically, a paper version can be requested and will be provided within 5 business days at no cost. (State Contract Section 1.12.3.5 "Distribution Guidelines") (2024 Recommendation 3) **KFMC 2025 Update:** The policy and procedure *4500.15 New, Existing and Reinstated Member Information* was not resubmitted in the 2025 review. Aetna submitted a new policy and procedure *4600.13 New, Existing and Reinstated Member Information* that includes the clarification that "If the original member material is provided electronically, a paper version can be requested and will be provided within five (5) business days at no cost to the member." This recommendation is fully addressed.	Fully Addressed
	Humana 1. On the Humana website page "Member Handbook," revise the language to include that there is no cost and the requested paper documents will be mailed within five (5) business days from the date of the request. (State Contract Section 1.12.3.5 "Distribution Guidelines," letter e) (2024 Recommendation 8) **KFMC 2025 Update:** Humana revised the website page "Member Handbook," section "Your Member Handbook," to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs		
	Subpart B – State Responsibilities (Continued)	
§ 438.10(c)(6)(v) Information requirements – Basic rules (Continued)	**Humana (Continued)** 2. To the Humana policy and procedure *OK.MHB.001 - Medicaid Enrollee Handbook New State Implementation: Development and Distribution of Enrollee Handbook*, section "Procedures," sub-section "Distribution," number 2 (page 4), add the required timeframe of "five (5) Business Days," and add information that the requested paper forms are available at no cost. (State Contract Section 1.12.3.5 "Distribution Guidelines," letter e) (2024 Recommendation 9) **KFMC 2025 Update:** Humana revised the procedure *OK.MHB.001-Medicaid Enrollee Handbook New State Implementation: Development and Distribution of Enrollee Handbook*, section "Procedures," subsection "Distribution," number 2 (page 4), to include the required timeframe the recommended information. This recommendation is fully addressed.	Fully Addressed
	OCH 1. On the OCH webpage "Member Handbook and Forms," revise the language to include there is no cost and change the "7 business days" to "five (5) business days." It would read: "Any documents and items offered in electronic format can be requested in paper format. To request a document in paper format **at no cost**, please contact Member Services at 1-833-752-1664 (TTY: 771). Once you have completed your request, the paper format item(s) will be mailed within **five (5) business days** from the date of the request." (State Contract Section 1.12.3.5 "Distribution Guidelines," letter e) (2024 Recommendation 1) **KFMC 2025 Update:** KFMC reviewed the OCH webpage Member Handbook and Forms and it was revised to state, "To request a document in paper format **at no cost**, please contact Member Services at 1-822-752-1664 (TTY: 771). Once you have completed your request, the paper format item(s) will be mailed within **five (5) business days** from the date of the request." The recommendation is fully addressed.	Fully Addressed
	2. To the OCH policy and procedure *Member Handbook*, section "Procedure," sub-section "Distribution," number 4 (page 4), add the timeframe of "five (5) Business Days" and that the requested paper forms are available at no cost. It would read, "Members may request a printed copy of the Member Handbook **at no cost** by calling Member Services. Re quests for a print copy will be fulfilled within **five (5) business days**." (State Contract Section 1.12.3.5 "Distribution Guidelines," letter e) (2024 Recommendation 2) **KFMC 2025 Update:** OCH stated, "*Member Handbook* is in the process of being updated to include these changes. It will go live with the new plan year starting 7/1/2025." However, the recommendation that was made was related to the policy and procedure *OK.MRKT.06 Member Handbook*. OCH did not submit the policy and procedure in the follow-up to prior recommendations. Therefore, the recommendation is not addressed. For the recommendation to be fully addressed, OCH needs to submit the revised and approved policy and procedure.	Not Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs		
	Subpart B – State Responsibilities (Continued)	
§ 438.10(d)(3-5) Information requirements – Language and format	**Aetna** 3. To the following *SoonerSelect Member Handbook* sections, add information that interpreter services are available free of charge/at no cost: a. Second paragraph (page ii) b. Section "Help from Member Services," last paragraph (page 2) c. Section "Part III: Plan Procedures," sub-section "If You Have Problems with Your Health Plan," second paragraph (page 50). (State Contract Sections 1.12.1.2 "Interpretation Services" and 1.12.1.3 "Enrollee Notification of Interpretation Services and Alternative Formats," letter c) (2024 Recommendation 4) **KFMC 2025 Update:** Aetna submitted the OHCA approved *SoonerSelect Member Handbook* that was revised to include that interpreter services are available free of charge/at no cost. This recommendation is fully addressed.	Fully Addressed
	4. To the Aetna policy and procedure *4500.15 New, Existing and Reinstated Member Information*, section "Member Handbook," page 6, tenth bullet and page 8, third bullet, add information that the services are available free of charge/at no cost. (State Contract Sections 1.12.1.2 "Interpretation Services" and 1.12.1.3 "Enrollee Notification of Interpretation Services and Alternative Formats," letter c) (2024 Recommendation 5) **KFMC 2025 Update:** The policy and procedure *4500.15 New, Existing and Reinstated Member Information* was not resubmitted in the 2025 review. Aetna submitted a new policy and procedure *4600.13 New, Existing and Reinstated Member Information* that includes information that the services are available at no cost to the member. This recommendation is fully addressed.	Fully Addressed
	Humana 3. To the Humana policy and procedure *OK.GAA.002 - Oklahoma Medicaid Grievance and Appeal Policy*, where most appropriate, add language that details the services are available free of charge/at no cost. (2024 Recommendation 10) **KFMC 2025 Update:** Humana revised the procedure *OK.GAA.002-Oklahoma Medicaid Grievance and Appeal Policy*, section "Procedures," subsection "Enrollee Grievances and Appeals Receipts and System," last paragraph (page 2) to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs		
Subpart B – State Responsibilities (Continued)		
§ 438.10(d)(3-5) Information requirements – Language and format (Continued)	**Humana (Continued)** 4. To the following *Member Handbook* sections, add information that interpreter services are available free of charge/at no cost: a. Section "Help from Member Services," last paragraph (page 16) b. Section "Other Ways We Can Help," sub-section "For people with disabilities," (page 17) c. Section "If You Have Problems with Your Health Plan," third paragraph (page 66) (2024 Recommendation 11) **KFMC 2025 Update:** Humana revised the *Member Handbook*, in the identified sections, to include information that interpreter services are available free of charge/at no cost. This recommendation is fully addressed.	Fully Addressed
	OCH 3. To the following *Member Handbook* sections, add language that the services are available free of charge/at no cost: a. Second paragraph, second page. b. Section "Help from Member Services," last paragraph. c. Section "Other Ways We Can Help," first paragraph. d. Section "If You Have Problems with Your Health Plan," second paragraph. (State Contract Sections 1.12.1.2 "Interpretation Services" and 1.12.1.3 "Enrollee Notification of Interpretation Services and Alternative Formats," letter c) (2024 Recommendation 3) **KFMC 2025 Update:** In the *Member Handbook* (dated May 2025), the recommended language was added for letters a, b, and d. However, for letter c, the recommended language was not added to the section "Other Ways We Can Help," first bullet [medical]/paragraph [CSP] (letter c). The recommendation is partially addressed. For the recommendation to be fully addressed, language needs to be added for letter c.	Partially Addressed
§ 438.10(g)(2)(ix) Information requirements: Information for enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Enrollee handbook	**Aetna** 5. In the *SoonerSelect Member Handbook*, add "OHCA and" to the member responsibility that states, "Check Aetna Better Health information, correct inaccuracies and allow government agencies, employers and providers to release records to OHCA or Aetna Better Health." It would read, "Check **OHCA and** Aetna Better Health information, correct inaccuracies and allow government agencies, employers and providers to release records to OHCA or Aetna Better Health." (State Contract Section 1.12.5.4 "Enrollee Handbook Content," second paragraph, letter a) (2024 Recommendation 7) **KFMC 2025 Update:** Aetna submitted the OHCA approved *SoonerSelect Member Handbook,* that was revised to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	*Follow-Up to Previous Recommendations (2024)*	*2025 Completion Status*
Common Among the SoonerSelect Medical CEs		
	Subpart B – State Responsibilities (Continued)	
§ 438.10(g)(2)(ix) Information requirements: Information for enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Enrollee handbook (Continued)	**Aetna (Continued)** 6. In the *SoonerSelect Member Handbook*, add "OHS" and change "Work on" to "Respond to" in the member responsibility that states, "Work on requests for assistance from the Office of Child Support Services." It would read, "**Respond to** requests from the **Oklahoma Department of Human Services (OHS)** Office of Child Support Services." (State Contract Section 1.12.5.4 "Enrollee Handbook Content," second paragraph, letter d) (2024 Recommendation 8) **KFMC 2025 Update:** ABH submitted the OHCA approved *SoonerSelect Member Handbook,* that was revised to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	7. To the *SoonerSelect Member Handbook*, in the list of member rights, add the member right to file a grievance and appeal. (2024 Recommendation 9) **KFMC 2025 Update:** Aetna submitted the OHCA approved *SoonerSelect Member Handbook,* that was revised to include "File a grievance and appeal" in the list of member rights. This recommendation is fully addressed.	Fully Addressed
	8. Review and revise the "Member Rights and Responsibilities" listed in policies and procedures *4500.35 Member Rights & Responsibilities* and *4500.15 New, Existing and Reinstated Member Information,* the *SoonerSelect Member Handbook*, and the *Provider Manual* to be consistent. (Also applies to § 438.100[a]) (2024 Recommendation 10) **KFMC 2025 Update:** Aetna submitted the policy and procedure *4500.35 Member Rights & Responsibilities,* the *SoonerSelect Member Handbook*, and the *Provider Manual*. The policy and procedure *4500.15 New, Existing and Reinstated Member Information* was not resubmitted in the 2025 review. Aetna submitted a new policy and procedure *4600.13 New, Existing and Reinstated Member Information.* These were all revised for consistency of the Member Rights and Responsibilities, as detailed in the regulatory requirements and State Contract. The policy continues to include more member rights and responsibilities than what are listed in the *Member Handbook* and *Provider Manual*. This recommendation is fully addressed since the documents include the federal and State required member rights and responsibilities.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(g)(2)(ix) Information requirements: Information for enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Enrollee handbook (Continued)	**Humana** 5. In the Humana policy and procedure *OK.MHB.001 Medicaid Enrollee Handbook New State Implementation: Development and Distribution of Enrollee Handbook*, section "Procedures" complete the following: a. Either list the specific enrollee rights and responsibilities or add a footnote to identify the "References" section (page 7) that lists the specific enrollee rights and responsibilities. b. Ensure the enrollee rights and responsibilities are consistent throughout Humana documents. (2024 Recommendation 14) **KFMC 2025 Update:** In the procedure *OK.MHB.001 Medicaid Enrollee Handbook New State Implementation: Development and Distribution of Enrollee Handbook*, section "Procedures" related to letter a, Humana listed the enrollee rights. Related to letter b, Humana revised the enrollee rights and responsibilities; however, they continue to not be consistent between the *Member Handbook*, *Provider Manual*, and procedure *OK.MHB.001 Medicaid Enrollee Handbook New State Implementation: Development and Distribution of Enrollee Handbook*. The *Provider Manual* and *Member Handbook* detail two member rights and three member responsibilities that are not listed in the procedure. They include: • Member Rights: "Voice complaints or appeals about Humana Healthy Horizons or the care it provides" and "Make recommendations about the member rights and responsibilities policy." • Member Responsibilities: "Supply Information (to the extent possible) that Humana Healthy Horizons and its providers need to provide care"; "Follow plans and instructions for care that they have agreed to with their provider"; and "Understand their health problems and participate in setting agreed on goals, to the degree possible)." This recommendation is partially addressed.	Partially Addressed
	6. To the *Member Handbook* and Humana policy and procedure *OK.MHB.001 Medicaid Enrollee Handbook New State Implementation: Development and Distribution of Enrollee Handbook*, for consistency, add the enrollee right that states, "Request a provider with the same race, ethnicity, and language as the member if there is a provider available in the network." (Also applies to § 438.100[a][1], [b][1], and [b][2][i]) (2024 Recommendation 15) **KFMC 2025 Update:** Humana removed, from the *Provider Manual*, the identified member right. Therefore, it is no longer needed in the identified documents. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(g)(2)(ix) Information requirements: Information for enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Enrollee handbook (Continued)	**Humana (Continued)** 7. In the *Member Handbook*, add "OHCA/" to the member responsibility that states, "Check Humana information; correct inaccuracies; and allow government agencies, employers and providers to release records to OHCA or Humana." It would read, "Check **OHCA/**Humana information; correct inaccuracies; and allow government agencies, employers and providers to release records to OHCA or Humana." (2024 Recommendation 16) **KFMC 2025 Update:** Humana revised the *Member Handbook* to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	8. In the *Member Handbook* and *Provider Manual*, change the verbiage "Work on" to "Respond to" and add "OHS" to the Member responsibility that states, "Work on requests for assistance from the Office of Child Support Services." It would read, "**Respond to** requests for assistance from the **OHS** Office of Child Support Services." (State Contract Section 1.12.5.4 "Enrollee Handbook Content," letter d) (2024 Recommendation 17) **KFMC 2025 Update:** Humana revised the *Member Handbook* and *Provider Manual*, to change the verbiage "Work on" to "Respond to" and "OHS" was added to the identified member responsibility. This recommendation is fully addressed.	Fully Addressed
	OCH 4. In the *Member Handbook*, add "OHS" and change "Work on" to "Respond to" in the member responsibility "Work on requests for assistance from the Office of Child Support Services." It would read, "**Respond to** requests from the **OHS** Office of Child Support Services." (State Contract Section 1.12.5.4 "Enrollee Handbook Content, second paragraph, letter d) (2024 Recommendation 5) **KFMC 2025 Update:** The *Member Handbook* (dated May 2025), section "Member Rights and Responsibilities," sub-section "Your Responsibilities," eighth bullet includes the recommended language, "Respond to requests for assistance from the OHS Office of Child Support Services." The recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(g)(2)(ix) Information requirements: Information for enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Enrollee handbook (Continued)	**OCH (Continued)** 5. To the OCH policy and procedure *CC.MBRS.25 Member Rights & Responsibilities*, section "Rights and Responsibility Statement" (page 1), in the list of member rights and responsibilities, revise the following: a. Include the right that states, "… the right to request a copy of medical records including amendments or corrections in accordance with HIPAA Rules and other applicable federal and State laws and regulations." (State Contract Section 1.11.5.4 "Enrollee Handbook Content," letter q, roman numeral vi; also applies to CFR § 438.100[b][2][vi]) b. Remove either number 9 or 14, as they state the same right, "A right to voice complaints or appeals about the organization or the care it provides." (2024 Recommendation 6) **KFMC 2025 Update:** OCH stated, "The policy has been updated." However, OCH did not submit the policy and procedure in the follow-up to prior recommendations. For this recommendation to be fully addressed, OCH needs to submit the revised and approved policy and procedure *CC. MBRS.25 Member Rights & Responsibilities*.	Partially Addressed
	6. Review and revise the "Member Rights and Responsibilities" listed in policies and procedures *CC.MBRS.25 Member Rights & Responsibilities* and *OK.MRKT.06 Member Handbook*, the *Member Handbook*, and the *Provider Manual to be consistent across documents*. (2024 Recommendation 7) **KFMC 2025 Update:** OCH stated, "The policy has been updated." However, OCH did not submit the policies and procedures in the follow-up to prior recommendations. For the recommendation to be fully addressed, OCH needs to submit the updated and approved policies and procedures *CC.MBRS.25 Member Rights and Responsibilities* and *OK.MRKT.06 Member Handbook*. KFMC cannot review for consistency across documents until all documents have been received. KFMC received the 2025 *Provider Manual* and *Member Handbook*.	Partially Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(g)(2)(xii) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook and related provisions § 438.3(j)(1-4) Advance directives and related provisions § 438.3(j)(1-4) Standard contract requirements: Advance directives, § 422.128 Information on advance directives, and § 417.436 Rules for enrollees: Advance directives	**<u>Aetna</u>** 9. To the Aetna policy and procedure *7500.90 Advance Directives*, add information on how Aetna Beter Health implements and carries out the federal regulatory requirement, "If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the HMO or CMP may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The HMO or CMP is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time." (2024 Recommendation 11) **KFMC 2025 Update:** The Aetna policy and procedure *7500.90 Advance Directives* was revised to include the federal regulatory requirement, however, Aetna reported that the revised policy, when submitted to KFMC, had not been approved, therefore this recommendation is in progress. To be fully addressed, Aetna needs to submit the final, approved policy.	In Progress
	<u>Humana</u> 9. To the Humana policy and procedure *OK.CLI.004 – Advance Directives*, section "Procedures," add the federal regulatory and State Contract language and detail how Humana implements and/or carries out the requirement, "The MCO, PIHP, or PAHP subject to the requirements of this paragraph (j) must provide adult enrollees with written information on advance directives policies and include a description of applicable State law." (§ 438.3[j][3]) (2024 Recommendation 18) **KFMC 2025 Update:** Humana revised the procedure *OK.CLI.004-Advance Directives*, section "Procedures," third paragraph (page 1), to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	10. To the Humana policy and procedure *OK.CLI.004 – Advance Directives*, section "Procedures," add the federal regulatory and State Contract language r and detail how Humana implements and/or carries out the requirement, "The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change." (§ 438.3[j][4]) (2024 Recommendation 19) **KFMC 2025 Update:** Humana revised the procedure *OK.CLI.004-Advance Directives*, section "Procedures," (page 1) to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(g)(2)(xii) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook and related provisions § 438.3(j)(1-4) Advance directives and related provisions § 438.3(j)(1-4) Standard contract requirements: Advance directives, § 422.128 Information on advance directives, and § 417.436 Rules for enrollees: Advance directives (Continued)	**Humana (Continued)** 11. To the Humana policy and procedure *OK.CLI.004 – Advance Directives*, section "Procedures," add the federal regulatory and State Contract language and detail how Humana implements and/or carries out the requirement, "An MCO must provide written information to those individuals with respect to the following: Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that the requirements of this section are met. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law." (§ 422.128[b][1][i] and § 417.436[d][1][i][A]) (2024 Recommendation 20) **KFMC 2025 Update:** Humana revised the procedure *OK.CLI.004-Advance Directives*, section "Procedures," second paragraph, to include the recommended language and detailed how the requirement is carried out. This recommendation is fully addressed.	Fully Addressed
	12. To the Humana policy and procedure *OK.CLI.004 – Advance Directives*, section "Procedures," add the federal regulatory and State Contract language and detail how Humana implements and/or carries out the requirement, "The MCO's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the MCO cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following: (A) Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians. (B) Identify the state legal authority permitting such objection. (C) Describe the range of medical conditions or procedures affected by the conscience objection." (2024 Recommendation 21) **KFMC 2025 Update:** Humana revised the procedure *OK.CLI.004 – Advance Directives*, section "Procedures," second full paragraph (page 2) to include the recommended language and detailed how the requirement is carried out. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(g)(2)(xii) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook and related provisions § 438.3(j)(1-4) Advance directives and related provisions § 438.3(j)(1-4) Standard contract requirements: Advance directives, § 422.128 Information on advance directives, and § 417.436 Rules for enrollees: Advance directives (Continued)	**Humana (Continued)** 13. To the Humana policy and procedure *OK.CLI.004 – Advance Directives*, section "Procedures," add the federal regulatory and State Contract language and detail how Humana implements and/or carries out the requirement, "If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the MCO or PIHP may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The MCO or PIHP is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time." (§ 422.128[b][1][ii][D] and § 417.436[d][1][ii]) (2024 Recommendation 22) **KFMC 2025 Update:** Humana revised the procedure *OK.CLI.004-Advance Directives*, section "Procedures," second full paragraph, to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	14. To the Humana policy and procedure *OK.CLI.004 – Advance Directives*, section "Procedures," add the federal regulatory and State Contract language and detail how Humana implements and/or carries out the requirement, "The MCO must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency." (§ 422.128[b][3] and § 417.436[d][3]) (2024 Recommendation 23) **KFMC 2025 Update:** Humana revised the procedure *OK.CLI.004-Advance Directives*, section "Procedures," first full paragraph (page 1), to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(g)(2)(xii) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook and related provisions § 438.3(j)(1-4) Advance directives and related provisions § 438.3(j)(1-4) Standard contract requirements: Advance directives, § 422.128 Information on advance directives, and § 417.436 Rules for enrollees: Advance directives (Continued)	**OCH** 7. To OCH policy and procedure *OK.CM.10 Advance Directives* and any additional applicable advance directive policies and procedures, add the federal regulatory language that states, "If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the MCO or PIHP organization may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The MCO or PIHP organization is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time." (2024 Recommendation 8) **KFMC 2025 Update:** OCH stated, "The policy has been updated." However, OCH did not submit the policies and procedures in the follow-up to prior recommendations. For the recommendation to be fully addressed, OCH needs to submit the updated and approved policy and procedure *OK.CM.10 Advance Directives* and any additional policies and procedures applicable to Advance Directives with the recommended federal regulatory language included.	Partially Addressed
Subpart D – MCO, PIHP, and PAHP		
§ 438.210(c) Coverage and authorization of services – Notice of adverse benefit determination and related provision § 438.404(a-c) Timely and adequate notice of adverse benefit determination	**Aetna** 10. To the Aetna policy and procedure *7200.03 Utilization Management (UM) Timeliness Standards and Decision Notification*, section "E. Notice of Action Requirements," third paragraph, fourth bullet (pages 8-9), add the federal regulatory and State Contract language indicating there is no cost. It would read, "Notification that, upon request **and at no cost**, the practitioner/provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based." (State Contract Section 1.18.6.2 "Notice and Content," letter b) (2024 Recommendation 12) **KFMC 2025 Update:** The policy and procedure *7200.03 Utilization Management (UM) Timeliness Standards and Decision Notification* was not resubmitted in the 2025 review. Aetna submitted a new policy *Aetna Medicaid Administrators LLC (AMA) 7200.88 Utilization Management (UM) Timeliness Standards and Decision Notification Oklahoma Policy* that was revised to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs (Continued)		
	Subpart D – MCO, PIHP, and PAHP (Continued)	
§ 438.210(c) Coverage and authorization of services – Notice of adverse benefit determination and related provision § 438.404(a-c) Timely and adequate notice of adverse benefit determination (Continued)	**Aetna (Continued)** 11. To the *Provider Manual*, section "Notice of action (NOA) requirements," second paragraph, fifth bullet (pages 73-74), add the federal regulatory and State Contract language indicating there is no cost. It would read, "Notification that, upon request **and at no cost**, the provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based." (State Contract Section 1.18.6.2 "Notice and Content," letter b) (2024 Recommendation 13) **KFMC 2025 Update:** The Aetna *Provider Manual* was revised to include the recommended language. The State approved *Provider Manual* dated July 1, 2025, also included the language. This recommendation is fully addressed.	Fully Addressed
	Humana 15. To the *Provider Manual*, section "Time Frames and notifications for responding to PA [Prior Authorization] requests," third bullet (page 40), add the federal regulatory and State Contract language that states, "Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires." (2024 Recommendation 29) **KFMC 2025 Update:** Humana revised the *Provider Manual*, section "Time Frames and notifications for responding to requests for services," third bullet (page 43), to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	OCH 8. To the OCH policy and procedure *OK.UM.08 Adverse Benefit Determination (Denial)* Notices, section "Termination, Suspension, and Reduction of Previously Authorized Covered Services," second paragraph, roman numeral viii, add the rest of the federal regulatory and State Contract language related to § 431.213. (State Contract Section 1.18.6.2 "Notice and Content," letter b) (2024 Recommendation 9) **KFMC 2025 Update:** OCH stated, "The policy is being reviewed to include additional language related to the regulatory and state contract. Will update policy once approved by committee." To be fully addressed, OCH needs to submit the updated and approved policy and procedure *OK.UM.08 Adverse Benefit Determination (Denial) Notices* with the recommended federal regulatory language related to § 431.213.	In Progress

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs		
	Subpart D – MCO, PIHP, and PAHP (Continued)	
§ 438.210(d)(1)(i-ii) Coverage and authorization of services – Timeframe for decisions: Standard authorization decisions	**Aetna** 12. To the *SoonerSelect Member Handbook*, section "Prior Authorization and Timeframes," add the federal regulatory and State Contract requirement that standard authorization decisions may have an extension to the timeframe up to 14 additional calendar days if – "The enrollee or the provider request the extension; or, the CE justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." (State Contract Section 1.18.6.6 "Prior Authorization Denial or Limitation") (2024 Recommendation 15) **KFMC 2025 Update:** Aetna submitted the OHCA approved *SoonerSelect Member Handbook* that was revised to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	13. To the *Provider Manual*, "Chapter 12: Prior authorization," sub-section "Decision/notification requirements," in the second row of the table "Non-urgent preservice decision (approvals and denials)," add the federal regulatory and State Contract requirement that details the provider can also request the extension. (State Contract Section 1.18.6.6 "Prior Authorization Denial or Limitation") (2024 Recommendation 16) **KFMC 2025 Update:** Aetna submitted the OHCA approved *Provider Manual* that was revised to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	Humana 16. To the *Provider Manual*, section "Time Frames and notifications for responding to PA requests," add the federal regulatory and State Contract language that states, standard authorization decisions may have an extension to the timeframes up to fourteen (14) additional calendar days if "The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." (2024 Recommendation 30) **KFMC 2025 Update:** Humana revised the *Provider Manual*, section "Time Frames and notifications for responding to requests for services," third bullet "Extensions," to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs		
Subpart D – MCO, PIHP, and PAHP (Continued)		
§ 438.210(d)(1)(i-ii) Coverage and authorization of services – Timeframe for decisions: Standard authorization decisions (Continued)	**Humana (Continued)** 17. To the *Member Handbook*, section "Prior Authorization and Timeframes," add the federal regulatory and State Contract language that standard authorization decisions may have an extension to the timeframe up to fourteen (14) additional calendar days if "The enrollee or the provider request the extension; or, The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." (2024 Recommendation 31) **KFMC 2025 Update:** Humana revised the *Member Handbook*, section "Prior Authorization and Timeframes," sixth paragraph (page 59), to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	OCH 9. To the *Provider Manual*, section "Prior Authorization Determination Timelines," add language that the timeframe for standard authorization decisions may extend up to 14 additional calendar days if the enrollee or provider requests the extension; or, the CE justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. (State Contract Section 1.18.6.6 "Prior Authorization Denial or Limitation") (2024 Recommendation 10) **KFMC 2025 Update:** The *Provider Manual* (dated 2025), section "Prior Authorization Determination Timelines" (page 79), does not include the recommended language. Therefore, the recommendation is not addressed. For the recommendation to be fully addressed, OCH needs to make the recommended change.	Not Addressed
	10. In the *Member Handbook*, section "Prior Authorization Determination Timelines," add language that the timeframe for standard authorization decisions may extend up to 14 additional calendar days if the enrollee or provider requests the extension and how the extension is in the enrollee's interest. [§ 438.210(d)(1)(ii)(A-B)] (State Contract Section 1.18.6.6 "Prior Authorization Denial or Limitation") (2024 Recommendation 11) **KFMC 2025 Update:** In the *Member Handbook* (dated May 2025), section "Prior Authorization and Timeframes," first bullet (page 50), OCH added the language, "Authorization decisions may be extended by up to 14 calendar days if we need more information." However, it does not include the language "…if the enrollee or provider requests the extension and how the extension is in the enrollee's interest." The recommendation is partially addressed. For the recommendation to be fully addressed, the additional language needs to be added.	Partially Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the SoonerSelect Medical CEs		
	Subpart D – MCO, PIHP, and PAHP (Continued)	
§ 438.210(d)(2)(i-ii) Coverage and authorization of services – Timeframe for decisions: Expedited authorization decisions and related provision § 438.404(c)(6) Timely and adequate notice of adverse benefit determination – Timing of notice	**Aetna** 14. To the *SoonerSelect Member Handbook*, section "Prior Authorization and Timeframes," add the federal regulatory and State Contract requirement that expedited authorization decisions may have an extension to the timeframe up to 14 additional calendar days if – "The enrollee or the provider request the extension; or, The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." (State Contract Section 1.18.6.6 "Prior Authorization Denial or Limitation") (2024 Recommendation 17) **KFMC 2025 Update:** Aetna submitted the OHCA approved *SoonerSelect Member Handbook* that was revised to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	Humana 18. To the *Provider Manual*, section "Time frames and notifications for responding to PA requests," add the federal regulatory and State Contract language that states, expedited authorization decisions may have an extension to the timeframes up to fourteen (14) additional calendar days if "The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." (2024 Recommendation 32) **KFMC 2025 Update:** Humana revised the *Provider Manual*, section "Time frames and notifications for responding to requests for services," second bullet "Expedited," to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	19. To the *Member Handbook*, section "Prior Authorization and Timeframes," add the federal regulatory and State Contract language that expedited authorization decisions may have an extension to the timeframe up to fourteen (14) additional calendar days if "The enrollee or the provider request the extension; or, The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." (2024 Recommendation 33) **KFMC 2025 Update:** Humana revised the *Member Handbook*, section "Prior Authorization and Timeframes," sixth paragraph (page 59), to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	***Follow-Up to Previous Recommendations (2024)***	***2025 Completion Status***
Common Among the SoonerSelect Medical CEs		
Subpart D – MCO, PIHP, and PAHP (Continued)		
§ 438.210(d)(2)(i-ii) Coverage and authorization of services – Timeframe for decisions: Expedited authorization decisions and related provision § 438.404(c)(6) Timely and adequate notice of adverse benefit determination – Timing of notice (Continued)	**OCH** 11. To the *Provider Manual*, section "Prior Authorization Determination Timelines," add language that the timeframe for expedited authorization decisions may extend up to 14 additional calendar days if the enrollee or provider requests the extension, or, the CE justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. (State Contract Section 1.18.6.6 "Prior Authorization Denial or Limitation") (2024 Recommendation 12) **KFMC 2025 Update:** The *Provider Manual*, section "Prior Authorization Determination Timelines" (page 79), does not include the recommended language. Therefore, the recommendation is not addressed. For the recommendation to be fully addressed, OCH needs to make the recommended change.	Not Addressed
	12. To the *Member Handbook*, section "Prior Authorization Determination Timelines," add language that the timeframe for expedited authorization decisions may extend if the enrollee requests the extension and how the extension is in the enrollee's interest. (State Contract Section 1.18.6.6 "Prior Authorization Denial or Limitation") (2024 Recommendation 13) **KFMC 2025 Update:** In the *Member Handbook* (dated May 2025), the section "Prior Authorization Determination Timelines" was removed. The section "Prior Authorization and Timeframes" (page 50 [medical]/page 48 [CSP]) does not include language that the timeframe for expedited authorization decisions may extend if the member requests the extension and how the extension is in the member's interest. Therefore, the recommendation is not addressed. For the recommendation to be fully addressed, OCH needs to make the recommended change.	Not Addressed
Aetna		
Subpart B – State Responsibilities		
§ 438.56(f)(1) Disenrollment – Requirements and limitations: Notice and appeals	15. To the Aetna policy and procedure *4400.15 Enrollee Enrollment*, section "Patient Pay Liability (PPL) or Share of Cost (SOC)," sub-section "Open Enrollment - Medicaid," first paragraph (page 7), add the federal regulatory and State Contract language, "Written notices of the Open Enrollment Period and Enrollee Disenrollment rights will be provided to Enrollees at least sixty (60) Days prior to the start of the Open Enrollment Period."(Also applies to § 438.10[f][2]; State Contract Section 1.6.5 "Annual and Special Enrollment Periods") (2024 Recommendation 1) **KFMC 2025 Update:** Aetna revised the policy and procedure *4400.15 Enrollee Enrollment*, section "Patient Pay Liability (PPL) or Share of Cost (SOC)," sub-section "Open Enrollment - Medicaid," first paragraph to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Aetna (Continued)		
	Subpart B – State Responsibilities (Continued)	
§ 438.10(g)(2)(ii)(A–B) Information requirements: Information for enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Enrollee handbook	16. To the *SoonerSelect Member Handbook*, where most appropriate, add information related to covered benefits that could be denied based on moral and religious objections and how the enrollee can obtain information on how to access the covered benefit. (State Contract Section 1.12.5.4 "Enrollee Handbook Content," letter g, "Limitations or exclusions to benefits," roman numeral i) (2024 Recommendation 6) **KFMC 2025 Update:** Aetna submitted the OHCA approved *SoonerSelect Member Handbook* revised to include the language, "In the case of a counseling or referral service that contracted providers or health systems do not provide due to moral or religious objections, Aetna amends the provider agreement to acknowledge these objections and works directly with you in these cases to refer you to a provider or health system that does not have such moral or religious objections to treat your need." This recommendation is fully addressed.	Fully Addressed
	Subpart D – MCO, PIHP and PAHP Standards (Continued)	
§ 438.210(d)(2)(i-ii) Coverage and authorization of services – Timeframe for decisions: Expedited authorization decisions and related provision § 438.404(c)(1-3) Timely and adequate notice of adverse benefit determination	17. To the Aetna policy and procedure *7100.05 Prior Authorization,* section "Termination, Suspension, or Reduction of Services" (page 17) or most appropriate policy and procedure, add the federal regulatory and State Contract requirements that state: • "The agency may send a notice not later than the date of action if— (a) The agency has factual information confirming the death of a beneficiary; (b) The agency receives a clear written statement signed by a beneficiary that— (1) He no longer wishes services; or (2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; (c) The beneficiary has been admitted to an institution where he is ineligible under the plan for further services; (d) The beneficiary's whereabouts are unknown, and the post office returns mail directed to him indicating no forwarding address; (e) The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; (f) A change in the level of medical care is prescribed by the beneficiary's physician; (g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act." • "The agency may shorten the period of advance notice to 5 days before the date of action if— (a) The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and (b) The facts have been verified, if possible, through secondary sources."	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Aetna (Continued)		
	Subpart D – MCO, PIHP and PAHP Standards (Continued)	
	(State Contract Section 1.18.6.4 "Termination, Suspension, or Reduction of Previously Authorized Covered Services," letters a and b[i-viii]) (2024 Recommendation 14) **KFMC 2025 Update:** The policy and procedure *7100.05 Prior Authorization* was not resubmitted in the 2025 review. Aetna submitted a new policy Aetna Medicaid Administrators LLC (AMA) *7200.45 Prior Authorization Oklahoma Policy*. It was revised to include the recommended language. This recommendation is fully addressed.	
§ 438.214(e) Provider selection – State requirements	18. To the Aetna policy and procedure *6400.6 Practitioner and Provider Availability: Network Composition and Contracting Plan* or most appropriate policy and procedure, add the federal regulatory and State Contract requirement, "The Contractor shall comply with any and all additional Participating Provider Network selection requirements established by OHCA or the State, in accordance with 42 C.F.R. §§ 438.12(a)(2); 42 C.F.R. 438.214(e) and 56 O.S. 2021 § 4002.4. This shall include all requirements included in this Contract and any amendments thereto, along with all other OHCA guidance on Participating Provider selection along with any applicable State law during the term of this Contract." (State Contract Section 1.13.1.3.4 "Compliance with OHCA-Determined Provider Selection Requirements") (2024 Recommendation 18) **KFMC 2025 Update:** Aetna submitted the revised policy and procedure *6400.6 Practitioner and Provider Availability: Network Composition and Contracting Plan* that was revised to include the recommended language. This recommendation is fully addressed.	Fully Addressed
Humana		
	Subpart B – State Responsibilities	
§ 438.56(a-b) Disenrollment – Requirements and limitations: (a) Applicability and (b) Disenrollment requested by the MCO, PIHP, PAHP, PCCM, or PCCM entity	20. To the Humana policy and procedure *OK.MCC.003 - Disenrollment Requests*, section "Procedures," add the federal regulatory and State Contract language and detail how Humana implements and/or carries out the requirement, "The Contractor must comply with Section 1.6.1: "Non-Discrimination" of this Contract and seek to disenroll an Enrollee only for good cause in accordance with 42 C.F.R. § 438.56(b)(3)." (§ 438.56[a-b]; State Contract Section 1.6.7.1 "Contractor Request") (2024 Recommendation 1) **KFMC 2025 Update:** Humana revised the procedure *OK.MCC.003-Disenrollment Requests,* section "Procedures," subsection "Disenrollment without "Cause" (page 2), to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Humana (Continued)		
	Subpart B – State Responsibilities (Continued)	
§ 438.56(b)(1) Disenrollment – Requirements and limitations: Disenrollment requested by the MCO, PIHP, PAHP, PCCM, or PCCM entity (Continued)	21. To the Humana policy and procedure *OK.MCC.003 - Disenrollment Requests*, section "Procedures," add the federal regulatory and State Contract language and detail how Humana implements and/or carries out the requirement, "The Contractor must make a written request to OHCA for Enrollee Disenrollment, in a format to be specified by OHCA. The Contractor's request for Disenrollment must document the reasonable steps taken to educate the Enrollee regarding proper behavior and that the Enrollee refused to comply, if applicable. The Contractor must communicate its request to the Enrollees in writing, in a format to be specified by OHCA." (§ 438.56[a-b]; State Contract Section 1.6.7.1 "Contractor Request") (2024 Recommendation 2) **KFMC 2025 Update:** Humana revised the procedure *OK.MCC.003-Disenrollment Requests,* section "Procedures," subsection "Disenrollment without "Cause," subsection "Cause for Disenrollment," third paragraph, to include the recommended language. This recommendation is fully addressed.	Fully Addressed
	22. Revise Humana policy and procedure *OK.MCC.003 - Disenrollment Requests*, section "Procedures," sub-section "Disenrollment for 'Good Cause," first sentence (page 2) to state the good cause reasons for disenrollment are reasons Humana may seek to disenroll an enrollee. It would read, "**<u>Humana</u>** may request disenrollment **<u>of an enrollee</u>** for reasons known as just cause reasons." (2024 Recommendation 6) **KFMC 2025 Update:** Humana revised the procedure *OK.MCC.003-Disenrollment without "Cause,"* section "Cause for Disenrollment," third and fourth paragraphs (page 3) to include the recommended language. This recommendation is fully addressed.	Fully Addressed
§ 438.56(e)(2) Disenrollment – Requirements and limitations: Timeframe for disenrollment determinations	23. To the Humana policy and procedure *OK.MCC.003 - Disenrollment Requests*, section "Procedures," add the federal regulatory and State Contract language that details how Humana implements and/or carries out the requirement, "If the MCO, PIHP, PAHP, PCCM, PCCM entity, or the State agency (whichever is responsible) fails to make the determination within the timeframes specified in paragraph (e)(1) of this section [{e}{1} No later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM, or PCCM entity refers the request to the State], the disenrollment is considered approved for the effective date that would have been established had the State or MCO, PIHP, PAHP, PCCM, PCCM entity complied with paragraph (e)(1) of this section." (§ 438.56[e][2]; State Contract Section 1.6.7.2 "Enrollee Request") (2024 Recommendation 3) **KFMC 2025 Update:** Humana revised the procedure *OK.MCC.003-Disenrollment without "Cause,"* section "Cause for Disenrollment," sixth paragraph (page 3) to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Humana (Continued)		
	Subpart B – State Responsibilities (Continued)	
§ 438.56(e)(2) Disenrollment: Requirements and limitations – Timeframe for disenrollment determinations	24. To the Humana policy and procedure *OK.ENT.003 - Disenrollment of an Enrollee*, section "Procedures," add language related to how Humana implements and carries out the requirement, "If the MCO, PIHP, PAHP, PCCM, PCCM entity, or the State agency (whichever is responsible) fails to make the determination within the timeframes specified in paragraph (e)(1) of this section [no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM, or PCCM entity refers the request to the State], the disenrollment is considered approved for the effective date that would have been established had the State or MCO, PIHP, PAHP, PCCM, PCCM entity complied with paragraph (e)(1) of this section. (State Contract Section 1.6.7.2 "Enrollee Request") (2024 Recommendation 7) **KFMC 2025 Update:** Humana revised the procedure *OK.ENT.003 - Disenrollment of an Enrollee*, section "Procedures," subsection "Voluntary Disenrollment," first full paragraph (page 2) to include the recommended language. This recommendation is fully addressed.	Fully Addressed
§ 438.56(f)(1) Disenrollment – Requirements and limitations: Notice and appeals	25. To the Humana policy and procedure *OK.MCC.003 - Disenrollment Requests*, section "Procedures," add the federal regulatory and State Contract language that details how Humana implements and/or carries out the requirement, "Provide that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. The notice must include an explanation of all of the enrollee's disenrollment rights as specified in this section." (§ 438.56[f][1]; State Contract Section 1.6.5 "Annual and Special Enrollment Periods") (2024 Recommendation 4) **KFMC 2025 Update:** Humana revised the procedure *OK.MCC.003-Disenrollment without "Cause,"* section "Cause for Disenrollment," seventh paragraph (page 4) to include the recommended language. This recommendation is fully addressed.	Fully Addressed
§ 438.56(f)(2) and (g) Disenrollment – Requirements and limitations: (f) Notice and appeals and (g) Automatic reenrollment: Contract requirement	26. To the Humana policy and procedure *OK.MCC.003 - Disenrollment Requests*, section "Procedures," add the federal regulatory and State Contract language that details how Humana implements and/or carries out the requirement, "Ensure timely access to State fair hearing for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment." (§ 438.56[f][2]; State Contract Section 1.6.11 "Re-enrollment Following Loss of Eligibility") (2024 Recommendation 5) **KFMC 2025 Update:** Humana revised the procedure *OK.MCC.003-Disenrollment Requests*, section "Procedures," sub-section "Disenrollment for "Cause," first sentence (page 5) to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Humana (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.10(f)(1) Information requirements: Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities – General requirements	27. In the Humana policy and procedure *OK.NNO.003 Provider Terminations* and OHCA Notifications, section "Scope," sub-section "D. Member Notification of Provider Termination" second paragraph (page 5), change "30 calendar days" to "fifteen (15) calendar days." It would state, "If a provider notifies Humana of their intent to terminate or non-renew their participation less than 30 calendar days prior to the effective date, Contractor shall notify the affected members as soon as possible, but no later than **fifteen (15) calendar days** after receipt of the notification, shorter notification may be required, please verify state and Medicaid requirements." (2024 Recommendation 12) **KFMC 2025 Update:** Humana revised the procedure *OK.NNO.003 Provider Terminations and OHCA Notifications*, section "Procedure," letter "D. Member Notification of Provider Termination," second paragraph (page 5), to change the language "30 calendar days" to "fifteen (15) calendar days." This recommendation is fully addressed.	Fully Addressed
	28. In the *Member Handbook*, section "PART III: Plan Procedures," sub-section "Your Care When You Change Health Plans or Doctors (Transition of Care)," sixth paragraph, first sentence (page 68), review and revise, as appropriate, the conflicting timeframes, "fifteen (30) days." (2024 Recommendation 13) **KFMC 2025 Update:** Humana revised the *Member Handbook*, section "PART III: Plan Procedures," sub-section "Your Care When You Change Health Plans or Doctors (Transition of Care)," seventh paragraph, (page 66), to change the conflicting timeframe, "fifteen (30) days" to "thirty (30) days." This recommendation is fully addressed.	Fully Addressed
§ 438.10(h) Information requirements: Information for all enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Provider Directory	29. To Humana policy and procedure *OK.PNM.001 Provider On-line Directory*, section "Procedures," add the following: a. Mapping capabilities (State Contract Section 1.12.14.2 "Content," letter i) b. Provider's cultural capabilities, including languages (American Sign Language included) offered by the Provider or by skilled medical interpreter at the Provider's office (State Contract Section 1.12.14.2 "Content," letter j) c. Related to accommodations for persons with disabilities, include offices, exam room(s) and equipment. (State Contract Section 1.12.14.2 "Content," letter k) d. Whether the provider offers covered services via telehealth. (§ 438.10[h][1][ix]) e. Behavioral Health Providers (State Contract Section 1.12.14.2 "Content," letter iv) Whether the Provider Directory available on the Humana website is in a machine-readable file and format as specified by the Secretary of Health and Human Services (HHS). (§ 438.10[h][4]; State Contract Sections 1.12.7.6 "Machine Readable Data" and 1.12.14.5 "Website Publication") (2024 Recommendation 24) **KFMC 2025 Update:** Humana revised the procedure *OK.PNM.001 Provider On-line Directory*, section "Procedures" (page 1) to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Humana (Continued)		
	Subpart B – State Responsibilities (Continued)	
§ 438.10(i) Information requirements: Information for all enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Formulary	30. In the *Member Handbook*, include information on the Preferred Drug List (PDL) and how enrollees can access it. (2024 Recommendation 25) **KFMC 2025 Update:** Humana revised the *Member Handbook*, section "Pharmacy," second paragraph, to include language related to the PDL and how enrollees can access it. This recommendation is fully addressed.	Fully Addressed
	31. Add to Humana policy and procedure whether the Formulary drug list available on the Humana website is in a machine-readable file and format as specified by the Secretary of HHS. (§ 438.10[i][3]; State Contract Section 1.12.7.6 "Machine Readable Data") (2024 Recommendation 26) **KFMC 2025 Update:** Humana revised the procedure *Oklahoma Medicaid Printable Drug List Upload*, section "detailed Procedure," number "4. Machine Readable Files" (page 2) to include the recommended information. This recommendation is fully addressed.	Fully Addressed
§ 438.114(c)(1)(i-ii) Emergency and poststabilization services: Coverage and payment – Emergency services	32. To Humana policy and procedure *OK.CLI.009 Covered Benefits*, section "Procedures," add language related to federal regulatory requirements § 438.114(c)(1)(ii)(A-B) that state, "The MCO may not deny payment for treatment obtained under either of the following circumstances: a. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would result in the following: i. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. ii. Serious impairment to bodily functions. iii. Serious dysfunction of any bodily organ or part. b. A representative of the MCO, PIHP, PAHP, PCCM, or PCCM entity instructs the enrollee to seek emergency services." (State Contract Section 1.7.16.1 "Emergency Services," letters c and d and emergent Behavioral Health Services, letters b and d) (2024 Recommendation 27) **KFMC 2025 Update:** Humana revised the procedure *OK.CLI.009 Covered Benefits*, section "Procedures," first paragraph (page 17), to include the recommended language. This recommendation is fully addressed.	Fully Addressed

Regulatory Area	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Humana (Continued)		
Subpart B – State Responsibilities (Continued)		
§ 438.114(d)(1-3) Emergency and poststabilization services: Coverage and payment – Additional rules for emergency services	33. To the Humana policy and procedure *OK.CLI.009 Covered Benefits*, section "Procedures," add language related to regulatory requirements § 438.114(d)(1)(ii) and (d)(2-3) that states: (1) "The MCO may not— (ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. (2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. (3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO as responsible for coverage and payment." (State Contract Section 1.7.16.1 "Emergency Services," second paragraph letter b and third paragraph related to emergent Behavioral Health Services, letter c) (2024 Recommendation 28) **KFMC 2025 Update:** Humana revised the procedure *OK.CLI.009 Covered Benefits*, section "Procedures," second paragraph (page 17), to include the recommended language. This recommendation is fully addressed.	Fully Addressed
OCH		
Subpart B – State Responsibilities		
§ 438.10(f)(1) Information requirements – Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: General requirements	13. In the *Member Handbook*, section "How to Choose Your PCP," change the timeframe of "15 days" to "15 calendar days." It would read, "If your provider leaves Oklahoma Complete Health, we will tell you within 15 **calendar** days from when we know about this." (State Contract Section 1.12.13.3 "Notification of PCP Termination") (2024 Recommendation 4) **KFMC 2025 Update:** In the *Member Handbook* (dated May 2025), section "How To Choose your PCP," eighth paragraph, the timeframe of "15 days" was changed to "15 calendar days." The recommendation is fully addressed.	Fully Addressed

Early and Periodic Screening, Diagnostic, and Treatment

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
DentaQuest		
1.	Enhance the EPSDT section of the *Enrollee Handbook* to further explain the EPSDT dental benefits and link to the list of covered services. Consider adding the schedule of preventive dental care by age group. **KFMC 2025 Update:** The *Enrollee Handbook* was not updated to include this information.	Not Addressed
2.	In the Enrollee Handbook table for covered services and the Other Covered Services section below the table, consider ways to increase clarity regarding what qualifies as EPSDT services. **KFMC 2025 Update:** The tables were not updated to improve clarity.	Not Addressed
3.	Include a section on EPSDT in the *Office Reference Manual* (provider manual) with pertinent information regarding dental EPSDT services, including the related periodicity schedule and how members can access these services. Provide links to EPSDT resources for further information. **KFMC 2025 Update:** Section 10.06 Early and Periodic Screening, Diagnostic, and Treatment Exceptions was added to the *Office Reference Manual*. However, the age range of members eligible for EPSDT services is referenced in this section as both "under 20 years of age" and "ages 20 and younger," potentially leading to confusion. Therefore, this recommendation is partially addressed.	Partially Addressed
4.	In the *Office Reference Manual* identify the services in the Child Benefits table that qualify as EPSDT benefits and include associated requirements. **KFMC 2025 Update:** The Child Benefits Table in the *Office Reference Manual* was not updated to identify the services that qualify as EPSDT benefits.	Not Addressed
5.	Consider providing a summary of the preventive care schedule by age group in the provider manual for convenience of use and to enhance understanding of what comprises preventive EPSDT services. **KFMC 2025 Update:** This was not added to the *Office Reference Manual*.	Not Addressed
6.	Develop an EPSDT policy and procedure if there isn't one already. **KFMC 2025 Update:** No EPSDT policy was submitted in the 2025 review.	Not Addressed

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
LIBERTY		
1.	Enhance the EPSDT section of the *Member Handbook* to further explain the EPSDT benefits and link to the list of covered services. Consider adding the schedule of preventive dental care by age group. **KFMC 2025 Update:** The *Member Handbook* was not updated.	Not Addressed
2.	In the table for covered services and the Other Covered Services section below the table, consider ways to increase clarity regarding what qualifies as EPSDT services. **KFMC 2025 Update:** The *Member Handbook* was not updated.	Not Addressed
3.	Consider providing a summary of the preventive care schedule by age group in the *Provider Reference Guide* (provider manual) for convenience of use and to enhance understanding of what comprises preventive EPSDT services. **KFMC 2025 Update:** The *Provider Reference Guide* was not updated.	Not Addressed
4.	Provide more information regarding what treatment requests are covered only under EPSDT. **KFMC 2025 Update:** The *Provider Reference Guide* was not updated.	Not Addressed
5.	Address in LIBERTY's *Provider Reference Guide*, EPSDT policy and procedure, and other documents as needed, the requirement for the CE to pay claims for preventive pediatric services, including EPSDT, and then bill the responsible third-party. Ensure this process is implemented, if not already. **KFMC 2025 Update:** No new documentation was submitted to provide evidence this was done.	Not Addressed
OCH		
6.	Regarding third-party payments pertaining to preventive pediatric services, including EPSDT, address in the provider manual, EPSDT policy and procedure, and other documents as needed, the requirement for the CE to pay claims for preventive pediatric services, including EPSDT, and then bill the responsible third-party. Ensure this process is implemented, if not already. **KFMC 2025 Update:** KFMC reviewed the 2025 OCH Provider Manual. The "Third Party Liability/Coordination of Benefits" section was unchanged from the 2024 Provider Manual. There was no other reference to third-party payments in the Provider Manual or in other documentation submitted by OCH. The recommendation is not addressed.	Not Addressed

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
OCH-CSP		
1.	Regarding third-party payments pertaining to preventive pediatric services, including EPSDT, address in the provider manual, EPSDT policy and procedure, and other documents as needed, the requirement for the CE to pay claims for preventive pediatric services, including EPSDT, and then bill the responsible third-party. Ensure this process is implemented, if not already. **KFMC 2025 Update:** KFMC reviewed the 2025 OCH Provider Manual. The "Third Party Liability/Coordination of Benefits" section was unchanged from the 2024 Provider Manual. There was no other reference to third-party payments in the Provider Manual or in other documentation submitted by OCH. The recommendation is not addressed.	Not Addressed
2.	Specifically address EPSDT for the Oklahoma CSP population in member and provider handbooks, and OCH-CSP policies and procedures. **KFMC 2025 Update:** A CSP Member Handbook was created in May 2025. It addresses EPSDT. The Provider Handbook and OCH-CSP policies were not updated to specifically address EPSDT for the CSP population.	Partially Addressed
3.	In OCH-CSP policies and procedures, provider and member handbooks (as appropriate), address screening and assessment services that align with Child Welfare League of America standards for children and teens in foster care. **KFMC 2025 Update:** Neither the Provider Handbook, nor EPSDT policies, were updated to reflect the Child Welfare League of America standards for children and teens in foster care. While a CSP Member Handbook was created, it does not address screening and assessment services that align with the standards.	Not Addressed

Quality Assessment and Performance Improvement Review

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
DentaQuest		
1.	Provide the rationale for committee member selection in the Program Description. **KFMC 2025 Update:** DentaQuest reported (as documented in the DEN-1600) that committee membership is designed to ensure multidisciplinary representation across key operational and clinical areas and that member and provider representation on the committees inform the review and evaluation of quality improvement initiatives.	Fully Addressed
2.	Provide clarification on how members and providers are engaged in quality efforts and how QAPI results will be communicated to them. **KFMC 2025 Update:** DentaQuest reported (as documented in the DEN-1600) that member and provider representatives contribute to the review and evaluation of quality improvement initiatives. DentaQuest stated that QAPI findings are communicated to members and participating providers through targeted newsletters, postings on the provider and member portals, website updates, and other communication methods.	Fully Addressed
3.	Include more detail regarding performance measures in QAPI documents (i.e., include specific performance measures and rates). **KFMC 2025 Update**: DentaQuest identified (as documented in the DEN-1600) data indicators and specific performance measures it intends to monitor.	Fully Addressed
4.	Include more detail on quality improvement activities in QAPI documents. **KFMC 2025 Update**: DentaQuest submitted a high-level overview (as documented in the DEN-1600) of its quality improvement goals and objectives. The information provided did not include additional detail describing the specific quality improvement activities or how or when the tasks associated with the stated objectives would be carried out.	Partially Addressed
5.	Ensure that initiatives and activities described in the Program Description are captured in the Work Plan. **KFMC 2025 Update:** DentaQuest's Work Plan (as documented in the DEN-1600) listed a quarterly Quality Improvement Meeting and the ongoing activity of "active monitoring and evaluation of all quality metrics." The Program Description (as documented in the DEN-1600) did not describe specific initiatives or activities that would align with or supplement those listed in the Work Plan.	Partially Addressed

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
DentaQuest (Continued)		
6.	In the Work Plan, identify and include the data indicators for tracking Planned Activities, as appropriate. **KFMC 2025 Update:** DentaQuest identified performance measures and descriptions of data indicators in its Work Plan (as documented in the DEN-1600); however, the corresponding metrics or data indicators that would be used to track progress on the Planned Activities were not included.	Partially Addressed
7.	Provide details regarding quality staff training and performance improvement projects in future QAPI documents. **KFMC 2025 Update:** DentaQuest completed this recommendation.	Fully Addressed
8.	The activities described in the Program Description and Work Plan should be assessed and reported in the annual QAPI Evaluation. **KFMC 2025 Update:** DentaQuest completed this recommendation.	Fully Addressed
LIBERTY Dental		
1.	Provide the rationale for committee member selection and a list of committee members where the various committees are described in the Program Description. **KFMC 2025 Update:** LIBERTY's Program Description (as documented in the DEN-1600) includes a list of quality improvement committee members, but no members are listed for the eight subcommittees.	Partially Addressed
2.	Provide the process for reporting findings to OHCA, Participating Providers, and Enrollees in future Program Descriptions. **KFMC 2025 Update:** LIBERTY's DEN-1600 does not provide sufficient detail to understand how findings are reported to the executive management team and other relevant stakeholders.	Not Addressed
3.	Include more detail regarding performance measures in QAPI documents (i.e., include specific performance measures and rates). **KFMC 2025 Update**: The Program Description (as documented in the DEN-1600) did not provide detail about performance measure rates, or goals. LIBERTY did not include HEDIS or CAHPS data in its annual QAPI program Evaluation for measurement year 2024 or baseline rates in the Program Description (as documented in the DEN-1600).	Partially Addressed
4.	When submitting QAPI documents in 2025, include a Work Plan, and ensure that initiatives and activities described in the Program Description are captured in the Work Plan. **KFMC 2025 Update**: The Program Description (as documented in the DEN-1600) did not provide detailed descriptions of QAPI program initiatives or activities. The Work Plan was not submitted for review.	Not Addressed

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
LIBERTY Dental (Continued)		
5.	Provide details regarding quality staff training and performance improvement projects in future QAPI documents. **KFMC 2025 Update:** LIBERTY completed this recommendation.	Fully Addressed
6.	The activities described in the Program Description and Work Plan should be assessed and reported in the annual QAPI Evaluation. **KFMC 2025 Update:** LIBERTY lists objectives for the QAPI program, but specific activities documented in the DEN-1600 are limited to the interventions for its performance improvement project. The Work Plan was not submitted for review.	Not Addressed
Aetna		
1.	Provide the rationale for committee member selection in the Program Description. **KFMC 2025 Update:** In the 2025 QAPI Program Description (as documented in the SoonerSelect reporting template SEL-1600), Aetna provided the rationale for the selection of committee representatives for each of their QAPI program committees.	Fully Addressed
2.	Include more detail regarding performance measures in QAPI documents (i.e., include specific performance measures and rates). **KFMC 2025 Update:** Aetna described clinical measurement activities and performance measures in their Program Description and provided baseline data and goal rates for performance measures in their Annual QAPI Evaluation.	Fully Addressed
3.	Ensure that initiatives and activities described in the Program Description are captured in the Work Plan. **KFMC 2025 Update**: Aetna completed this recommendation.	Fully Addressed
4.	In the Work Plan, identify and include the data indicators for tracking Planned Activities, as appropriate. **KFMC 2025 Update**: Aetna provided a description of the activities, when the activity is to be completed or approved by the QIC, and the data indicators for the activity, when appropriate.	Fully Addressed
5.	Provide details regarding quality staff training and performance improvement projects in future QAPI documents. **KFMC 2025 Update:** Aetna's Program Description (as documented in the SEL-1600) listed the types of training, including specific topics covered. The QAPI Annual Evaluation provided the names of courses, training dates, and the number of quality staff who completed the training.	Fully Addressed
6.	The activities described in the Program Description and Work Plan should be assessed and reported in the annual QAPI Evaluation. **KFMC 2025 Update:** Aetna completed this recommendation.	Fully Addressed

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Humana		
1.	Provide the rationale for committee member selection and include a list of committee members where the various quality committees are described in the Program Description. **KFMC 2025 Update:** Humana provided the rationale for the selection of committee representatives for each of their QAPI program committees in the Program Description (as documented in the SoonerSelect reporting template SEL-1600).	Fully Addressed
2.	In future Program Descriptions, clearly distinguish Goals and Objectives. **KFMC 2025 Update:** Humana addressed the recommendation by distinguishing its quality goals from the associated objectives in the Program Description (as documented in the SoonerSelect reporting template SEL-1600).	Fully Addressed
3.	Include more detail regarding performance measures in QAPI documents (i.e., include specific performance measures and rates). **KFMC 2025 Update**: Humana provided measurable goals for specific performance measures in their Program Description (as documented in the SoonerSelect reporting template SEL-1600). In their Annual Evaluation, Humana included their CAHPS report for measurement year 2024 and documented baseline rates for HEDIS measures.	Fully Addressed
4.	Ensure that initiatives and activities described in the Program Description are captured in the Work Plan. **KFMC 2025 Update**: Humana completed this recommendation.	Fully Addressed
5.	Ensure Goals, Objectives, and Planned Activities in the Work Plan are distinct. **KFMC 2025 Update:** Humana's Work Plan (as documented in the SEL-1600) defines Goals, Objectives, and Planned Activities as separate and distinct elements.	Fully Addressed
6.	Provide details regarding quality staff training and performance improvement projects in future QAPI documents. **KFMC 2025 Update:** Humana's Program Description (as documented in the SEL-1600) described the types of training provided, including specific subjects covered. The QAPI Annual Evaluation provided the titles or subject matter of courses, training dates, and the number of quality staff who completed training. Both QAPI documents contained details regarding Humana's performance improvement projects.	Fully Addressed
7.	The activities described in the Program Description and Work Plan should be assessed and reported in the annual QAPI Evaluation. **KFMC 2025 Update:** Humana completed this recommendation.	Fully Addressed

	Follow-Up to Previous Recommendations (2024)	***2025 Completion Status***
OCH		
1.	Provide the rationale for committee member selection in the Program Description. **KFMC Update:** OCH reported (as documented in the SEL-1600) that committee members are selected based on relevant expertise, roles, and alignment with the issue under review. OCH also indicated that representation from all impacted teams is prioritized to ensure diverse perspectives and support comprehensive decision-making.	Fully Addressed
2.	Ensure that Goals and Objectives in the Program Description are clearly displayed so the reader may understand how they are connected. **KFMC Update:** OCH completed this recommendation (as documented in the SEL-1600).	Fully Addressed
3.	Include more detail regarding performance measures in QAPI documents (i.e., include specific performance measures and rates). **KFMC Update:** OCH outlined the processes used to monitor quality, including the use of dashboards, scorecards, baseline analyses, and alignment with HEDIS, CAHPS, CMS, and OHCA measures. However, the Program Description did not include specific performance rates or baselines for the measures referenced. OCH noted that the QAPI Evaluation was "based on data through 2024 and is continuously being monitored and assessed as data through Q1 2025 becomes available."	Partially Addressed
4.	Ensure that initiatives and activities described in the Program Description are captured in the Work Plan. **KFMC Update:** OCH completed this recommendation (as documented in the SEL-1600).	Fully Addressed
5.	Provide details regarding quality staff training and PIPs in future QAPI documents. **KFMC Update:** The OCH Program Description (as documented in the SEL-1600) identified the types of training provided, including the specific topics covered. The QAPI Evaluation included the names of the courses and the dates each course was offered; however, it did not report the number of quality staff who completed the training. OCH provided the objectives for the two PIPs approved by OHCA in the QAPI documents; however, no detail was included regarding the third PIP, *Increase Submissions of Notice of Pregnancy (NOP) Forms*, beyond noting that it was pending OHCA approval.	Partially Addressed
6.	The activities described in the Program Description and Work Plan should be assessed and reported in the annual QAPI Evaluation. **KFMC Update:** OCH completed this recommendation.	Fully Addressed

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
OCH-CSP		
1.	Provide the rationale for committee member selection in the Program Description. **KFMC Update:** OCH-CSP reported (as documented in the SEL-1600) that committee members are selected based on relevant expertise, roles, and alignment with the issue under review. OCH-CSP also indicated that representation from all impacted teams is prioritized to ensure diverse perspectives and support comprehensive decision-making.	Fully Addressed
2.	Provide detail on the quality improvement initiatives for the CSP population and how these efforts differ from the medical plan. **KFMC Update:** OCH-CSP described (as documented in the SEL-1600) that the CSP population is supported by dedicated Care Managers and the CSP program is overseen by the CSP and Behavioral Health Advisory Board. For this recommendation to be fully addressed, OCH-CSP should further enhance its QAPI documentation by clearly describing the distinct activities and processes, where applicable, used specifically to monitor and improve quality for the CSP population.	Partially Addressed
3.	Ensure that Goals and Objectives in the Program Description are clearly displayed so the reader may understand how they are connected. **KFMC Update:** OCH-CSP completed this recommendation (as documented in the SEL-1600).	Fully Addressed
4.	Include more detail regarding performance measures in QAPI documents (i.e., include specific performance measures and rates). **KFMC Update:** OCH-CSP outlined the processes used to monitor quality, including the use of dashboards, scorecards, baseline analyses, and alignment with HEDIS, CAHPS, CMS, and OHCA measures. However, the Program Description did not include specific performance rates or baselines for the measures referenced. OCH-CSP noted that the QAPI Evaluation was "based on data through 2024 and is continuously being monitored and assessed as data through Q1 2025 becomes available."	Partially Addressed
5.	Ensure that initiatives and activities described in the Program Description are captured in the Work Plan. **KFMC Update:** OCH-CSP completed this recommendation.	Fully Addressed

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
OCH-CSP (Continued)		
6.	Provide details regarding quality staff training and performance improvement projects in future QAPI documents. **KFMC Update:** The OCH-CSP Program Description (as documented in the SEL-1600) identifies the types of training provided, including the specific topics covered. The QAPI Evaluation includes the names of the courses and the dates each course was offered; however, it does not report the number of quality staff who completed the training. OCH-CSP provided the objectives for the two performance PIPs approved by OHCA in the QAPI documents; however, no detail was included regarding the third PIP, *Children's Specialty Program Foster Care*, beyond noting that it was pending OHCA approval.	Partially Addressed
7.	The activities described in the Program Description and Work Plan should be assessed and reported in the annual QAPI Evaluation. **KFMC Update:** OCH-CSP completed this recommendation.	Fully Addressed

Network Adequacy Validation

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
State		
1.	As intended, the State should continue to work with the CEs to improve the completeness of the provider directory files. **2025 OHCA Response:** The state continues to work with the CEs to improve the completeness of provider directory files through ongoing technical assistance, routine data validation, and oversight activities, including review of submission and follow-up on identified deficiencies. Feedback and corrective actions are communicated to ensure alignment with contractual and regulatory requirements. **2025 KFMC Update:** The State has recognized a continued need for improvements to provider directory files. Efforts aimed at improving the directories are ongoing.	In Progress
Common Among the CEs		
2.	CEs should strive to populate the Accommodations for Persons with Disabilities directory field. **2025 Aetna Response:** Aetna has updated its systems to ensure the Accommodations for Persons with Disabilities field populates in the online Provider Directory. The updates to the print Provider Directory are in progress. **2025 Humana Response:** Historically, population of the Accommodations for Persons with Disabilities directory field has relied heavily on providers to provide this information as part of their roster submission process. In order to increase capture rate, Humana is leveraging the use of internal teams, like the provider relations, to capture this information when it is not initially provided. Additionally, Humana has added this topic to our Systems of the Future Steering Committee to look at ways of implementing technology to facilitate capturing and publishing this important information for our members. **2025 Oklahoma Complete Health SoonerSelect Response:** CEs should prioritize populating the *Accommodations for Persons with Disabilities* directory field. With the rollout of the new Medicaid credentialing process on July 1, 2025, Americans with Disabilities Act (ADA) accommodation information is now being captured systematically. As credentialing progresses throughout the year, this initiative will significantly improve the accuracy and completeness of both online and printed directories. **2025 Oklahoma Complete Health Children's Specialty Program Response:** CEs should prioritize populating the *Accommodations for Persons with Disabilities* directory field. With the rollout of the new Medicaid credentialing process on July 1, 2025, ADA accommodation information is now being captured systematically. As credentialing progresses throughout the year, this initiative will significantly improve the accuracy and completeness of both online and printed directories.	In Progress ABH, HHH, OCH, OCH-CSP, DentaQuest, LIBERTY

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the CEs (Continued)		
	2025 DentaQuest Response: Provider directory accuracy is a priority we address during our daily interactions with providers through general inquiries. To maintain this accuracy, the Provider Engagement team conducts quarterly reviews of provider fields based on information gathered directly from providers. Additionally, we currently have inquiries regarding Accommodations for Persons with disabilities, which are included within the credentialing application. We are excited about the potential enhancements that our new internal platform, Jira, can potentially offer in improving these responses. These enhancements aim to provide a more robust and efficient way to manage and improve the content questions. We are in the process of thoroughly reviewing the overall capabilities of the Jira program to leverage its full potential for our needs. **2025 LIBERTY Response:** We have made this update but agree to needed identifiers for ADA. **2025 KFMC Update:** KFMC considers this recommendation to be In Progress. Any area that continues to be an opportunity for improvement will result in a recommendation based on current evaluation efforts.	
3.	CEs should ensure that the technical specifications for the network adequacy report are unambiguous to allow for better interrater reliability and to limit the potential for misinterpretation. **2025 Aetna Response:** Aetna adheres to the technical specifications for network adequacy reporting as outlined by OHCA. If OHCA identifies any potential ambiguities, Aetna collaborates with OHCA and other CEs as needed, to minimize any risk of misinterpretation and ensure interrater reliability is clear. **2025 Humana Response:** In order to ensure that the technical aspects of network adequacy reporting are unambiguous, Humana has established quarterly network adequacy meetings with OHCA, Oklahoma Complete Health, and Better Health Oklahoma. This joint meeting is a time to discuss/resolve any questions, changes, or concerns related to the technical aspects of network adequacy like the SEL-1101 and SEL-1102. **2025 Oklahoma Complete Health SoonerSelect Response:** To reduce ambiguity and improve interrater reliability, CEs must ensure technical specifications for network adequacy reports are clear and standardized. Feedback from OHCA and KFMC has informed refinements to our network adequacy mapping, minimizing misinterpretation and enhancing reporting accuracy. **2025 Oklahoma Complete Health Children's Specialty Program Response:** To reduce ambiguity and improve interrater reliability, CEs must ensure technical specifications for network adequacy reports are clear and standardized. Feedback from OHCA and KFMC has informed refinements to our network adequacy mapping, minimizing misinterpretation and enhancing reporting accuracy. **2025 DentaQuest Response:** At this time, there have been no updates regarding the technical specifications. Due to the recent changes in the template, we have not been able to initiate this process until we can confirm the long-term consistency of the reporting template. We are continually reviewing opportunities within the new reporting templates to streamline this process. Additionally, we are open to reviewing potential misinterpretations for future adjustments. We appreciate your understanding and will keep you updated on any progress.	In Progress ABH, HHH, OCH, OCH-CSP, DentaQuest, LIBERTY

	Follow-Up to Previous Recommendations (2024)	2025 Completion Status
Common Among the CEs (Continued)		
	2025 LIBERTY Response: CEs and OHCA should work with each organizational SMEs [Subject Matter Expert] to create clear specifications and guidance. CEs being consulted prior in all processes would reduce ambiguity. **2025 KFMC Update:** KFMC considers this recommendation to be In Progress. Any area that continues to be an opportunity for improvement will result in a recommendation based on current evaluation efforts.	
4.	CEs should work together, and with the State, to ensure that providers and locations are counted consistently among all medical and the dental CEs. This would allow for a more accurate comparison between each of the medical and dental CE's networks. **2025 Aetna Response:** Aetna collaborates with other CEs on a quarterly basis to review commonalities in OHCA's evaluations and compare counts, results, and reporting. This process fosters a shared learning and promotes consistency in reporting to OHCA. Additionally, Aetna engages in ad hoc projects to address identified gaps – such as Maternal Fetal Medicine ("MFE") – and develop mutually beneficial solutions that strengthen network adequacy for our collective membership. **2025 Humana Response:** Humana has established a quarterly network adequacy meeting cadence with Oklahoma Complete Health, Better Health Oklahoma, and OHCA. This time is used to discuss challenges and strategies around improving network adequacy in Oklahoma. Topics of discussion often include provider counts and locations, along with any variances among the 3 CEs. This meeting has been very helpful in improving alignment across network adequacy reporting to OHCA. This meeting and continuing to improve alignment will remain a priority for 2026. **2025 Oklahoma Complete Health SoonerSelect Response:** CEs should work collaboratively – with each other and the State – to ensure consistent counting of providers and locations across medical and dental networks. This alignment will enable accurate comparisons and support efforts to address gaps in rural areas. Quarterly meetings with CE partners are ongoing to validate uniform procedures and explore opportunities for network improvement. **2025 Oklahoma Complete Health Children's Specialty Program Response:** CEs should work collaboratively – with each other and the State – to ensure consistent counting of providers and locations across medical and dental networks. This alignment will enable accurate comparisons and support efforts to address gaps in rural areas. Quarterly meetings with CE partners are ongoing to validate uniform procedures and explore opportunities for network improvement. **2025 DentaQuest Response:** There are certain provider specialties we have that do not align with those of LIBERTY. This issue has been raised previously, and we welcome any efforts to achieve greater continuity and consistency between our programs and the OHCA. By aligning our specialties more closely, we can ensure a smoother and more integrated experience for all involved parties. **2025 LIBERTY Response:** LIBERTY did not provide a response. **2025 KFMC Update:** KFMC considers this recommendation to be In Progress. Any area that continues to be an opportunity for improvement will result in a recommendation based on current evaluation efforts.	In Progress ABH, HHH, OCH, OCH-CSP, DentaQuest, LIBERTY

Appendix E

SoonerSelect Program Annual External Quality Review Technical Report

2025-2026 Reporting Cycle

List of Abbreviations and Acronyms

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
ADA	Americans with Disabilities
Aetna or ABH	Aetna Better Health of Oklahoma
ATR	Annual Technical Report
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CCC	Children with Chronic Conditions
CE	Contracted Entities
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program (Title XXI)
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CSP	Children's Specialty Program
DQ	DentaQuest
ED	Emergency Department
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FM	Fully Met
FUA	Follow-up After Emergency Department Visit for Substance Use
FUH	Follow-Up After Hospitalization for Mental Illness
FUM	Follow-up After Emergency Department Visit for Mental Illness
HEDIS	Healthcare Effectiveness Data and Information Set
HRS	Health Risk Screening
Humana or HHH	Humana Healthy Horizons in Oklahoma
ISCA	Information Systems Capabilities Assessment
KFMC	KFMC Health Improvement Partners
LIBERTY or LD	LIBERTY Dental Plan
LOPO	Local Oklahoma Provider Organization
MCO	Managed Care Organization
MM	Minimally Met
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NM	Not Met
NOP	Notification of Pregnancy
NPI	National Program Identifier
NR	Not Reported
OCH	Oklahoma Complete Health
OCH-CSP	Oklahoma Complete Health - Children's Specialty Program
OHCA	Oklahoma Health Care Authority
OHS	Oklahoma Human Services

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
ORM	Office Reference Manual
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCD	Primary Care Dentists
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PM	Partially Met
PMV	Performance Measures Validation
QS	Quality Strategy
RC	Reporting Cycle
PIP	Performance Improvement Project
PA	Prior Authorization
QAPI	Quality Assessment and Performance Improvement
QIC	Quality Improvement Committee
SDOH	Social Determinants of Health
SM	Substantially Met
UM	Utilization Management