Managed Care Program Annual Report (MCPAR) for Oklahoma: SoonerSelect Dental

Due date	Last edited	Edited by	Status
12/27/2025	12/23/2025	Mavredes Stephanie	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected
	Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If “No”, please complete the following questions under each plan.	Plan to submit on 12/27/2025

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Oklahoma
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Stephanie Mavredes
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	stephanie.mavredes@okhca.org
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Mavredes Stephanie
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	stephanie.mavredes@okhca.org
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/23/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	02/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2025
A6	**Program name** Auto-populated from report dashboard.	SoonerSelect Dental

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

	Indicator	Response
	Plan name	DentaQuest USA Insurance Company Liberty Dental Plan of Oklahoma

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Oklahoma Health Care Authority Eligibility and Coverage Services Unit Maximus, Inc.

Add In Lieu of Services and Settings (A.9)

Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

Indicator	Response
ILOS name	

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,046,756
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	620,281

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter “No PI activities were performed during the reporting period” as your response. “N/A” is not an acceptable response.	The OHCA Program Integrity unit regularly conducts reviews of network providers to identify and address potential fraud, waste and abuse. The OHCA also reviews PAHP operational reports to identify potential over- and under-utilization for further investigation.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 1.18.11: Overpayments to Providers
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard selected in indicator B.X.2.	The State allows Contracted Entities (CEs) to retain recovery of overpayments resulting from waste or abuse audits that originated with the CE. If a fraud referral originates from the CE, the State first retains its costs of pursuing the action and actual documented loss; the State pays the remainder to the CE, up to its documented loss. If the State identifies an overpayment to a provider, it may recover the funds from the CE, which in turn may then recover from the provider.

BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	Contracted Entities (CEs) must report overpayments due to fraud within three business days of identification or recovery. CEs must report overpayments due to abuse within 30 calendar days of identification or recovery. CEs must report monthly on all payment errors and recoveries. The State monitors compliance as part of regular oversight activities.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The Contracted Entity (CE) is responsible for performing a monthly reconciliation of enrollment roster data against Capitation Payments and notifying OHCA of discrepancies in accordance with 42 C.F.R. § 438.608(c)(3). In addition, the CE must promptly notify OHCA when the CE or a Subcontractor receives information about changes in an Enrollee's circumstances that may affect the Enrollee's eligibility to participate in the program. The information is provided on a weekly basis.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	Contracted Entities (CEs) must report monthly on provider terminations using a State-developed reporting template. The template does not currently classify by termination type. However, the State is adding a column for this purpose. The State will be monitoring timeliness using the revised template and by documenting the date the termination is

		reported through the SoonerSelect dashboard tool. Terminations must be reported within 10 days of their occurrence.
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	No such audits were conducted during the reporting year (year 1). The State and EQRO will conduct audits in future contract years.

Topic XIII. Prior Authorization

Beginning June 2026, Indicators B.XIII.1a-b–2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	SoonerSelect Dental Program Dental Contract
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	08/01/2023
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://oklahoma.gov/ohca/soonerselect/contracts.html
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Prepaid Ambulatory Health Plan (PAHP)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Dental
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter “N/A” if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per	615,334

	month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter “There were no major changes to the population or benefits during the reporting year” as your response. “N/A” is not an acceptable response.	There were no major changes to the population or benefits during the reporting year.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Quality/performance measurement Monitoring and reporting Program integrity
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	1.19.5 SoonerSelect Dental Enrollee Encounter Data

C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Appendix 1E: Liquidated Damages
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with “N/A” if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter “The state did not experience any barriers to collecting or validating encounter data during the reporting year” as your response. “N/A” is not an acceptable response.	During the initial months of the program, Contracted Entities (CEs) had difficulties getting all encounters to pass OHCA edits, particularly those related to provider identification. Performance is improving.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	Timely resolution is defined as no longer than 30 calendar days from the day the Contracted Entity (CE) receives the appeal (see contract section 1.16.7.3: Timeframe for Standard Appeal Resolution).
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	Timely resolution is defined as no longer than 72 hours after the Contracted Entity (CE) receives the expedited appeal (see contract section 1.16.7.4: Timeframe for Expedited Resolution).

C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	Timely resolution is defined as no longer than 30 calendar days from the day the Contracted Entity (CE) receives the grievance (see contract section 1.16.6.11: Timeframe for Resolution of Grievance).

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	Under fee-for-service, the Medicaid program historically faced challenges with dental provider participation. The SoonerSelect Dental Contracted Entities (CEs) at the start of the program faced the same challenges, which they are working to address.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	Contracted Entities (CEs) must submit semi-annual network adequacy reports that identify gaps and steps being taken to address. The OHCA reviews these reports and follows-up as appropriate.

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	SoonerSelect member portal of OHCA website is located at: https://oklahoma.gov/ohca/soonerselect/choice-counseling.html
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Beneficiary Support Services are available through the internet, by telephone and in-person. All services are offered in English and Spanish; the BSS uses a third-party language line to accommodate individuals with other language needs. Hearing impaired persons can receive telephone assistance via the state's 711 line. The BSS website meets ADA/WCAG requirements. In-person assistance is available through state agency, tribal and community partners with access to the OHCA electronic eligibility application.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	N/A
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The BSS conducts ongoing supervisory audits of customer service representative performance. The BSS provides the OHCA with a monthly Key Performance Indicators report that includes a quality score based on audit findings. The quality score is based, among other factors, on whether the caller is provided appropriate information about programs relevant programs to their circumstances. The BSS also provides data on call center performance, including volume and average time to answer. The data is stratified to break-out Choice Counseling activities from other components.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If “Yes”, please complete the following questions.	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**DentaQuest USA Insurance Company** 273,218 **Liberty Dental Plan of Oklahoma** 342,116
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid enrollment (B.I.1)	**DentaQuest USA Insurance Company** 26.1% **Liberty Dental Plan of Oklahoma** 32.7%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**DentaQuest USA Insurance Company** 44% **Liberty Dental Plan of Oklahoma** 55.2%
D1I.4: Parent	**Organization: The name of the parent entity that controls the Medicaid Managed Care Plan.** If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.	**DentaQuest USA Insurance Company** Sun Life Financial, Inc. **Liberty Dental Plan of Oklahoma** Liberty Dental Plan Corporation

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**DentaQuest USA Insurance Company** 106.9% **Liberty Dental Plan of Oklahoma** 92.7%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**DentaQuest USA Insurance Company** Statewide all programs & populations **Liberty Dental Plan of Oklahoma** Statewide all programs & populations
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter “N/A” if not applicable. See glossary for the regulatory definition of MLR.	**DentaQuest USA Insurance Company** TANF - child and parent Expansion Custody and Adoption Former Foster Care **Liberty Dental Plan of Oklahoma** TANF - child and parent Expansion Custody and Adoption Former Foster Care
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**DentaQuest USA Insurance Company** Yes **Liberty Dental Plan of Oklahoma** Yes

N/A	Enter the start date.	**DentaQuest USA Insurance Company** 07/01/2024 **Liberty Dental Plan of Oklahoma** 07/01/2024
N/A	Enter the end date.	**DentaQuest USA Insurance Company** 06/30/2025 **Liberty Dental Plan of Oklahoma** 06/30/2025

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**DentaQuest USA Insurance Company** The Contracted Entity (CE) shall collect and submit Encounter Data to the OHCA MMIS within seven days of adjudication for dental claims. (Refer to Contract Section 1.19.5.3 Timeliness) Within 30 days of receipt of notice by OHCA of encounters being denied or rejected, the CE must accurately resubmit 100 percent of all encounters. (Refer to Contract Section 1.19.5.4 Timeliness Remediation) **Liberty Dental Plan of Oklahoma** The Contracted Entity (CE) shall collect and submit Encounter Data to the OHCA MMIS within seven days of adjudication for dental claims. (Refer to Contract Section 1.19.5.3 Timeliness) Within 30 days of receipt of notice by OHCA of encounters being denied or rejected, the CE must accurately resubmit 100 percent of all encounters. (Refer to Contract Section 1.19.5.4 Timeliness Remediation)
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**DentaQuest USA Insurance Company** 85.6% **Liberty Dental Plan of Oklahoma** 99.4%

D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**DentaQuest USA Insurance Company** 100% **Liberty Dental Plan of Oklahoma** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year.An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**DentaQuest USA Insurance Company** 1,087 **Liberty Dental Plan of Oklahoma** 138
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	**DentaQuest USA Insurance Company** 295 **Liberty Dental Plan of Oklahoma** 29
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	**DentaQuest USA Insurance Company** 77 **Liberty Dental Plan of Oklahoma** 10
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**DentaQuest USA Insurance Company** 49 **Liberty Dental Plan of Oklahoma** 10
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma**

	of LTSS users. Enter “N/A” if not applicable.An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	N/A
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”.Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”.The appeal and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.5a	**Standard appeals for which timely resolution was**	**DentaQuest USA Insurance Company**

	provided Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year.See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	1,121 **Liberty Dental Plan of Oklahoma** 148
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year.See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**DentaQuest USA Insurance Company** 21 **Liberty Dental Plan of Oklahoma** 14
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**DentaQuest USA Insurance Company** 1,094 **Liberty Dental Plan of Oklahoma** 154
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0

	payment for a service that was already rendered.	
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 5
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services.Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A

	substance use services. If the managed care plan does not cover outpatient behavioral health services, enter “N/A”.	
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter “N/A”.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter “N/A”.	**DentaQuest USA Insurance Company** 1,087 **Liberty Dental Plan of Oklahoma** 138

D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.7k:	**Resolved appeals related to durable medical equipment (DME) & supplies** Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.7l:	**Resolved appeals related to home health / hospice** Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.7m:	**Resolved appeals related to emergency services / emergency department** Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.7n:	**Resolved appeals related to therapies** Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A

	the managed care plan does not cover this type of service, enter “N/A”.	
D1IV.7o	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	**DentaQuest USA Insurance Company** 4 **Liberty Dental Plan of Oklahoma** 2
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**DentaQuest USA Insurance Company** 1 **Liberty Dental Plan of Oklahoma** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**DentaQuest USA Insurance Company** 2 **Liberty Dental Plan of Oklahoma** 0
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter “N/A”.External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A

D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A".External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.A grievance is “resolved” when it has reached completion and been closed by the plan.	**DentaQuest USA Insurance Company** 169 **Liberty Dental Plan of Oklahoma** 302
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**DentaQuest USA Insurance Company** 12 **Liberty Dental Plan of Oklahoma** 13
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users.An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A

	an LTSS user.If the managed care plan does not cover LTSS, the state should enter “N/A” in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter “N/A” in this field.To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year.See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**DentaQuest USA Insurance Company** 165 **Liberty Dental Plan of Oklahoma** 280

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma**

	were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	N/A
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter “N/A”.	**DentaQuest USA Insurance Company** 169 **Liberty Dental Plan of Oklahoma** 302

D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.15k	**Resolved grievances related to durable medical equipment (DME) & supplies** Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.15l	**Resolved grievances related to home health / hospice** Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.15m	**Resolved grievances related to emergency services / emergency department** Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A
D1IV.15n	**Resolved grievances related to therapies** Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A

	respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.	
D1IV.15o	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter “N/A”.	**DentaQuest USA Insurance Company** N/A **Liberty Dental Plan of Oklahoma** N/A

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service.Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**DentaQuest USA Insurance Company** 4 **Liberty Dental Plan of Oklahoma** 0
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management.Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0
D1IV.16c	**Resolved grievances related to network adequacy or access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**DentaQuest USA Insurance Company** 27 **Liberty Dental Plan of Oklahoma** 38
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care.Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**DentaQuest USA Insurance Company** 71 **Liberty Dental Plan of Oklahoma** 168
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the	**DentaQuest USA Insurance Company**

	reporting year that were related to plan communications.Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	0 **Liberty Dental Plan of Oklahoma** 0
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**DentaQuest USA Insurance Company** 55 **Liberty Dental Plan of Oklahoma** 0
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud.Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation.Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0

D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal.Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**DentaQuest USA Insurance Company** 31 **Liberty Dental Plan of Oklahoma** 122

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 5

Complete

D2.VII.1 Measure Name: OEV - Oral evaluation

1 / 5

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

0897

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 02/01/2024 - 12/31/2024

D2.VII.8 Measure Description

This is part of a standardized national measure set.

Measure results

DentaQuest USA Insurance Company

48.55%

Liberty Dental Plan of Oklahoma

47.80%

Complete

D2.VII.1 Measure Name: PEV - Periodontal evaluation

2 / 5

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

TBD

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 02/01/2024 - 12/31/2024

D2.VII.8 Measure Description

This is part of a standardized national measure set.

Measure results

DentaQuest USA Insurance Company

Not Yet Reportable

Liberty Dental Plan of Oklahoma

Not Yet Reportable

Complete

D2.VII.1 Measure Name: SFM - Sealant receipt on permanent first molars - Rate 1

3 / 5

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

0830

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 02/01/2024 - 12/31/2024

D2.VII.8 Measure Description

This is part of a standardized national measure set.

Measure results

DentaQuest USA Insurance Company

Not Yet Reportable

Liberty Dental Plan of Oklahoma

Not Yet Reportable

Complete

D2.VII.1 Measure Name: SFM - Sealant receipt on permanent first molars - Rate 2

4 / 5

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

0830

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 02/01/2024 - 12/31/2024

D2.VII.8 Measure Description

This is part of a standardized national measure set.

Measure results

DentaQuest USA Insurance Company

Not Yet Reportable

Liberty Dental Plan of Oklahoma

Not Yet Reportable

Complete

D2.VII.1 Measure Name: TFL - Topical fluoride

5 / 5

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

1672

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 02/01/2024 - 12/31/2024

D2.VII.8 Measure Description

There are three metrics for this standardized measure set: (1) dental or oral health services, (2) dental services, and (3) oral health services. Only metric 2 is applicable for the SoonerSelect Dental program.

Measure results

DentaQuest USA Insurance Company

Not Yet Reportable

Liberty Dental Plan of Oklahoma

Not Yet Reportable

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count: 8

Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 8

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

DentaQuest USA Insurance Company

D3.VIII.4 Reason for intervention

Failure to meet reporting requirements for data quality and timeliness.

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

$37,500

D3.VIII.7 Date assessed

06/06/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

2 / 8

D3.VIII.2 Plan performance issue

Contract Compliance

D3.VIII.3 Plan name

DentaQuest USA Insurance Company

D3.VIII.4 Reason for intervention

Failure to meet call center performance standards for timeliness

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

$170,000

D3.VIII.7 Date assessed

06/06/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 8

D3.VIII.2 Plan performance issue

Contract Compliance

D3.VIII.3 Plan name

DentaQuest USA Insurance Company

D3.VIII.4 Reason for intervention

Failure to meet prior authorization performance standards for timeliness

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

06/06/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

4 / 8

D3.VIII.2 Plan performance issue

Contract Compliance

D3.VIII.3 Plan name

DentaQuest USA Insurance Company

D3.VIII.4 Reason for intervention

Failure to incorporate appropriate credentialing performance standards for timeliness in policies and procedures.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

05/17/2024

Yes, remediated 09/10/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

5 / 8

D3.VIII.2 Plan performance issue

Contract Compliance

D3.VIII.3 Plan name

Liberty Dental Plan of Oklahoma

D3.VIII.4 Reason for intervention

Failure to meet prior authorization performance standards for timeliness.

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$20,000

D3.VIII.7 Date assessed

06/06/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

6 / 8

D3.VIII.2 Plan performance issue

Contract Compliance

D3.VIII.3 Plan name

Liberty Dental Plan of Oklahoma

D3.VIII.4 Reason for intervention

Failure to meet claims adjudication performance standards for timeliness.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

06/06/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

7 / 8

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Liberty Dental Plan of Oklahoma

D3.VIII.4 Reason for intervention

Failure to meet reporting requirements for data quality, timeliness, incorrect template, incorrect reporting period and failure to submit a required report.

Sanction details

D3.VIII.5 Instances of non-compliance

21

D3.VIII.6 Sanction amount

$80,000

D3.VIII.7 Date assessed

06/06/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

8 / 8

D3.VIII.2 Plan performance issue

Contract Compliance

D3.VIII.3 Plan name

Liberty Dental Plan of Oklahoma

D3.VIII.4 Reason for intervention

Modification to process for routing of call center overflow calls

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/01/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/10/2024

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**DentaQuest USA Insurance Company** 4 **Liberty Dental Plan of Oklahoma** 6
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**DentaQuest USA Insurance Company** 5 **Liberty Dental Plan of Oklahoma** 49
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**DentaQuest USA Insurance Company** 1 **Liberty Dental Plan of Oklahoma** 5
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**DentaQuest USA Insurance Company** Makes some referrals to the SMA and others directly to the MFCU **Liberty Dental Plan of Oklahoma** Makes some referrals to the SMA and others directly to the MFCU
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made to the SMA and the MFCU in aggregate.	**DentaQuest USA Insurance Company** 0 **Liberty Dental Plan of Oklahoma** 0
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**DentaQuest USA Insurance Company** 07/01/2024 **Liberty Dental Plan of Oklahoma** 07/01/2024

D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**DentaQuest USA Insurance Company** 06/30/2025 **Liberty Dental Plan of Oklahoma** 06/30/2025
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**DentaQuest USA Insurance Company** $7,919.95 **Liberty Dental Plan of Oklahoma** $299,438.01
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**DentaQuest USA Insurance Company** $78,651,336 **Liberty Dental Plan of Oklahoma** $101,873,916
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**DentaQuest USA Insurance Company** Weekly **Liberty Dental Plan of Oklahoma** Weekly

Topic XI: ILOS

Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**DentaQuest USA Insurance Company** Not answered **Liberty Dental Plan of Oklahoma** Not answered

Topic XIII. Prior Authorization

Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If “Yes”, please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Oklahoma Health Care Authority Eligibility and Coverage Services Unit** State Government Entity **Maximus, Inc.** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Oklahoma Health Care Authority Eligibility and Coverage Services Unit** Beneficiary Outreach Other, specify – Operation of state enrollment web portal **Maximus, Inc.** Enrollment Broker/Choice Counseling

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to “Review & submit.”

Number	Indicator	Response
F1	**Notes (optional)**	Not answered