SoonerSelect Program Annual External Quality Review Technical Report

2024-2025 Reporting Cycle

Request for Proposal No.: 8070001252

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DentaQuest, LIBERTY Dental Plan, Aetna Better Health of Oklahoma, Humana Healthy Horizons in Oklahoma, and Oklahoma Complete Health, Inc. (Medical and CSP)

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Introduction

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 Medicaid managed care). 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]

Two CEs were awarded the SoonerSelect Dental contract, LIBERTY Dental (LIBERTY) and DentaQuest; implementation of these contracts began February 1, 2024. Three CEs were awarded the SoonerSelect Medical contract: Aetna Better Health of Oklahoma (Aetna), Humana Healthy Horizons of Oklahoma (Humana), and Oklahoma Complete Health (OCH). OCH was also awarded the contract for the SoonerSelect Children's Specialty Program (CSP). Implementation for the SoonerSelect Medical and CSP contracts began April 1, 2024.

As the EQRO, KFMC evaluated services provided in 2024-2025 by the CEs, basing the evaluation on protocols developed by the Centers for Medicare & Medicaid Services (CMS), updated in February 2023. No SoonerSelect CE was exempt from external quality review. This report includes summaries of reports (submitted to the State November 2024 through April 2025) evaluating the following activities for each CE.

- Information Systems Capabilities Assessment (ISCA)
- Review of Compliance with Medicaid and CHIP Managed Care Regulations (Compliance Review)
- Network Adequacy Validation
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Evaluation

[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.

For this reporting cycle, Performance Improvement Project (PIP) Validation activities did not include evaluation of PIP results, as PIP methodology development continues at the time of this report. The PIP section below contains a summary of activities during this reporting cycle as the CEs developed their PIP methodologies. Simarly, the Quality Assessment and Performance Improvement (QAPI) Review activity did not include an evaluation of the impact and effectiveness of the CE QAPI programs, but assessed CE QAPI documentation for completeness and adherance to the SoonerSelect CE contracts. KFMC will evaluate the impact and effectiveness of the CEs' QAPI programs beginning in 2025, after the CEs have conducted their own initial evaluations of their programs (as required by the SoonerSelect CE contracts).

KFMC used and referenced the following CMS *EQR* [External Quality Review] *Protocol* worksheets and narratives in the completion of these activities[2]:

- EQR Protocol 1: Validation of Performance Improvement Projects
- EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations
- EQR Protocol 4: Validation of Network Adequacy
- EQR Appendix A: Information Systems Capabilities Assessment

As the CEs begin reporting performance measures in 2025, KFMC will begin conducting related validation activities using Protocol 2: Validation of Performance Measures.

In early 2024, KFMC began meeting with the CEs to provide education and training regarding the EQR activities described above. These "EQRO Overview" meetings covered general EQR information, as well as process details for each EQR activity to be conducted in 2024.

KFMC completed individual reports for each activity throughout the 2024-2025 reporting cycle to provide the State and CEs timely feedback on program progress. These individual reports contain more detail, and additional feedback beyond what is required, than 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.

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; and recommendations for quality improvement. In subsequent years, an assessment of the degree to which the previous year's EQRO recommendations have been addressed will be included. 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.

Most EQR-related activities require that findings be tied to access, quality, and timeliness of care. Table I.1 presents an overview of CE-level strengths and opportunities for improvement identified via the

[2] Centers for Medicare & Medicaid Services, *CMS External Quality Review (EQR) Protocols*, February 2023, OMB Control No. 0938-0786, Expires December 31, 2025.

external quality review activities conducted during the 2024-2025 reporting cycle. 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.

PIP and QAPI findings are not reflected in the table, as formal evaluations were not applicable in year one as previously noted. Additionally, findings for the Network Adequacy Validation were compiled at the SoonerSelect level and not included below.

Table I.1. CE-Level Strengths and Opportunities for Improvement

CE		Strengths (S*) and Opportunities (O*)	Domain
Review of Compliance with Medicaid and CHIP Managed Care Regulations			
DentaQuest	S	Of the 3 regulatory areas reviewed, 2 had compliance scores above 90%.	Access, Quality, Timeliness
	O	DentaQuest had the greatest opportunity for improvement within Subpart C related to regulatory area §438.100 *Enrollee Rights*.	Access, Quality, Timeliness
LIBERTY	S	Of the 3 regulatory areas reviewed, 2 had compliance scores above 90%.	Access, Quality, Timeliness
	O	LIBERTY had the greatest opportunity for improvement within Subpart C related to regulatory area §438.100 *Enrollee Rights,* and Subpart D related to regulatory area §438.210 *Coverage and authorization of services*.	Access, Quality, Timeliness
Aetna	S	Of the 3 regulatory areas reviewed, 2 had compliance scores above 90%.	Access, Quality, Timeliness
	O	Aetna had the greatest opportunity for improvement within Subpart C related to regulatory area §438.100 *Enrollee Rights,* and within Subpart D related to regulatory area §438.214 *Provider selection.*	Access, Quality, Timeliness
Humana	S	Of the 3 regulatory areas reviewed, all had compliance scores above 90%.	Access, Quality, Timeliness
	O	Humana had the greatest opportunity for improvement within Subpart C related to regulatory area §438.100 *Enrollee Rights*.	Access, Quality, Timeliness
OCH and OCH-CSP	S	Of the 3 regulatory areas reviewed, 2 had compliance scores above 90%.	Access, Quality, Timeliness
	O	OCH had the greatest opportunity for improvement within Subpart C related to regulatory area §438.100 *Enrollee Rights,* and Subpart D related to regulatory area §438.210 *Coverage and authorization of services*.	Access, Quality, Timeliness

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

Table I.1. CE-Level Strengths and Opportunities for Improvement (Continued)			
CE	**Strengths (S*) and Opportunities (O*)**		**Domain**
Information Systems Capabilities Assessment			
DentaQuest	S	• DentaQuest has processes in place to ensure regular upgrades and updates to systems without adverse incidents. • DentaQuest holds Utilization Review Accreditation Commission's (URAC's) Dental Plan Accreditation and National Committee for Quality Assurance (NCQA) accreditation for Utilization Management. • Primary and secondary data centers are geographically distant from each other. • DentaQuest provides quarterly outreach to its providers to ensure the accuracy of its provider directory.	Access, Quality, Timeliness
	O	• The ISCA was performed prior to the first full year of the implementation of managed care by SoonerSelect and DentaQuest. Pre-implementation planning, readiness reviews, and testing assisted in the successful kick-off of a new program, but it should be expected that roll out into a production environment would reveal unforeseen issues requiring close collaboration for corrections and process improvements.	Access, Quality, Timeliness
LIBERTY	S	• LIBERTY has processes in place to ensure regular upgrades and updates to systems without adverse incidents. • Primary and secondary data centers are geographically distant from each other. • LIBERTY provides quarterly outreach to its providers to ensure the accuracy of its provider directory.	Access, Quality, Timeliness
	O	• LIBERTY's response to the ISCA indicated that removal of systems access for staff would occur on the same day as staff termination or resignation. It's Access Control Policy did not address removal of access due to termination or resignation, or involuntary terminations or other high risk scenarios. • The ISCA was performed prior to the first full year of the implementation of managed care by SoonerSelect and DentaQuest. Pre-implementation planning, readiness reviews, and testing assisted in the successful kick-off of a new program, but it should be expected that roll out into a production environment would reveal unforeseen issues requiring close collaboration for corrections and process improvements.	Access, Quality, Timeliness
Aetna	S	• Aetna has processes in place to ensure regular upgrades and updates to systems without adverse incidents. • Aetna's Availity provider portal includes a direct link to the State to facilitate provider demographic updates. Aetna also assists providers with updates during provider representative meetings with providers and during weekly "office hours." • Aetna's SoonerSelect plan is in the process of obtaining NCQA Health Plan accreditation (expected May 2025).	Access, Quality, Timeliness
	O	• Although Aetna has geographically distant data centers, the primary and secondary data centers used for SoonerSelect are in close geographic proximity. • Aetna's quarterly verification regarding consistency of data from the State that is used for the on-line provider directory against provider-submitted data is limited to a random sample of five to ten providers. • The ISCA was performed prior to the first full year of the implementation of managed care by SoonerSelect and Aetna. Pre-implementation planning, readiness reviews, and testing assisted in the successful kick-off of a new program, but it should be expected that rollout into a production environment would reveal unforeseen issues requiring close collaboration for corrections and process improvements.	Access, Quality, Timeliness
* S = Strength: High performance or notable mentions/O = Opportunity: Low performance			

Table I.1. CE-Level Strengths and Opportunities for Improvement

CE		Strengths (S*) and Opportunities (O*)	Domain
Information Systems Capabilities Assessment (Continued)			
Humana	S	• Humana's claims processing staff have met performance goals since implementation of the plan in April 2024. • Humana provided an abundance of quality documentation outlining organization standards, business processes, and system and data workflows. • Humana's SoonerSelect plan is in the process of obtaining NCQA Health Plan accreditation (expected September 2025).	Access, Quality, Timeliness
	O	• The locations of Humana's primary and secondary data centers used for SoonerSelect are in close geographic proximity. • The ISCA was performed prior to the first full year of the implementation of managed care by SoonerSelect and Humana. Pre-implementation planning, readiness reviews, and testing assisted in the successful kick-off of a new program, but it should be expected that rollout into a production environment would reveal unforeseen issues requiring close collaboration for corrections and process improvements.	Access, Quality, Timeliness
OCH and OCH-CSP	S	• OCH has its own instance for claims, encounters, and enrollment systems and has control over deployment. • OCH claims processing staff have met or exceeded production, availability, financial, and payment accuracy goals since implementation of the plan in April 2024. • OCH's SoonerSelect plan is in the process of obtaining NCQA Health Plan accreditation (expected June 2025).	Access, Quality, Timeliness
	O	• OCH's member portal includes a member's medical history, care plans, authorizations, and health assessments. The member portal does not require multi-factor authentication. • The ISCA was performed prior to the first full year of the implementation of managed care by SoonerSelect and OCH. Pre-implementation planning, readiness reviews, and testing assisted in the successful kick-off of a new program, but it should be expected that rollout into a production environment would reveal unforeseen issues requiring close collaboration for corrections and process improvements.	Access, Quality, Timeliness
Early and Periodic Screening, Diagnostic, and Treatment			
DentaQuest	O	• DentaQuest had the greatest opportunities regarding the EPSDT benefit details in their enrollee and provider handbooks. • DentaQuest's provider manual did not specify that in the case of a third-party payor, the CE first pays the claim for pediatric preventive services, including EPSDT, and then bills the third-party. • DentaQuest did not submit an EPSDT policy and procedure for review. • Documentation submitted did not include processes for EPSDT reporting.	Access Quality Timeliness
Liberty	O	• LIBERTY had the greatest opportunities regarding the EPSDT benefit details in their enrollee and provider handbooks. • LIBERTY's EPSDT policy and procedure and the provider manual did not specify that in the case of a third-party payor, the CE first pays the claim for pediatric preventive services, including EPSDT, and then bills the third-party.	Access Quality Timeliness
Aetna	O	• Aetna's EPSDT policy could be misinterpreted that assistance with scheduling is only pertaining to scheduling transportation, whereas it should be assistance with scheduling appointments and assisting with transportation to the appointments. • In the member and provider handbooks, links to more EPSDT information were to home pages, requiring further searching and the information wasn't easy to find.	Access Quality Timeliness

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

Table I.1. CE-Level Strengths and Opportunities for Improvement			
CE	**Strengths (S*) and Opportunities (O*)**		**Domain**
Early and Periodic Screening, Diagnostic, and Treatment (Continued)			
Humana	S	• Humana has a monthly Oklahoma Market EPSDT Workgroup meeting that brings the various departmental teams together to focus on how to meet the goal of EPSDT.	Quality
	O	• In the member and provider handbooks, links to more EPSDT information were to home pages, requiring further searching and the information wasn't easy to find.	Access Quality
OCH	O	• OCH's EPSDT policy and procedure and the provider manual did not specify that in the case of a third-party payor, the CE first pays the claim for pediatric preventive services, including EPSDT, and then bills the third-party. • In the member and provider handbooks, links to more EPSDT information were to home pages, requiring further searching and the information wasn't easy to find.	Access Quality Timeliness
OCH-CSP	O	• The greatest opportunities were regarding policies and procedures, member and provider handbooks and other documentation not being individualized for the specific needs of the CSP population. • OCH-CSP's EPSDT policy and procedure and the provider manual did not specify that in the case of a third-party payor, the CE first pays the claim for pediatric preventive services, including EPSDT, and then bills the third-party.	Access Quality Timeliness
* S = Strength: High performance or notable mentions/O = Opportunity: Low performance			

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Summary of Individual EQR Components

1. *Performance Improvement Project Validation*

Background/Objectives

As noted in SoonerSelect CE Dental Contract section 1.10.6, DentaQuest and LIBERTY are each required to conduct at least two PIPs annually. Section 1.11.6 of the Medical and CSP SoonerSelect contracts require Aetna, Humana, OCH and OCH-CSP to each conduct at least three PIPs annually. The first year of the CE contracts focused on proposed PIP topics and methodologies. The purpose of KFMC's review in 2024-2025 was to evaluate the PIP proposals and provide CE technical assistance, to help ensure they are designed in a methodologically sound and robust manner. The objective is for the CEs to design PIPs that will achieve and sustain significant improvement in the identified concern, leading to improved health outcomes.

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

In 2024-2025, regular interagency meetings occurred that included focused PIP discussions among staff from OHCA, KFMC, and each of the CEs. KFMC provided feedback on PIP topic proposals and PIP methodologies, including PIP aim and goals, interventions, measure technical specifications, and data analytic plans.

In early 2024, KFMC worked with OHCA to review and approve each CE's PIP topics that they would work on during this contract cycle. Once topics were approved, KFMC distributed electronic copies of the *PIP Reporting Template* and *PIP Instructional Guide*. KFMC facilitated virtual meetings with OHCA and the CEs to review next steps, including use of the template and instructional guide. These documents outline nine steps for designing and conducting PIPs and provide key points to consider for each step.

With the first year of PIP methodology submissions, each PIP has gone through at least a few cycles of the CE submitting a draft, KFMC and OHCA reviewing the draft and providing written feedback via comments in the document, and conducting feedback meetings with the CE and OHCA before the CE completes revisions and resubmits the methodology. Following is a summary of KFMC activities over the past year, by CE and PIP topic.

- DentaQuest
  - *Increase Utilization of Sealant Receipt on Permanent Molars by Age 10* PIP methodology was submitted for review in March 2024. KFMC provided feedback and several revisions were submitted by DentaQuest. DentaQuest requested a new PIP topic, *Increase the Percentage of Children Receiving a Dental Visit by their First Birthday*, in December 2024.
  - *Increase the Percentage of Children Receiving a Dental Visit by their First Birthday* PIP methodology was initially received on 2/21/2025 for review. At that time, KFMC completed their initial review and provided feedback for revisions. KFMC plans to conduct feedback meetings with DentaQuest over the next few months to discuss revisions and questions. Anticipated approval is set for June 2025.
  - *Oral Health Literacy Assessment for Oklahoma American Indians and Alaska Natives (AI/AN) Adults* PIP methodology was received from DentaQuest on 3/6/2025 for review. KFMC will complete this review and provide feedback for revisions. Feedback meetings with DentaQuest

will be scheduled to discuss revisions and questions with an anticipated approval date in June 2025.

- LIBERTY
  - *Increasing Preventative Services for Children* PIP methodology final evaluation was completed on 2/24/2025. The methodology evaluation consisted of 14 methodology submission revisions with feedback provided to LIBERTY, and 4 feedback meetings were held with LIBERTY to discuss the feedback and address any questions. Final PIP methodology approval was given by OHCA on 2/27/2025.
  - *Improving Access to Care through Appointment Scheduling and Transportation Assistance* PIP methodology was submitted on 2/27/2025 for review. KFMC completed their initial review and feedback for revisions was provided. Feedback meetings with LIBERTY will be scheduled over the next few months. Anticipated approval is set for June 2025.
- Aetna
  - The final review for the *Childhood Immunization Status Combo 3* PIP methodology was completed by KFMC on 1/9/2025. The Childhood Immunization Status Combo 3 methodology evaluation consisted of 9 methodology submission revisions, with feedback provided to Aetna, and 2 meetings were held with Aetna to discuss the feedback and address any questions. PIP methodology approval was given by OHCA on 1/30/2025.
  - *Improve Rate of Follow-Up Care for Children Prescribed ADHD* [Attention-Deficit/Hyperactivity Disorder] *Medication, Initiation and Continuation Sub Measures* PIP methodology was initially received on 2/18/2025 for review. KFMC completed their initial review and feedback for revisions was provided. Feedback meetings with Aetna will be scheduled over the next few months to discuss revisions and questions. Anticipated approval is set for June 2025.
  - *Improving Social Determinants of Health (SDOH) Assessment in Adults 18-64* PIP methodology was initially received on 2/28/2025 for review. KFMC is currently completing an initial review. Feedback for revisions will be provided to Aetna once the initial review is complete. Feedback meetings with Aetna will be scheduled to discuss revisions and questions. Anticipated approval is set for June 2025.
- Humana
  - *Comprehensive Diabetes Care (Hemoglobin HbA1c Control for Patients with Diabetes)* PIP methodology final evaluation was completed by KFMC on 2/3/2025. This methodology evaluation consisted of 8 methodology submission revisions; feedback was provided to Humana and 3 meetings were held to discuss the feedback and talk through any questions. Approval for the Comprehensive Diabetes Care (Hemoglobin HbA1c Control for Patients with Diabetes) PIP methodology was given by OHCA on 2/26/2025.
  - *Follow-up After Hospitalizations for Mental Illness* PIP methodology was received on 3/7/2025 for review. Anticipated approval is set for June 2025. KFMC will provide feedback, review revisions, and schedule feedback meetings with Humana to discuss revisions and questions before approval.
  - *SDoH* PIP methodology is scheduled to be submitted from Humana by 3/19/2025 for review. KFMC will complete this review and provide feedback for revisions. Feedback meetings with Humana will be scheduled to discuss revisions and questions with an anticipated approval date in June 2025.
- OCH
  - *Improve Performance of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* Healthcare Effectiveness Data and Information Set (HEDIS)

Measure PIP methodology final evaluation was completed by KFMC on 2/24/2025. The methodology evaluation consisted of 8 methodology submission revisions with feedback provided; 3 meetings were held with OCH to discuss the feedback and address any questions. Approval was given by OHCA on 2/26/2025.

- *Improve Performance of the Follow-Up After Hospitalization for Mental Illness (FUH)* PIP methodology is scheduled to be submitted by 3/12/2025 for review. KFMC will complete this review and provide feedback for revisions. Feedback meetings with OCH will be scheduled to discuss revisions and questions. Anticipated approval is set for June 2025.
- *Notification of Pregnancy* PIP methodology is scheduled to be submitted for review by 3/24/2025. Anticipated approval is set for June 2025. KFMC will provide feedback, review revisions, and schedule feedback meetings with OCH to discuss revisions and questions before approval.

- OCH–CSP
  - *Improve Performance of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* HEDIS Measure & Annual Wellness Visits PIP methodology final evaluation was completed by KFMC on 2/24/2025. The methodology evaluation consisted of 8 methodology submission revisions with feedback provided; 3 meetings were held with OCH to discuss feedback provided.
  - *Improve Performance of the Follow-Up After Hospitalization for Mental Illness (FUH)* PIP methodology is scheduled to be submitted by 3/12/2025 for review. KFMC will complete this review and provide feedback for revisions. Feedback meetings with OCH will be scheduled to discuss revisions and questions. Anticipated approval is set for June 2025.
  - *Enhanced Foster Care* PIP methodology is scheduled to be submitted for review by 4/11/2025. Anticipated approval is set for June 2025. KFMC will provide feedback, review revisions, and schedule feedback meetings with OCH to discuss revisions and questions before approval.

Conclusions Drawn from the Data

KFMC provided review, feedback and technical assistance during the methodology writing and approval process, to help facilitate the design of PIP methodologies that will lead to significant improvements in the need being addressed. Each PIP has required multiple cycles of draft resubmissions, evaluations, and feedback meetings, before PIP implementation approval by OHCA.

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

Common Among the CEs

Examples of reasons for revisions included

- Clarity and detail to be increased throughout the proposal,
- Refining the AIM statement,
- Increasing the impact of the PIP through expanding the PIP population,
- Increasing the number and/or robustness of the interventions, and
- Clearly defining process and outcome measures.

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.

Recommendations for Quality Improvement

Common Among the CEs

- Increase the detail provided in the PIP methodologies to decrease the amount of follow-up questions.
- 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.
- Consider the potential impact on the PIP outcome when determining PIP and intervention population sizes, and designing interventions.

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2. 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.[3] The objective of KFMC's review is to assess the CE's 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 November 13, 2020. The Oklahoma Dental CEs submitted their documentation to KFMC on May 14, 2024, and the Medical and CSP CEs submitted their documentation to KFMC on July 10, 2024. Therefore, the CMS regulatory changes that were effective July 9, 2024, applicable to the Year 1 review (§438.10[g][2][ix] and §438.214[d][2]), were not included in this review.

The current review period is 2024-2026, with KFMC conducting one-third of the regulatory compliance review in Year 1 (2024). The remaining two-thirds will be conducted in Year 2 (2025) and Year 3 (2026), along with needed follow-up. KFMC's compliance review results for the Year 1 (2024) review is included in this *2024-2025 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 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 included policies, procedures, manuals, and other materials related to the federal regulations.

The following Medicaid Managed Care Regulatory Provisions were reviewed in Year 1 for the CEs.

- Subpart B – State Responsibilities
- Subpart C – Enrollee Rights and Protections

[3] Managed Care, 42 C.F.R. §438 (2025). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438?toc=1

- Subpart D – MCO [Managed Care Organization], PIHP [Prepaid Inpatient Health Plan] and PAHP [Prepaid Ambulatory Health Plan] Standards (§438.210 *Coverage and authorization of services* and §438.214 *Provider selection*)

The regulatory areas were divided and categorized by year reviewed per CE within the three-year review period (2024–2026), as displayed in Table 2.1.

Table 2.1. 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			
§438.330 Quality assessment and performance improvement program			X

* Reporting Cycle (RC)
^ 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 *2024 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 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. 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, Year 1 Review – 2024

For the areas reviewed in Year 1, DentaQuest and LIBERTY had the greatest opportunity for improvement within Subpart C for elements within §438.100 *Enrollee rights*.

DentaQuest, Year 1 Review – 2024

Overall, DentaQuest was 93% compliant with the federal regulatory requirements reviewed in 2024. Table 2.2 summarizes the 2024 compliance review findings for DentaQuest.

Table 2.2. Summary of 2024 Compliance Review – 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							
§438.210 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)
Subpart D Total	**17**	**(15/17)**	**(2/17)**	**(0/17)**	**(0/17)**	**(0/17)**	**97% (66/68)**
OVERALL COMPLIANCE	**37**	**(26/37)**	**(11/37)**	**(0/37)**	**(0/37)**	**(0/37)**	**93% (137/148)**

* 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). Case Review will occur in Year 3 (2026).

Of the individual regulatory areas reviewed, in 2024, within Subparts C and D, DentaQuest has the greatest opportunity for improvement within Subpart C for elements within §438.100 *Enrollee rights*.

LIBERTY, Year 1 Review – 2024

Overall, LIBERTY was 90% compliant with the federal regulatory requirements reviewed in 2024. Table 2.3 summarizes the 2024 compliance review findings for LIBERTY Dental.

Table 2.3. Summary of 2024 Compliance Review – 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^ §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							
§438.210 Coverage and authorization of services	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)
Subpart D Total	**17**	**(14/17)**	**(1/17)**	**(2/17)**	**(0/17)**	**(0/17)**	**93% (63/68)**
OVERALL COMPLIANCE	**37**	**(24/37)**	**(11/37)**	**(2/37)**	**(0/37)**	**(0/37)**	**90% (133/148)**

* 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). Case Review will occur in Year 3 (2026).

Of the individual regulatory areas reviewed, in 2024, within Subparts C and D, LIBERTY has the greatest opportunity for improvement within Subpart C for elements within §438.100 *Enrollee rights*, and Subpart D for elements within §438.210 *Coverage and authorization of services*.

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

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

Common Among the SoonerSelect Dental CEs

- DentaQuest and LIBERTY staff are knowledgeable about their jobs and the services provided to Oklahoma SoonerSelect members.
- 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

- 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.

LIBERTY

- 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.
- 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.

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

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

Common Among the Dental CEs

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

- §438.10 *Information requirements*: Federal regulatory and State Contract language updates to policies and procedures, the *Member Handbook*, and the *Provider Manual.*
- §438.210 *Coverage and authorization of services* – (c) *Notice of adverse benefit determination,* (d) *Timeframe for decisions,* and related provisions §438.404(b) and (c)(1-4) *Timely and adequate notice of adverse benefit determination:* Federal regulatory and State Contract language updates to policies and procedures and the *Member Handbook*.
- §438.100 *Enrollee rights* – (b) *Specific Rights* and (c) *Free exercise of rights:* Updates to the *Provider Manual*

DentaQuest

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

- §438.56(d)(2)(i) *Disenrollment: Requirements and limitations – Procedures for disenrollment-Cause for disenrollment*: Federal regulatory and State Contract language updates to the *Member Handbook*.
- §438.100(a) *Enrollee rights – General Rule*: Federal Regulatory and State Contract language updates to the *Member Handbook* and policies and procedures.

LIBERTY

As a result of KFMC's 2024 compliance review for LIBERTY, an opportunity was identified related to §438.56 *Disenrollment: Requirements and limitations* – (b)(3) *Disenrollment requested by the MCO, PIHP, PAHP, PCCM* [Primary Care Case Management]*, or PCCM entity* and (c)(1-2) *Disenrollment requested by the enrollee*: Federal regulatory and State Contract language updates to policies and procedures.

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

Because the Dental CE contracts began February 1, 2024, there are no prior recommendations.

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

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

Summary of 2024 Compliance Review

Table 2.4 details a summary of the CEs' overall 2024 compliance review results for Subpart C and two parts of Subpart D. 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 2.4. Summary of 2024 Compliance Review Results 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		
§438.210 Coverage and authorization of services	96%	90%
§438.214 Provider selection	100%	100%
Subpart D Total	**97%**	**93%**
OVERALL COMPLIANCE	**93%**	**90%**

SoonerSelect Medical and CSP CEs

Conclusions Drawn from the Data

Compliance

Common Among the SoonerSelect Medical and CSP CEs, Year 1 Review – 2024

For the areas reviewed for the SoonerSelect Medical and CSP CEs in Year 1, all three had the greatest opportunity for improvement within Subpart C for elements within §438.100 *Enrollee rights*.

Aetna, Year 1 Review – 2024

KFMC reviewed all regulatory areas in Subparts B and C and two regulatory areas in Subpart D in Year 1. Overall, Aetna was 90% compliant with the federal regulatory requirements reviewed in 2024. Subpart B State Responsibilities is not included because these requirements are not applicable to the health plan. Table 2.5 summarizes the 2024 compliance review findings for Aetna.

Table 2.5. Summary of 2024 Compliance Review – 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							
§438.210 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)
Subpart D Total	**18**	**(14/18)**	**(2/18)**	**(2/18)**	**(0/18)**	**(0/18)**	**92% (66/72)**
OVERALL COMPLIANCE	**44**	**(32/44)**	**(7/44)**	**(5/44)**	**(0/44)**	**(0/44)**	**90% (159/176)**

* 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). Case Review will occur in Year 3 (2026).

Of the individual regulatory areas reviewed within Subparts C and D that were reviewed in 2024, Aetna has the greatest opportunity for improvement within Subpart C for elements within §438.100 *Enrollee rights* and Subpart D for elements within §438.214 *Provider selection*.

Humana, Year 1 Review – 2024

KFMC reviewed all regulatory areas in Subparts B and C and two regulatory areas in Subpart D in Year 1. Overall, Humana was 86% compliant with the federal regulatory requirements reviewed in 2024. Subpart B State Responsibilities is not included because these requirements are not applicable to the health plan. Table 2.6 summarizes the 2024 compliance review findings for Humana Healthy Horizons.

Table 2.6. Summary of 2024 Compliance Review – 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	27	(9/27)	(12/27)	(6/27)	(0/27)	(0/27)	78% (84/108)
SUBPART C TOTAL	**27**	**(10/27)**	**(12/27)**	**(5/27)**	**(0/27)**	**(0/27)**	**80% (86/108)**
Subpart D – MCO, PIHP and PAHP Standards							
§438.210 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)
Subpart D Total	**18**	**(15/18)**	**(3/18)**	**(0/18)**	**(0/18)**	**(0/18)**	**96% (69/72)**
OVERALL COMPLIANCE	**45**	**(25/45)**	**(15/45)**	**(5/45)**	**(0/45)**	**(0/45)**	**86% (155/180)**

* 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). Case Review will occur in Year 3 (2026).

Of the individual regulatory areas reviewed within Subparts C and D that were reviewed in 2024, Humana has the greatest opportunity for improvement within Subparts C for elements within §438.100 *Enrollee rights*.

OCH, Year 1 Review – 2024

KFMC reviewed all regulatory areas in Subparts B and C and two regulatory areas in Subpart D in Year 1. Overall, OCH was 93% compliant with the federal regulatory requirements reviewed in 2024. Subpart B State Responsibilities is not included because these requirements are not applicable to the health plan. Table 2.7 summarizes the 2024 compliance review findings for OCH.

Table 2.7. Summary of 2024 Compliance Review – Oklahoma Complete Health							
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							
§438.210 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)
Subpart D Total	**18**	**(15/18)**	**(2/18)**	**(1/18)**	**(0/18)**	**(0/18)**	**94% (68/72)**
OVERALL COMPLIANCE	**45**	**(34/45)**	**(10/45)**	**(1/45)**	**(0/45)**	**(0/45)**	**93% (168/180)**

* 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). Case Review will occur in Year 3 (2026).

Of the individual regulatory areas reviewed within Subparts C and D that were reviewed in 2024, OCH has the greatest opportunity for improvement within Subpart C for elements within §438.100 *Enrollee rights* and Subpart D for elements within §438.210 *Coverage and authorization of services*.

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

As a result of KFMC's 2024 compliance review, 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.

Aetna

- Aetna has been conducting Provider Tours around the state to ensure that all providers are aware of what managed care has to offer and the services that ABH provides to members.
- Aetna was highly involved in community-level initiatives, including attendance at events such as Community Baby Showers, the Rural Health Innovation Challenge, and a Back to School Bash.
- 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 851 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 had innovative ways to track emergency department utilization and wait times, as well as fraud, waste, and abuse.

Humana

- 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's internal goals go beyond member satisfaction, and included provider satisfaction scores, as well as employee satisfaction.
- Humana utilized their Mentor system that outlined internal processes and made it easy for Customer Service Advocates to address member needs quickly and consistently.
- 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 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.

OCH and OCH-CSP

- OCH sent notification to each member to celebrate their birthday.
- Employees had 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, 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.
- Members were called within 48 hours to notify of provider terminations.
- 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 OU Health-Fostering Hope Clinic to provide trauma-informed medical homes to CSP members.
- OCH had a variety of Value-Added Benefits tailored to the unique needs of the populations within CSP.
- OCH required National Adoption Competency Mental Health Training Initiative (NTI) for staff.
- OCH had staff with personal and professional experience with the populations within the Children's Specialty Program.

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

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

Common Among the SoonerSelect CEs

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

- §438.10 *Information requirements*: Federal regulatory and State Contract language updates to policies and procedures and the *Member Handbook.*

- §438.210(c) *Coverage and authorization of services* and related provision §438.404(a-c) *Timely and adequate notice of adverse benefit determination – Notice of adverse benefit determination*: Federal regulatory and State Contract language updates to the policy and procedure and the *Provider Manual*.

Aetna

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

- §438.56(f)(1) *Disenrollment: Requirements and limitations-Notice and appeals*: Federal regulatory and State Contract language updates to policies and procedures.
- §438.10(c)(6)(v) *Information requirements:* Federal regulatory and State Contract language updates to the *Member Welcome Notice.*
- §438.100(a) *Enrollee rights*: *General rule:* Federal regulatory and State Contract language updates to policy and procedures.
- §438.210 *Coverage and authorization of services* and related provision §438.404 *Timely and adequate notice of adverse benefit determination:* Federal regulatory and State Contract language updates to policies and procedures.
- §438.214(e) *Provider selection – State requirements*: Federal regulatory and State Contract language updates to policies and procedures.

Humana

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

- §438.56 *Disenrollment – Requirements and limitations-* (a) *Applicability*, (b) *Disenrollment requested by the MCO, PIHP, PAHP, PCCM, or PCCM entity*, (e)(2) *Timeframe for disenrollment determinations*, (f)(1-2) *Notice and appeals*, and (g) *Automatic reenrollment - Contract requirement*: Federal regulatory and State Contract language updates to policies and procedures.
- §438.10 *Information requirements*: Federal regulatory and State Contract language updates to the *Provider Manual* and the Humana website.
- §438.100 *Enrollee rights*: (a)(1) *General rule*, (b) *Specific rights-* (1) *Basic requirement* and (2): Federal regulatory and State Contract language updates to policy and procedures.
- §438.114(c-d) *Emergency and poststabilization*: Federal regulatory and State Contract language updates to policy and procedure.

OCH and OCH-CSP

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

- §438.10(c)(6)(v) *Information requirements*: Federal regulatory and State Contract language updates to the *Provider Manual* and the OCH website.
- §438.100(b) *Enrollee rights*: *Specific Rights:* Federal regulatory and State Contract language updates to policy and procedures.
- §438.210(c) *Coverage and authorization of services – Notice of adverse benefit determination* and related provision §438.404(c)(1-3) *Timely and adequate notice of adverse benefit determination:* Federal regulatory and State Contract language updates to policies and procedures.

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

Because the Medical and CSP CE contracts began April 1, 2024, there are no prior recommendations.

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

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

OCH

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

Summary of 2024 Compliance Review

Table 2.8 details a summary of the CEs' overall Year 1 compliance review results for Subpart C and two parts of Subpart D. 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 2.8. Summary of 2024 Compliance Review Results 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			
§438.210 Coverage and authorization of services	92%	94%	92%
§438.214 Provider selection	90%	100%	100%
Subpart D Total	**92%**	**96%**	**94%**
OVERALL COMPLIANCE	**90%**	**86%**	**93%**

3. *Information Systems Capabilities Assessment*

Background/Objectives

The SoonerSelect CEs were required to undergo an ISCA in 2024. The ISCA is a requirement for the CMS *CMS External Quality Review (EQR) Protocols*, February 2023, Protocols 1, 2, and 3 (Performance Improvement Projects, Performance Measures, Regulatory Compliance) and applicable to Protocols 4, 5, and 7 (Network Adequacy, Encounter Data, and Additional Performance Measures). Baseline ISCAs were conducted with all CEs in the third quarter of 2024 as noted below.

The ISCA objectives were to assess the potential of the CEs' information systems (IS) on their ability to

- conduct quality assessment and improvement initiatives,
- calculate valid performance measures,
- collect and submit complete and accurate encounter data to the State, and
- oversee and manage the delivery of health care to the CEs' enrollees.

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

KFMC reviewed the State's IS requirements for contracted entities, as well as the CEs' contracts with the State to identify specific IS contractual requirements. KFMC provided the ISCA data collection tool, included in the CMS 2023 Protocols and supplemented with additional questions related to ancillary systems and provider networks, to the dental CEs in March 2024 and to the medical and CSP CEs in April 2024. The tool included text boxes to collect current information. The CEs also returned the completed tool with supporting documentation over the summer 2024. KFMC reviewed the materials, provided agendas to ensure the availability of appropriate staff, and developed follow-up questions to clarify the information provided by the CEs. Virtual meetings were held with the CEs as follows:

- DentaQuest – August 26, 2024
- LIBERTY – September 3, 2024
- Humana – September 23, 2024
- Aetna – September 24, 2024
- OCH and OCH-CSP – September 26, 2024

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

Conclusions Drawn from the Data

Common Among the CEs

The CEs are subsidiaries of national organizations. Consequently, the Oklahoma organizations 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.

Overall, the CEs' information systems appear to be adequate to manage the delivery of care to SoonerSelect enrollees. The systems and processes in place are capable of maintaining up-to-date and accurate enrollee and provider information. Claims processing procedures are sufficient to ensure timely payment to providers and availability of encounters to the State.

DentaQuest

DentaQuest's information system for claims processing and adjudication, as well as analytics and reporting, is Windward, a proprietary platform. Claims processing staff are not segregated by market. At the time of the virtual meeting, DentaQuest reported that it was meeting the State's requirements for timeliness of processing. From program implementation through August 2024, DentaQuest reported an auto-adjudication rate of 78% for claims and prior authorizations. Data from Windward are extracted to its enterprise data repository for reporting quality and performance measures.

LIBERTY

LIBERTY's information system for enrollment, providers, claims processing, other data from member and provider interactions, analysis, and reporting is Conduent's Health Solutions Plus (HSP) platform. Claims processing staff are market-specific. LIBERTY reported that processing timeliness requirements were being met. The claims auto-adjudication rate was approximately 76%. Data warehouses, updated nightly from HSP, are used to generate performance and quality data. If NCQA-certified software is required for measure reporting, LIBERTY uses Cognizant's Claims Sphere. The availability of both systems for measure calculations allows for comparison of results to ensure proper system configuration.

Aetna

Aetna's primary system for member and provider management and claims processing is Cognizant's QNXT platform. Claims processing staff are specific to the SoonerSelect market. Aetna did not meet State requirements for timeliness of processing the first two months of implementation—all claims went through quality review to ensure contract alignment which increased processing time. Aetna reported that the timeliness requirements were being met thereafter. Through September 2024, Aetna reported a claims auto-adjudication rate of 91%. Data from QNXT and supporting systems are extracted to various databases from which files are created for HEDIS performance measure analysis and reporting using Inovalon's NCQA-certified Converged Analytics platform.

Humana

Humana's primary system for claims processing is its Claims Adjudication System (CAS). Claims processing staff are specific to the SoonerSelect plan. From April through June 2024, Humana reported that the State processing timeliness requirements were being met. The claims auto-adjudication rate through August was 69%. Data from CAS and other systems are exported to Humana's Enterprise Data Warehouse from which extracts are created for reporting and analysis. Humana uses Cotiviti's NCQA-certified Quality Intelligence platform for HEDIS performance measure analysis and reporting.

OCH and OCH-CSP

Centene's (OCH parent organization) primary system for adjudicating claims is SS&C Technologies' AMISYS Advance platform. Claims processing staff are specific to the SoonerSelect medical and CSP market, but processors may work claims for other plans as needed based on claims volume. From April through September 2024, OCH reported that the timeliness requirements for processing medical claims were met; for CSP, the requirement was not met for April but was thereafter. For September, OCH reported an auto-adjudication rate of 86%. Data from Amisys are output to Centene's Enterprise Data

Warehouse for analysis and reporting. These data are subsequently extracted and together with supplemental data are loaded to Inovalon's NCQA-certified Converged Analytics platform for calculation, analysis, and reporting of HEDIS measures.

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

DentaQuest

- DentaQuest has processes in place to ensure regular upgrades and updates to systems without adverse incidents.
- DentaQuest holds URAC's Dental Plan Accreditation and NCQA accreditation for Utilization Management.
- Primary and secondary data centers are geographically distant from each other.
- DentaQuest provides quarterly outreach to its providers to ensure the accuracy of its provider directory.

LIBERTY

- LIBERTY has processes in place to ensure regular upgrades and updates to systems without adverse incidents.
- Primary and secondary data centers are geographically distant from each other.
- LIBERTY provides quarterly outreach to its providers to ensure the accuracy of its provider directory.

Aetna

- Aetna has processes in place to ensure regular upgrades and updates to systems without adverse incidents.
- Aetna's Availity provider portal includes a direct link to the State to facilitate provider demographic updates. Aetna also assists providers with updates during provider representative meetings with providers and during weekly "office hours."
- Aetna's SoonerSelect plan is in the process of obtaining NCQA Health Plan accreditation (expected May 2025).

Humana

- Humana's SoonerSelect plan is in the process of obtaining NCQA Health Plan accreditation (expected September 2025).
- Humana's claims processing staff have met performance goals since implementation of the plan in April 2024.
- Humana provided an abundance of quality documentation outlining organizational standards, business processes, and system and data workflows.

OCH and OCH-CSP

- OCH has its own instance for claims, encounters, and enrollment systems and has control over deployment.
- OCH's SoonerSelect plan is in the process of obtaining NCQA Health Plan accreditation (expected June 2025).
- OCH claims processing staff have met or exceeded production, availability, financial, and payment accuracy goals since implementation of the plan in April 2024.

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

Common Among the CEs

The ISCAs were performed prior to the first full year of the implementation of managed care by SoonerSelect and the CEs. Pre-implementation planning, readiness reviews, and testing assisted in the successful kick-off of a new program, but it should be expected that rollout into a production environment would reveal unforeseen issues requiring close collaboration for corrections and process improvements.

DentaQuest

Other than the opportunity for improvement common to all CEs, no additional opportunities for improvement were noted.

LIBERTY

LIBERTY's response to the ISCA indicated removal of access to its systems would occur on the same day as staff termination or resignation. LIBERTY's Access Control Policy did not address removal of access due to staff terminations or resignations.

Aetna

- Although Aetna has geographically distant data centers, the primary and secondary data centers used for SoonerSelect are in close geographic proximity.
- Aetna's quarterly verification regarding consistency of data from the State that is used for the on-line provider directory against provider-submitted data is limited to a random sample of five to ten providers.

Humana

The locations of Humana's primary and secondary data centers used for SoonerSelect are in close geographic proximity.

OCH and OCH-CSP

OCH's member portal includes a member's medical history, care plans, authorizations, and health assessments. The member portal does not require multi-factor authentication.

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.

Recommendations for Quality Improvement

Common Among the CEs

Technical

1. Continue to work closely with OHCA to correct issues as they arise and fine-tune processes to ensure timely and accurate data exchange, processing, and reporting. This will help provide a foundation for a quality managed care program for SoonerSelect members.

DentaQuest

No additional recommendations beyond that common to all CEs were made.

Recommendations for Quality Improvement (Continued)

LIBERTY

1. The Access Control Policy should address the removal of access due to staff terminations or resignations, including involuntary terminations or other high risk scenarios.

Aetna

1. The use of more geographically distant data centers for SoonerSelect data would reduce risk from environmental factors.
2. Increase the number of providers whose data, obtained from the State, are compared against provider-submitted data.

Humana

1. The use of more geographically distant data centers for SoonerSelect data would reduce risk from environmental factors.

OCH and OCH-CSP

1. Multi-factor authentication would improve security for the Protected Health Information (PHI) available on the member portal.

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4. *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 (DentaQuest, LIBERTY, Aetna, Humana, OCH, OCH-CSP) specify requirements for provider directory fields that are to be accurate and kept up to date. In 2024, as the External EQRO for Oklahoma, KFMC validated data and methods used to assess and report, or to reflect (i.e., provider directories), CE network adequacy. KFMC used and referenced Protocol 4: Validation of Network Adequacy of the *EQR Protocols* (hereafter referred to as Protocol 4), provided by the CMS, revised February 2023.[1]

In accordance with Activity 1 of Protocol 4, KFMC met with OHCA to define the scope of the validation for 2024. The following were considered when defining the scope of activities: the fact that the CEs have only recently begun forming networks of providers; 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.[2] KFMC focused this initial year of network adequacy validation on assessing the completeness of the provider directories and ensuring that the CE's technical specifications align with the State's expectations.

This focus aligns 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 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 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

Data Sources

- Data from Oklahoma CEs
  - November 2024 Network Adequacy Report – a report from each CE submitted to the State detailing the number of unique providers and locations that members have access to, referred to as the DEL-1101 for dental CEs and the SEL-1101 for medical and CSP CEs.
  - Print directory files – PDF files containing providers listed in the CE's online provider directory (for Aetna and Humana).
  - Online provider directories – directory information captured using the CE's online provider directory tool (for DentaQuest, LIBERTY, OCH, and OCH-CSP).
  - CE Provider List process documentation – instructions, technical specifications, or coding steps for extracting provider data for reporting on the Provider List tab of the Network Adequacy Report.
  - CE provider and location counts documentation – instructions, technical specifications, or coding steps for determining the number of unique providers and locations reported on the Distance Standard tab and the provider specialty tabs of the Network Adequacy Report.

Assessment of Online Provider Directories

The primary method for validation of the CEs' online provider directories was to manually review a random sample of 300 directory pages to confirm basic information required by the State had been populated. The aim of KFMC's review for this report was not to determine the accuracy of the directory fields, but rather to establish a baseline of directory completeness. Future efforts will be focused on validating the accuracy of the directories. The source data were posted on the CEs' websites. If a current directory was available in PDF file format, then these PDF files were downloaded for review. Otherwise, provider data were obtained by following the website's directions for members. KFMC reviewed the contracts that OHCA holds with the medical/CSP and dental CEs and reviewed the CE directories to assess the completeness of the following fields:

- Gender of Provider
- Street Address
- Telephone Number
- Website or URL Information
- Languages Available
- Accepting New Patients (required in the online provider directory only)
- Accommodations for Persons with Disabilities
- Completion of Cultural Competency Training
- Certification in Evidence Based Treatment (For Medical CEs only)
- Provider Type
- Specialty Type
- Provider Name
- Group Affiliation

The CE-OHCA contracts require the online provider directories to contain mapping capabilities. Because mapping capability is a function of the website, review of maps for each of the randomly selected directory pages was not needed. By observing the maps produced for a few addresses per CE, KFMC was able to determine that the online provider directories met this requirement.

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

Validation of CE Technical Specifications and Processes

KFMC requested the CEs submit documentation or technical specifications used to create the programming code that generates the Provider List tab, as well as the documentation or technical specifications used to determine the number of providers and number of provider locations reported in the Distance Standard tab and the provider specialty tabs (e.g., Adult PCP tab, Cardiologists tab), of the Network Adequacy report. KFMC reviewed the submissions to determine how provider data are extracted for reporting and how the CEs intend to count providers and locations on the Network Adequacy report. KFMC also attempted to calculate the number of providers and locations using the additional documentation to verify that providers and locations were counted as intended.

Conclusions Drawn from the Data

Assessment of Online Provider Directories

The intent of this validation activity was to assess the completeness of the CEs' online provider directories. The review of the directories occurred in December 2024.

For both individual practices as well as group practices, Table 4.1 shows all CEs fully populated the Provider Name, Provider Type, Provider Specialty, and Telephone Number fields. The Street Address field was also well populated by all CEs. For Humana, individual providers without an address listed were looked up in the online provider directory and most were found to be serving a county (most observed offered behavioral health services).

Table 4.1. 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	92	134	336	302	115	115
Provider Name	100%	100%	100%	100%	100%	100%
Provider Type	100%	100%	100%	100%	100%	100%
Provider Specialty	100%	100%	100%	100%	100%	100%
Street Address	100%	100%	100%	94%	100%	100%
Telephone Number	100%	100%	100%	100%	100%	100%
Groups or Facilities						
Number of Providers	38	0	137	229	99	98
Provider Name	100%		100%	100%	100%	100%
Provider Type	100%		100%	100%	100%	100%
Provider Specialty	100%		100%	100%	100%	100%
Street Address	100%		100%	67%	100%	100%
Telephone Number	100%		100%	100%	99%	99%

Regarding Fields Sometimes Populated, Table 4.2 shows the completion rates for the Provider Gender, Accommodations for Persons with Disabilities, Languages Available, and Accepting New Patients fields.

Table 4.2. 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	92	134	336	302	115	115
Provider Gender	100%	0%	59%	78%	91%	98%
Accommodations for Persons with Disabilities	0%	0%	68%	84%	0%	0%
Languages Available	100%	97%	2%	8%	100%	100%
Accepting New Patients	100%	100%	88%*	0%*	100%	100%

*Not a required field in the print directory.

Table 4.2. Directory Review Results – Percentage of Records with Fields Sometimes Populated (Continued)						
Provider Type and Fields Assessed	**DentaQ.**	**LIBERTY**	**Aetna**	**Humana**	**OCH**	**OCH-CSP**
Groups or Facilities						
Number of Providers	38	0	137	229	99	98
Provider Gender						
Accommodations for Persons with Disabilities	0%		76%	75%	0%	0%
Languages Available	100%		1%	2%	100%	100%
Accepting New Patients	100%		72%*	0%*	100%	100%
*Not a required field in the print directory.						

Among the medical and CSP CEs, only Aetna and Humana populated the field of Accommodations for Persons with Disabilities. 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. Humana did not populate the Accepting New Patients field in any of the records reviewed by KFMC. Incorrect or absent information related to accessible facilities can dramatically impact the ability for persons with disabilities to access appropriate care.

The final category, Fields Rarely Populated, is displayed in Table 4.3. 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 records reviewed for OCH found any of these three fields to be populated for individuals. Only LIBERTY, Aetna, and Humana occasionally populated the Website URL field (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). Additionally, no records reviewed had the field of Certification in Evidence Based Treatment populated. Since this field is required by OHCA, all Medical CEs should work to include this field in their directories.

Table 4.3. 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	92	134	336	302	115	115
Website URL	0%	26%	16%	5%	0%	0%
Completion of Cultural Competency Training	0%	97%	6%	26%	0%	4%
Certification in Evidence Based Treatment			0%	0%	0%	0%
Groups or Facilities						
Number of Providers	38	0	137	229	99	98
Website URL	0%		20%	11%	0%	0%
Completion of Cultural Competency Training	0%		0%	5%	3%	5%
Certification in Evidence Based Treatment			0%	0%	0%	0%

Validation of CE Technical Specifications and Processes

The intent of this validation activity was to review CE process documentation, to determine if the data were extracted in accordance with the documentation, and to determine if provider and location counts were calculated and reported as each CE intended.

The Network Adequacy Reports for the dental CEs (DEL-1101) are slightly different compared to the reports for medical and CSP CEs (SEL-1101). Both reports include provider specialty tabs, a Provider List tab, and a Distance Standard tab. The provider specialty tabs contain counts of providers for a given specialty category, stratified by county. The Provider List tab displays provider information such as name, national provider identifier (NPI), specialty, and address. The Distance Standard tab contains counts of providers and locations for the respective CE's full network. For this tab, dental CEs are to provide counts of providers and locations for their full network, stratified by rendering and group providers in addition to providing counts stratified by population density (rural or urban) and counts of out-of-state providers and locations. The medical and CSP CEs need only include provider and location counts, stratified by population density (rural, urban, or sub-urban), for the Distance Standard tab. On the DEL-1101, group dental providers are listed on the primary care dentists (PCD) Facility List tab, separate from rendering dental providers; whereas both practitioners and groups are included in the Provider List tab on the SEL-1101.

KFMC used counts reported for the following specialties on the Distance Standard tab, along with counts calculated using the Provider List and CE documentation, to determine whether providers and locations were being counted as indicated by each CE:

- For dental CEs – General Dentistry Practitioner (specialty code 271), Oral Surgeon (272), Orthodontist (273), Pediatric Dentist (274), Oral Pathologist (276), Prosthodontist (277), and the location count of Federally Qualified Health Centers (080).
- For medical and CSP CEs – Cardiologist (specialty codes 312 and 550 for adult and pediatric, respectively), Cardiovascular Surgeon (313), Nutritionist (230), Endocrinologist (352 and 528), Urologist (343 and 552), and Pharmacy (240 and 241).

Counts calculated by KFMC were considered to match the reported counts if they differed by less than 1% (rounded to the nearest integer) or 1 provider or location, whichever was greater. Each CE submitted documentation and technical specifications that provided varying levels of detail regarding their processes for populating the Provider List tab and counts of providers and locations on the Network Adequacy Report. The CEs use a variety of methods to populate the Provider List tab and to determine the counts of providers and locations.

Aetna and Humana included groups in their counts of providers and locations, but OCH and OCH-CSP did not. Aetna, OCH, and OCH-CSP counted individual practitioners under each specialty code that the provider was registered, so one provider with two specialty codes under Adult Mental Health would be counted as two providers for that stratum. For Humana, only a single provider would be counted in this instance.

As indicated above, dental CEs have an additional tab (the PCD Facility List tab) that must be populated on the DEL-1101. Since groups and other business entities are included in the report on a separate tab, neither dental CE includes them in their counts of providers.

DentaQuest

DentaQuest did not explicitly state how counts of providers and locations are determined. Counts of providers based on deduplicated provider NPIs, stratified by provider specialty, and counts of locations based on distinct first address lines in the Provider List tab were close to those reported on the Distance Standard tab. Since the CEs use standardized mapping software to prepare the data for the report, it is also likely that location counts are based on a distinct count of latitude and longitude values calculated from provider address information.

Provider and location counts calculated by KFMC for prosthodontists did not match those reported by DentaQuest. Only one prosthodontist was in the Provider List tab at two locations, but there were four providers reported at three locations.

LIBERTY

LIBERTY indicated the count of providers is intended to represent the number of individual practitioners providing dental services, and they provided additional insight as to how these counts are determined. From this, KFMC assumed that a distinct count of provider NPIs would suffice to calculate the reported counts. LIBERTY's counts of locations are based on access points, that is, distinct combinations of provider NPI and location. Based on how LIBERTY populates the Provider List tab, a simple row count of that tab for a particular specialty should equal the location counts reported. LIBERTY also indicated that only providers who are actively practicing are included in the reported counts.

KFMC noted several discrepancies in the number of providers reported. The number of general dentists reported and their access points appeared to be based on records where providers indicated they offered PCD services, not a count of distinct provider NPIs with a specialty of general dentistry practitioner or a row count of providers with that specialty for location counts. Zeros were reported for pediatric dentists, periodontists, oral pathologists, and prosthodontists for their Full Network on the Distance Standard tab, even though there were providers in the Provider List tab with those specialties who were accepting new patients. LIBERTY reported that no general dentists were providing endodontic, oral surgery, or periodontic services for their Full Network on the Distance Standard tab, but that did not appear to be the case based on the percentage of members with access to these services and other tabs on the report. Only the reported provider counts for endodontists matched a deduplicated count of provider NPIs. Row counts for endodontists and general dentistry practitioners matched location counts reported in the Distance Standard tab, but this was not the case for other specialties. Only 49 rows appeared in the PCD Facility List tab for Federally Qualified Health Centers, but 154 locations were reported in the Distance Standard tab.

Aetna

Aetna indicated that provider counts are based on a count of provider records included in each group on the SEL-1101 and are taken directly from their standardized mapping software; only providers who are rendering services are to be included in the reported counts. Recall that for each of the medical and CSP CEs, counts providers with multiple specialties multiple times, even if each specialty falls under the same category on the report. Location counts are based on a count of distinct latitudinal and longitudinal values.

There appeared to be discrepancies in Aetna's Network Adequacy report for November 2024. There were multiple specialists in the Provider List tab with provider type code 53, licensed behavioral health provider, who had an inappropriate specialty (e.g., cardiology, urology). For the specialties checked, it

did not appear that the Provider List data could be used to derive provider counts close to those reported. Location counts could not be matched exactly, but this was expected since KFMC does not use the same mapping software used by Aetna. Location counts calculated by KFMC usually matched those reported within three. For provider counts that were unable to be matched, it could be that KFMC misunderstood Aetna's definition of a provider group. KFMC assumed that a count of records grouped by the appropriate specialty codes and rural or urban county status would match those reported, but that was not the case. Also, there were examples of physicians being counted as mid-level practitioners and vice versa.

Humana

Humana stated that counts of providers are based on distinct counts of NPIs within a given county. This means that a single provider that provides services in multiple counties will be counted once for each county that they serve in. Humana stated that providers are only to be counted at locations in which they are providing services and that groups with appropriate specialty codes are included in the provider counts. Location counts are based on distinct first address lines.

One discrepancy was noted in the counts reported on the November SEL-1101 report for Humana. The number of pharmacy providers and locations reported on the Distance Standard tab far exceeded the number of pharmacy providers and locations included on the Provider List tab. All other counts of providers and locations calculated by KFMC matched those reported by Humana.

OCH and OCH-CSP

The following findings apply to both the OCH and OCH-CSP Network Adequacy Reports submitted for November 2024.

Counts of providers, stratified by specialty code, 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. All access points are included in location counts and the counts are based on a distinct count of latitude and longitude values calculated from provider address information. This definition of an access point appears to differ from LIBERTY's. Details are provided in the following paragraph.

All reported provider counts were able to be reproduced. Location counts calculated by KFMC usually matched reported counts. The counts calculated by KFMC were also substantially lower than the number of distinct combinations of provider NPI and location. There was only one minor issue with the SEL-1101 reports submitted by OCH and OCH-CSP. In the Avg Distance to 1 Provider column of the Distance Standard tab, the average distance in miles was displayed as a percentage instead of a decimal number.

Limitations

There was potential for misinterpretation of the documentation provided that could lead to counts calculated by KFMC not matching those reported by the CEs. In addition, since some location counts were calculated using standardized mapping software, it is less likely that those counts could be matched as KFMC does not use the same software. Finally, it is possible that KFMC did not include all specialty codes in our counts of providers and locations that each CE included, particularly for the medical and CSP CEs. This limitation was mitigated by focusing on a subset of specialties that only included one or two specialty codes.

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

- The State and CEs continue working towards improving the completeness of the provider directory files.

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

Assessment of Online Provider Directories

- CEs have not fully populated all required directory fields.

Verification of CE Technical Specifications and Processes

- The technical specifications provided by the CEs were not always clear. For example, DentaQuest did not explicitly state how providers and locations are to be counted on the DEL-1101 Network Adequacy Report. The counts of providers reported by Aetna could also not be reproduced using the documentation provided.
- Providers and locations are not counted consistently among medical/CSP and dental CEs. This makes comparison between each CE's network difficult. As an example, although the number of providers was similar, the number of locations reported by LIBERTY for PCDs was substantially higher than the number reported by DentaQuest. For the medical and CSP CEs, although the number of locations was relatively similar, the number of providers reported by Aetna was much greater than the number of providers reported by Humana, OCH, and OCH-CSP combined for many specialty categories.

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.

Recommendations for Quality Improvement

Recommendations for the State

1. As intended, the State should continue to work with the CEs to improve the completeness of the provider directory files

Recommendations for the SoonerSelect CEs

1. CEs should strive to populate the Accommodations for Persons with Disabilities directory field.
2. 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.
3. CEs should work together, and with the State, to ensure that providers and locations are counted consistently among all medical/CSP and the dental CEs. This would allow for a more accurate comparison between each of the medical/CSP and dental CE's networks.

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.[4] 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's objective for this review was to assess the completeness of the CE QAPI documentation submitted in 2024 by the SoonerSelect Dental CEs (DentaQuest and LIBERTY), the SoonerSelect Medical CEs (Aetna, Humana, and OCH), and the SoonerSelect CSP CE (OCH-CSP). KFMC and OHCA discussed and determined the scope of review for the first year of managed care implementation. In subsequent years, KFMC's main objective for this activity will be to evaluate the impact and effectiveness of the CEs' QAPI programs. For 2024, KFMC reviewed the available *Program Descriptions* and *Work Plans*, described below, as the CEs won't submit their annual QAPI Evaluations until summer 2025. The findings of this review provide guidance for the CEs to help ensure their QAPI program documentation meets SoonerSelect requirements moving forward. The scope of this review will be adjusted in the 2025-2023/20242026 reporting cycle to assess the impact and effectiveness of the CEs' QAPI programs.

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

The CEs' QAPI documentation must comply with the SoonerSelect contract section, Quality Assessment and Performance Improvement, subsection, QAPI Documentation. Each CE must submit the following documentation to comply with SoonerSelect contract QAPI requirements (see Appendix B for more detail).

- *QAPI Program Description*–to include goals, objectives, structure, and policies and procedures
- *QAPI Work Plan*–to contain the scope, objectives, planned activities, timeframes, and data indicators for tracking performance and other relevant QAPI information
- *QAPI Evaluation*–to annually evaluate the prior year's QAPI activities

KFMC's process for the 2024 QAPI review consisted of the following steps.

- Assess CE QAPI *Program Descriptions* for compliance with the SoonerSelect contract section, QAPI Assessment and Performance Improvement, subsection, QAPI Documentation.
- Assess CE QAPI *Work Plans* for compliance with the SoonerSelect contract section, QAPI Assessment and Performance Improvement, subsection, QAPI Documentation.
- Assess whether CE *Work Plan* activities reflected the initiatives and activities described in the *Program Description*.

KFMC accessed the available CE QAPI documents from those submitted through the SoonerSelect Readiness Review process, via the SoonerSelect SharePoint site. KFMC documented the assessments using a worksheet developed from the SoonerSelect contract QAPI requirements (Appendix B). Findings were compiled into individual reports provided to each CE, and included opportunities for improvement,

[4] QAPI Description and Background. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition. Updated September 20, 2016. Accessed May 19, 2020.

strengths, and recommendations for quality improvement. The sections below describe the findings from KFMC's 2024 assessment of the CE QAPI documentation.

Conclusions Drawn from the Data

KFMC assessed whether the CEs included the required documentation in their *Program Descriptions* and *Work Plans*. Table 5.1 includes assessment results for the SoonerSelect contract requirements that were either Partially Met or Not Met. The definitions of these ratings are contained in the table below. For the complete list of requirements KFMC used in this review, please see Appendix B.

Table 5.1. 2024 QAPI Review Requirements Less Than Fully Met–All CEs

SoonerSelect QAPI Documentation Contract Requirement	CE Compliance*					
	DentaQuest	LIBERTY	Aetna	Humana	OCH	OCH-CSP
QAPI Program Description shall include						
Goals, objectives, structure, and policies and procedures				PM	PM	PM
QAPI program committee structure, including specific committees, committee representatives and why the representatives were chosen (letter c)	PM	PM	PM	PM	PM	PM
Roles of Enrollee and Provider representatives on the QIC [Quality Improvement Committee] (letter d)	NM					
Types of training, including any quality protocols developed by the CMS, provided to quality staff and QIC members (letter f)	PM	PM	PM	PM	PM	PM
How data will be collected and used (letter l)	PM	PM	PM	PM	PM	PM
Process for reporting findings to OHCA, Participating Providers, and Enrollees (letter o)	PM	NM				
Annual QAPI Work Plan shall contain						
Objectives		NM		PM		
Planned Activities		NM		PM		
Timeframes		NM				
Data indicators for tracking performance and other relevant QAPI information	NM	NM	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.

KFMC also assessed whether the *Work Plan* activities reflected the initiatives and activities described in the *Program Descriptions*. The opportunities for improvement, as well as strengths, KFMC identified during the review are listed below.

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

Common Among the CEs

- Descriptions of committees did not always include the rationale for membership selection in the *Program Description*.
- While the CEs included aspects of the performance measurement to be conducted, there was little mention of the performance measures OHCA is requiring of the CEs in either the *Program Description* or *Work Plan* (if provided).

- The *Work Plan* should capture the initiatives and activities described in the *Program Description*.
- KFMC expects to see more detail regarding CE PIPs in subsequent years' QAPI documents.

DentaQuest

- DentaQuest's *Program Description* and *Work Plan* lacked detail on the quality improvement activities that will be evaluated in 2025.
- It was unclear how members and providers will be engaged in quality efforts, including how QAPI findings will be communicated to them. For example, neither provider nor member advisory committees were described in the *Program Description*.
- The *Work Plan* did not contain data indicators for the Objectives/Planned Activities to show how success or completion of activities will be measured.

LIBERTY

- Descriptions of committees did not always include a list of committee members in the *Program Description*.
- The process for reporting findings to OHCA, Participating Providers, and Enrollees was not provided in the Program Description.
- No Work Plan was provided.

Aetna

- The *Work Plan* did not contain data indicators for the Objectives/Planned Activities to show how success or completion of activities will be measured.

Humana

- Goals and objectives in the *Program Description* were not clearly delineated.
- Descriptions of committees did not always include a list of committee members in the *Program Description*.
- There was no clear distinction between *Work Plan* Objectives, Goals, and Planned Activities.

OCH and OCH-CSP

- The same *Program Description* was submitted for both Medical and CSP. It seems an old version of the *Program Description* was provided for CSP, as the version submitted for Medical contained revisions.
- There was not a clear distinction between initiatives and activities for Medical and CSP; KFMC would have expected to see more detail on CSP-specific quality improvement programs.
- More clarity is needed to connect goals and objectives in the *Program Description*.

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

DentaQuest

- Several specific quality improvement strategies were described in the *Program Description*.

LIBERTY

- A Tribal Advisory Committee is part of LIBERTY's quality committee structure, as described in the *Program Description*.

Aetna

- Aetna's *Work Plan* was robust and included both Objectives and Planned Activities to meet NCQA accreditation requirements, as well as SoonerSelect contract and EQR requirements.

Humana

- Humana's *Program Description* contained a separate section for Study, Intervention and Evaluation design.

OCH and OCH-CSP

- Committee descriptions were detailed in the *Program Description*.
- Oklahoma Complete Health provided a thorough description of the provider profiling methodology in the *Program Description*.

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.

Recommendations for Quality Improvement

Common Among the CEs

1. Provide the rationale for committee member selection in the *Program Description*.
2. Include more detail regarding performance measures in QAPI documents (i.e., include specific performance measures and rates).
3. Ensure that initiatives and activities described in the *Program Description* are captured in the *Work Plan*.
4. Provide details regarding PIPs in future QAPI documents.
5. The activities described in the *Program Description* and *Work Plan* should be assessed and reported in the annual *QAPI Evaluation*.

DentaQuest

1. Include more detail on quality improvement activities in QAPI documents.
2. Provide clarification on how members and providers are engaged in quality efforts and how QAPI results will be communicated to them.
3. In the *Work Plan*, identify and include the data indicators for tracking Planned Activities, as appropriate.

LIBERTY

1. In the *Program Description*, include a list of committee members where the various quality committees are described.
2. Provide the process for reporting findings to OHCA, Participating Providers, and Enrollees in future *Program Descriptions*.
3. When submitting QAPI documents in 2025, include a *Work Plan*.

Aetna

1. In the *Work Plan*, identify and include the data indicators for tracking Planned Activities, as appropriate.

Recommendations for Quality Improvement (Continued)

Humana

1. In future *Program Descriptions*, clearly distinguish Goals and Objectives.
2. In the *Program Description*, include a list of committee members where the various quality committees are described.
3. Ensure Goals, Objectives, and Planned Activities in the *Work Plan* are distinct.

OCH and OCH-CSP

1. Provide detail on the quality improvement initiatives for the CSP population and how these efforts differ from the Medical plan.
2. Ensure that Goals and Objectives in the *Program Description* are clearly displayed so the reader may understand how they are connected.

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6. *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. KFMC and OHCA discussed and determined the scope of review for the first year of managed care implementation. KFMC's objective was to conduct an initial assessment of each CE's EPSDT program through a review of policies and procedures, beneficiary-informing materials, and provider manuals. Future review will include assessing how the CEs are operationalizing the EPSDT-related contract requirements.

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

The managed care CEs, in the administration of their EPSDT programs, must comply with the following sections in the SoonerSelect Dental, Medical, and CSP contracts:

Dental

- 1.7.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Provide Program description
- 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, (e) covered and non-covered services, ESPDT requirements
- 1.20.7.3 Determination of Third-Party Payment, (a) Payment of EPSDT claims
- 1.21.1.10 Covered Benefit Reports (e) EPSDT reports
- Appendix 1F: Deliverable 39, EPSDT Data

Medical

- 1.7.7.2 Non-Emergency Medical Transportation (NEMT) Covered Services
- 1.7.11 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Provide 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
- 1.15.4.2 Provider Manual Content (e) covered and non-covered services, ESPDT requirements
- 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 92, EPSDT Data
- Appendix 1F: Deliverable 92, EPSDT Protocols

CSP

In addition to all of the same EPSDT-related requirements as the Medical contracts, the CSP contract includes contract requirement 1.7.1 Medical and Related Benefits.

The following are federal regulations associated with the above dental, medical, and CSP contract requirements:

- *42 CFR §438.206: Availability of services: EPSDT Member Outreach Contacts, Coordinating Services, Provider Referrals, Family Involvement and Accessible services, Member Handbook*
- *42 CFR §438.207: Assurances of adequate capacity and services*
- *42 CFR §438.208 Coordination and Continuity of care: Prenatal and EPSDT appointment assistance, follow up and transportation*
- *42 CFR §438.210 Coverage and Authorization of services EPSDT Members Rights and Responsibilities*
- *42 CFR §438.228 Grievance and appeal systems EPSDT Non-Discrimination Compliance: Display of Non-Discrimination Information and Non-Discrimination Written materials*
- *42 CFR §441.50 EPSDT Basis and Purpose*
- *42 CFR §441.55 State Plan Requirements EPSDT Services*
- *42 CFR §441.56 Required Activities; §441.57 Discretionary services*
- *42 CFR §441.58 Periodicity schedule*
- *42 CFR §441.59 Treatment of request for EPSDT screening services*
- *42 CFR §441.60 Continuing Care*
- *42 CFR §441.61 Utilizations of providers and coordination with related programs*
- *42 CFR §441.62 Transportation and scheduling assistance*

In addition to OHCA's CE contract requirements and associated federal regulations, KFMC considered additional CMS guidance provided in the State Health Official letter #24-005, *Best Practices for Adhering to EPSDT Requirements* [5] 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.

For the 2024 review, KFMC assessed all EPSDT-related documentation submitted by the CEs, including policies and procedures, provider manuals, member handbooks, and additional supporting documents. See Appendix B for a detailed list of the documents reviewed for each CE. In 2025, additional assessment will occur regarding how the CEs apply their EPSDT-related policies and procedures. Potential review activities for 2025 include more targeted documentation review (e.g., specific training materials, internal EPSDT reporting, prior authorizations, denials), staff interviews, case record/medical record reviews, and/or claims analyses.

To determine 2024 compliance, a requirement was considered "met" if at least one document addressed the requirement. Recommendations are indicated when the CE was considered to partially or not meet an EPSDT-related contract requirement.

[5] 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.

Conclusions Drawn from the Data

Of the 8 EPSDT-related requirements for the SoonerSelect Dental CEs, DentaQuest and LIBERTY both had 1 not met and 2 partially met. Of the 14 requirements for the SoonerSelect Medical CEs, Aetna and Humana met all requirements and OCH met all but one requirement. The OCH-CSP contract has 15 EPSDT-related requirements, of which the OCH-CSP CE met 11, partially met 2, and did not meet 2.

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

Common Among the CEs

1.11.5.4 (Dental) 1.12.5.4 (Medical and CSP) [Met—Aetna, Humana, OCH, OCH-CSP; Partially Met—DentaQuest, LIBERTY] Enrollee Handbook Content: This information shall include at a minimum (d) The amount, duration and scope of benefits provided by the Contractor in sufficient detail to ensure that SoonerSelect Dental Enrollees understand the benefits to which they are entitled, including information about the EPSDT benefit and how to access component services.

- DentaQuest, LIBERTY [Partially Met] Both CEs' enrollee handbooks provide a table of covered services, with a column with services for children under age 21, noting amount and duration of the benefits. However, the table of covered services is not referenced in the *EPSDT* section of the enrollee handbook and the table does not specify which of these services qualify as EPSDT services. Below the table is a section *Other Covered Services* with a bullet that simply lists Early and Periodic, Screening, Diagnostic and Treatment as an "other covered" service. The EPSDT section of the handbook is very brief. Each CE includes a link to their website for more information regarding EPSDT services. However, the links are to their home page and it was not clear how to find information on EPSDT from the home page.
- Aetna [Met] The EPSDT section of Aetna's *SoonerSelect Member Handbook* includes a description of EPSDT service types and the table, *Services Covered by Aetna's Better Health Network*, includes EPSDT services. Aetna's *Member Handbook* also includes a section titled *Children's Health* that is not referenced in the EPSDT section. Likewise, the EPSDT benefit section does not include a reference to well-child visits or the *Children's Health* section for more information. Members may not understand these can be the same types of services. The EPSDT section provides a link to the Aetna website home page for more EPSDT information, and it is difficult to locate EPSDT-specific information.
    - Aetna's Member Handbook appropriately states the member can get help with scheduling appointments and arranging for free transportation to and from the appointments. However, Policy 8300.10 states, "Member Services department coordinates transportation for medically necessary services and provides scheduling assistance if requested for EPSDT eligible members who have transportation benefits." This is the only place "scheduling assistance" is noted in the policy and could be misinterpreted as only assisting with scheduling transportation. It could also be interpreted as meaning not all EPSDT eligible members have transportation benefits. CMS guidance provided in the State Health Official letter #24-005, *Best Practices for Adhering to EPSDT Requirements* emphasizes the federal regulation CFR §441.62 (a) and (b) *Transportation and Scheduling Assistance* requires providing assistance with scheduling appointments for services and providing assistance with transportation to those services.

1.13.4.2 (Dental)/1.15.4.2 (Medical and CSP) [Met—Aetna, Humana, OCH, OCH-CSP; Partially Met—DentaQuest, LIBERTY] Provider Manual Content: The Provider Manual shall include, at minimum, the following topics: (e) Listing and description of covered and non-covered services, requirements, and limitations, including applicable EPSDT requirements.

- DentaQuest [Partially Met] DentaQuest's *Office Reference Manual* (provider manual) does not provide information about EPSDT services in any section. The manual includes *Exhibit A, Benefits Covered for SoonerSelect Child Benefits*, and notes, *Member copayment is $0 for all covered procedures.* However, "EPSDT" is not mentioned.
- LIBERTY [Partially Met] The *EPSDT Benefits* section of the LIBERTY *Oklahoma Medicaid Provider Reference Guide* notes, "For all EPSDT service(s), a pre-estimate is required for any dental service that is not listed on the state Medicaid benefit schedule, and any service(s) that are listed on the Medicaid benefit schedule that is subject to frequency limitations, or periodicity schedule guidelines." However, a link or instructions on where to find the state Medicaid benefit schedule were not provided in the Reference Guide, and it wasn't clear what dental services are EPSDT services. The *OK SoonerSelect Child Coverage, Limitations and Prior Authorization Requirements* (OK Medicaid Child Benefit Schedule) document was submitted for review, as a separate document.
- Aetna, Humana, OCH [Met]. The resource links provided in the EPSDT section of the CEs' provider manuals take providers to home pages of the resource, requiring the provider to search for specific items, such as the periodicity schedule, billing guidelines, or specific EPSDT screening forms by age.

1.20.7.3 (Dental)/1.22.83 (Medical and CSP) [Met—Aetna, Humana; Not Met—DentaQuest, LIBERTY, OCH, OCH-CSP] Determination of Third-Party Payment Notwithstanding the forgoing, in accordance with 42 C.F.R. § 433.139(b), the Contractor shall pay claims for the following and then bill the responsible third-party: (a.) Preventive pediatric services, including EPSDT.

- DentaQuest, LIBERTY, OCH, OCH-CSP [Not Met] The requirement to pay claims for preventive services, including EPSDT, and then bill the third-party was not located in the EPSDT policies and procedures, or other documents provided by DentaQuest, LIBERTY, OCH and OCH-CSP.
  - DentaQuest did not submit an EPSDT policy and procedure for review. DentaQuest stated, "When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim."
  - LIBERTY stated, "A claim should always be sent to the primary carrier first. Following the primary carrier's payment, a copy of the primary carrier's Explanation of Benefits (EOBs) should be sent with the claim to LIBERTY."
  - OCH and OCH-CSP noted, "If a Member has other insurance that is primary, the Provider must submit the claim to the primary insurance for consideration and submit a copy of the Explanation of Benefits (EOB), Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for a Member with insurance primary to Medicaid, the claim will pend and/or deny until this information is received."
- Aetna, Humana [Met] While Aetna and Humana included the contractual language in their provider manuals, none of the CEs included this requirement in their EPSDT policies and procedures.

DentaQuest

1.10.5 Quality Performance Measures [Met] In addition to OHCA-established quality performance measures, the Contractor shall report EPSDT information utilizing Encounter Data submissions in accordance with specifications for the CMS-416 report. This report includes information on EPSDT participation, percentage of Children identified for referral, percentage of Children receiving follow-up services in a timely manner, and other measures.

- While DentaQuest has submitted required EPSDT reports and OHCA is reviewing them, indicating the contract requirement has been met, it is not clear whether DentaQuest has a policy and procedure for EPSDT reporting requirements. Related documentation was not submitted.

OCH-CSP

1.7.1 Medical and Related Benefits [Not Met] The Contractor shall utilize the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit to furnish the most holistic and advantageous combination of interventions necessary to reverse trauma, build resilience, and prepare for successful adulthood.

- OCH-CSP noted they employ the Families and Futures Model®: which is based on the four pillars of Care Management, partnership, a specialized network, and training, for CSP**.** However, there was no mention of EPSDT for the CSP population. Also, the EPSDT section of the provider manual did not include information on the Families and Futures Model to indicate a connection.
- The EPSDT policy and procedure did not mention the CSP population. The document is not named and the approved date is to be determined. It appears to be a corporate policy and it isn't clear how much is implemented in Oklahoma.

1.7.11 [Partially Met] The Contractor shall provide EPSDT benefits to all Enrollees under age twenty-one (21), including necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of The Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered during screening, whether or not such services are covered under the State Plan.

The Contractor will provide screening and assessment services that align with the standards specified by the American Academy of Pediatrics (AAP) and Child Welfare League of America (CWLA) for children and teens in foster care.

- Screening and assessment services that align with Child Welfare League of America standards for children and teens in foster care were not addressed.

1.7.11 (a) [Partially Met] The Contractor shall implement protocols to increase EPSDT screening visit rates, such as: (a) Educating Enrollees and their caregivers on the value of preventive health care, benefits provided as part of EPSDT, and how to access EPSDT services.

- While there is some evidence of outreach specific to the CSP population (e.g., Fostering Families newsletter to foster homes that includes EPSDT education), OCH's EPSDT Policy OK.QI.20 includes a variety of member and provider interventions for improvement where CSP-specific processes are not documented. For example, MyHealthpays Rewards, with a file name of MyHealth CSP, appears to provide the same rewards as the OCH-Medical program. The processes do not appear to be adapted to the CSP population. It is not clear who would register for the child on the member portal to be able to obtain rewards, whether it is the foster parent or the guardian, or how the My Health Pays Visa prepaid card works for children in foster care or with juvenile justice.

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

- Humana has a monthly Oklahoma Market EPSDT Workgroup meeting that brings the various Humana departmental teams together to focus on how to meet the goal of EPSDT. Topics have included staff education, team responsibilities, team collaboration, member education, population health, community collaboration, barriers, goal setting, data tracking and reporting.

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

Because the Dental CEs contract began February 1, 2024, and the Medical and CSP contracts began April 1, 2024, there are no prior recommendations.

Recommendations for Quality Improvement

1.20.7.3 (Dental)/1.22.83 (Medical and CSP)—*DentaQuest, LIBERTY, OCH, 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.
2. DentaQuest should develop an EPSDT policy and procedure, if they have not already.

1.13.4.2 (Dental)—*DentaQuest, LIBERTY*

1. DentaQuest—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.
2. DentaQuest—In the CE's provider manual identify the services in the Child Benefits table that qualify as EPSDT benefits and include associated requirements.
3. DentaQuest, LIBERTY—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.
4. LIBERTY—Provide more information regarding what treatment requests are covered only under EPSDT.

1.11.5.4 (Dental)—*DentaQuest, LIBERTY*

1. Enhance the EPSDT section of the Enrollee 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.
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.

1.7.1 (CSP) and 1.7.11 (a) (Medical and CSP)—*OCH-CSP*

1. Specifically address EPSDT for the Oklahoma CSP population in member and provider handbooks, and OCH-CSP policies and procedures.

1.7.11 (Medical and CSP)—*OCH-CSP*

1. In OCH-CSP policies and procedures, and 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.

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 2024-2025 reporting cycle. At this time, KFMC does not have suggestions for the State regarding the Quality Strategy. With additional findings in year two of the SoonerSelect program, KFMC will address how the State can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services.

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 planned PIPs related to this objective. Please see the PIP section of this report for more details. • Childhood Immunization Status Combo 3 (Aetna) • Increasing Preventive Services for Children (OCH-CSP) The EPSDT activity evaluated CE compliance with the EPSDT requirements set forth in the CE contracts. The objective was to conduct an initial assessment of each CE's EPSDT program through a review of policies and procedures, beneficiary-informing materials, and provider manuals. Please see the EPSDT section of this report for more details.
Objective 1.4: Improve access to oral health care for SoonSelect dental plan enrollees
There are three planned PIPs related to this objective. 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) • Increasing Preventive Services for Children (LIBERTY) • Improving Access to Care through Appointment Scheduling and Transportation Assistance (LIBERTY)
Goal 2: Improve behavioral and chronic condition management
Objective 2.1: Improve behavioral health care
There are three planned PIPs related to this objective. 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 to Hospitalizations for Mental Illness (Humana) • Improve Performance of the Follow-Up After Hospitalization for Mental Illness (FUH) (OCH and OCH-CSP)
Objective 2.2: Improve diabetes management
There is one planned PIP related to this objective. Please see the PIP section of this report for more details. • Comprehensive Diabetes Care (Hemoglobin HbA1c Control for Patients with Diabetes) (Humana)

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 3: Collaborate with community partners and other State agencies to improve population health
Objective 3.1: Address unmet health-related resource needs
There are five planned PIPs related to this objective. Please see the PIP section of this report for more details. • Oral Health Literacy Assessment (DentaQuest) • Improving Social Determinants of Health Assessment in Adults 18-64 (Aetna) • Social Needs Screening and Intervention (Humana) • (Placeholder for OCH's PIP to be submitted on 4/11) • Enhanced Foster Care (OCH-CSP)
Objective 3.5: Address obesity
There is one planned PIP related to this objective. 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. Please see the PIP section of this report for more details. • Notification of Pregnancy (OCH)
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 and whether the CEs' technical specifications aligned with OHCA's expectations. Two PIP topics address this goal. • OCH-CSP will be implementing the Improving Access to Care through Appointment Scheduling and Transportation Assistance PIP. • LIBERTY will be implementing the Improving Access to Care through Appointment Scheduling and Transportation Assistance PIP. Please refer to the Network Adequacy Validation and PIP sections of this report for more details.
Goal 5: Drive patient-cenered, 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

End of written report

Appendix A

SoonerSelect Program Annual External Quality Review Technical Report

2024-2025 Reporting Cycle

List of KFMC EQR Technical Reports

Below is a list of reports on the required and optional EQR activities described in 42 CFR 438.358 that have been submitted by KFMC to the Oklahoma Health Care Authority during the 2024-2025 reporting cycle.

Information Systems Capabilities Assessment

- DentaQuest *ISCA (CY* [Calendar Year] *2024) of DentaQuest,* January 27, 2025
- LIBERTY *ISCA (CY 2024) of LIBERTY,* January 27, 2025
- Aetna *ISCA (CY 2024) of Aetna,* February 20, 2025
- Humana *ISCA (CY 2024) of Humana,* March 27, 2025
- OCH Medical and CSP *ISCA (CY 2024) of OCH,* March 12, 2025

Review of Compliance with Medicaid and CHIP Managed Care Regulations

- DentaQuest *2024 Review of Compliance with Medicaid and CHIP Managed Care Regulations of DentaQuest,* November 7, 2024
- LIBERTY *2024 Review of Compliance with Medicaid and CHIP Managed Care Regulations of LIBERTY,* November 26, 2024
- Aetna *2024 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Aetna,* February 20, 2025
- Humana *2024 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Humana,* April 2, 2025
- OCH Medical and CSP *2024 Review of Compliance with Medicaid and CHIP Managed Care Regulations of OCH,* February 25, 2025

Quality Assessment and Performance Improvement

- DentaQuest *2024 Quality Assessment and Performance Improvement Review of DentaQuest,* April 29, 2025
- LIBERTY *2024 Quality Assessment and Performance Improvement Review of LIBERTY,* April 29, 2025
- Aetna *2024 Quality Assessment and Performance Improvement Review of Aetna,* April 29, 2025
- Humana *2024 Quality Assessment and Performance Improvement Review of Humana,* April 29, 2025
- OCH Medical and CSP *2024 Quality Assessment and Performance Improvement Review of OCH Medical,* April 29, 2025
  2024 Quality Assessment and Performance Improvement Review of OCH CSP, April 29, 2025

Early and Periodic Screening, Diagnosis, and Treatment

- DentaQuest *2024 EPSDT of DentaQuest,* April 28, 2025
- LIBERTY *2024 EPSDT of LIBERTY,* April 28, 2025
- Aetna *2024 EPSDT of Aetna,* April 28, 2025
- Humana *2024 EPSDT of Humana,* April 28, 2025
- OCH Medical and CSP *2024 EPSDT of OCH,* April 28 2025

Network Adequacy Validation

- SoonerSelect *2024 Network Adequacy Validation,* April 4, 2024.

Appendix B

SoonerSelect Program Annual External Quality Review Technical Report

2024-2025 Reporting Cycle

2024 Methodologies

The following EQR Activity methodologies are included in Appendix B:

- Network Adequacy Validation
- QAPI Review
- EPSDT Review

Technical Methods of Data Collection and Analysis/Description of Data Obtained – Network Adequacy Validation

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. If a current directory was available in PDF file format, then the PDF directory file was downloaded for review. Otherwise, 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. 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. Pottawatomie was randomly chosen to be a second representative urban county. The rural counties were subdivided by population size and region. Adair and Stephens were chosen from the 20 rural counties with the most enrollees; Haskell and Woodward represented the remaining 42 rural counties. Adair and Haskell are in the East region, and Stephens and Woodward 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 and CSP 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 so we could conclude 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 was 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 and CSP CE. LIBERTY's provider directory did not have entries for dental offices separate from the entries for dentists; therefore, a single sample of 30 pages was drawn. DentaQuest had separate sections for dentists and dental offices. The fields within the two sections appeared to be uniformly populated (which allowed for smaller samples), so 20 pages for dentists and 10 pages for dental offices were selected. Note, just reviewing 30 records only provides a rough estimate of the percent of records with

[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

the field populated throughout the directory if the field was not populated for all records reviewed. Future analysis may be conducted using larger sample sizes, calculated using this year's results, to obtain more accurate percentages.

Obtaining Provider Directories

This section provides the steps used to obtain the provider directories from the CEs' websites.

DentaQuest

A PDF file for the complete network was not available on DentaQuest's website. Therefore, the online tool was used to obtain providers in each of the six counties. The online tool required the user to select between two plans, Oklahome (OK) SoonerSelect Adult and OK SoonerSelect Child. For three counties, providers were selected from the adult plan; providers were selected from the child plan for the other three counties. Note, because the number of providers in Oklahoma County exceeded the number of providers that would be returned by the online tool, four cities were chosen for sampling (Oklahoma City, Choctaw, Edmond, and Luther). The selected pages were downloaded to 9 PDF files. These steps were completed November 26, 2024.

1. Open https://oklahoma.gov/ohca/soonerselect/about.html.
2. From sentence starting with, "You can pick between two dental plans," select "DentaQuest." The link opens https://www.dentaquest.com/.
3. Under "Let's get started," enter the county or city to be searched under "Confirm your location." Entries will be "Adair County, OK," "Haskell County, OK," "Pottawatomie County, OK," "Stephens County, OK," "Oklahoma County, OK," "Woodward County, OK," "Oklahoma City, OK," "Choctaw, OK," "Edmond, OK," and "Luther, OK."
4. Select "Medicaid (SoonerSelect)" as the type of insurance.
5. Choose the plan "OK SoonerSelect Adults (21 and Over)" for the cities in Oklahoma County and counties Adair and Stephens. For Adair, Pottawatomie, and Woodward counties, select "OK SoonerSelect Children (under 21)." Click "Find/Change a dentist."
6. Filter by distance. Set distance to 10 miles for the cities in Oklahoma County and to 15 miles for Pottawatomie County. Use the default value, 25 miles, for the remaining counties. Click "Update results."
7. Click "Download Results." On the page that opens, select "All Providers" and "All Offices." Click "Next." No changes need to be made on the page that opens. Click "Next." Under the message "PDF_viewer_not_supported," click "Download_PDF". When the file is downloaded, save it to the network.

LIBERTY

The PDF file for the complete network on LIBERTY Dental's website was not up to date (file was dated March 2024). Therefore, the online tool was used to obtain providers in each of the six counties. The selected pages were printed to PDF files (17 files). These steps were completed November 27, 2024.

1. Open https://oklahoma.gov/ohca/soonerselect/about.html.
2. From sentence starting with, "You can choose between three health plans," select "LIBERTY Dental." The link opens https://www.libertydentalplan.com/.
3. Select state "Oklahoma" and click Go. This takes you to https://www.libertydentalplan.com/Oklahoma/LIBERTY-Dental-Plan-of-Oklahoma.aspx.
4. Under "Member Tools," select "1 Find A Dentist" to get to https://www.libertydentalplan.com/Find-a-Dentist/Find-a-Dentist.aspx?state=OK.

5. Then enter the search criteria: "Oklahoma" for state, "SoonerSelect Adult" or "SoonerSelect Child" for network, select "City" instead of "Zip" and enter the county name, enter "30" for distance, enter "General Dentist" for specialty type. Uncheck box to get providers not accepting new patients. Click "Search."
6. Set "Display records" to "All", and filter records to the county (Example ": Stephens"). Click the Print icon. Print to a PDF file on the network.
7. Change network or specialties and repeat Steps 5 and 6, as needed.

Notes: Adair, Haskell, and Stephens had the same entries for Adult and Child; a single PDF file was saved for each. For the other counties, Adult and Child directory files were saved.

Aetna

Aetna's provider directory file, File Vol1 Aetna OK05 Accessible PaperDirectory_241112.pdf, was downloaded November 12, 2024. 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. At the bottom of the page, under "Choose A Directory," select "Full Directory" and download as a PDF file.

* Note: Aetna's website was changed since November 12, 2024. For the current website, insert this step between Steps 2 and 3: Near the bottom of the page, under "Resources and tools" select "Find a provider." This opens https://www.aetnabetterhealth.com/oklahoma/find-provider.

Humana

Humana's provider directory was downloaded November 14, 2024 (files were dated November 1, 2024). The following steps produced 8 PDF files.

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

The PDF file on Oklahoma Complete Health's website was not up to date (file was dated April 2024). Therefore, the online tool was used to obtain providers in each of the six counties. The selected pages were printed to PDF files (49 files for OCH, 50 files for OCH-CSP). These steps were completed November 27, 2024, for OCH and December 13, 2024, for OCH-CSP.

1. Open https://oklahoma.gov/ohca/soonerselect/about.html.
2. From sentence starting with, "You can choose between three health plans," select "Oklahoma Complete Health." This opened https://www.oklahomacompletehealth.com/.
3. Select "For Members," and then select "SoonerSelect" or "Children's Specialty Program." This opens https://www.oklahomacompletehealth.com/members/medicaid.html.
4. Under "Member Quick Links," select "Find A Provider." This opens https://www.oklahomacompletehealth.com/members/medicaid/find-a-doctor.html.html.

5. Under "Online," select "Find a Provider Tool."
6. Enter the county (e.g., Oklahoma County) and refine the selection from the drop down. Click "Select your plan" and choose "SoonerSelect" or "Children's Specialty Program." Click "Continue."
7. Choose the category (medical professionals, medical facilities, behavioral health, vision, or pharmacy and medical supplies), and then choose the subcategory. Click "search."
8. Change the radius to limit your search to the county (10 miles for Adair, Haskell, Pottawatomie; 25 miles for Oklahoma and Woodward; 25 miles for Stephens but then manually limit to 15 miles).
9. Check the number of records returned. Use the RandBetween function in Excel to randomly generate a starting record. Click the show more details tab at the bottom of that record and the next three records. Select "Print" to print to a PDF file, limiting the pages to those with expanded details, if possible.
10. Click "Search Again" to select additional categories for the same county.

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 adult and child online directories were divided between dentists and dental offices. Both general dentistry and specialty dental care were intermingled. Twelve pages were selected for Oklahoma County because it had the highest proportion of specialty providers (see Table B.1). Pages were randomly selected from the adult directory for Oklahoma, Stephens, and Haskell counties, and from the child directory for Pottawatomie, Adair, and Woodward counties (18 pages from adult directories, 12 pages from child directories). Most dentists and dental offices observed serve both adults and pediatric patients and had the same information in both directories, so having an equal number of pages selected from adult and child directories was not needed.

Table B.1. Number of Directory Pages Selected for Review – DentaQuest

Provider Type	Okla.	Pott.	Adair	Step.	Hask.	Wood.	Total
Total	**12**	**6**	**3**	**3**	**3**	**3**	**30**
Dentists	8	4	2	2	2	2	20
Dental Offices	4	2	1	1	1	1	10

LIBERTY

LIBERTY's online directory pages were downloaded by selecting the county, the network (SoonerSelect Adult or SoonerSelect Child), and specialty (general dentist, endodontist, oral surgeon, orthodontist, pedodontist, periodontist, or prosthodontist).

The number of directory pages for the rural counties was low, so most pages were selected from Oklahoma County (see Table B.2). All pages for general practice dentists were selected for Adair, Haskell, and Stephens counties (these counties had no specialists, and the adult and child general practice networks were the same). Woodward County had an orthodontist (child network) but no general practice dentists. The adult and child networks were slightly different for Oklahoma and Pottawatomie counties; pages were either selected from the larger network or the network was randomly selected.

Table B.2. Number of Directory Pages Selected for Review – LIBERTY							
Provider Type	**Okla.**	**Pott.**	**Adair**	**Step.**	**Hask.**	**Wood.**	**Total**
Dentists – General Practice	**14**	**3**	**1**	**2**	**1**	**0**	**21**
Dentists – Specialists	**7**	**1**	**0**	**0**	**0**	**1**	**9**
Endodontics	1	0				0	1
Oral Surgery	2	0				0	2
Orthodontics	0	1				1	2
Pedodontics	2	0				0	2
Periodontics	1	0				0	1
Prosthodontics	1	0				0	1
Total	**21**	**4**	**1**	**2**	**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. The number of pages reviewed per county and claim type are shown in Table B.3.

Table B.3. Number of Directory Pages Selected for Review – Aetna							
Provider Type	**Okla.**	**Pott.**	**Adair**	**Step.**	**Hask.**	**Wood.**	**Total**
Individual	**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
Groups and Facilities	**8**	**6**	**4**	**4**	**4**	**4**	**30**
Hospitals	1	1	1	1	1	1	6
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**	**12**	**8**	**8**	**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, and nursing facilities.

Humana

Humana's regional directories contained a "List of Provider" that served as a table of contents. Provider types and page ranges from the "List of Provider" were used to randomly select pages to review (see Table B.4).

Table B.4. Number of Directory Pages Selected for Review – Humana

Provider Type	Okla.	Pott.	Adair	Step.	Hask.	Wood.	Total
Individual and Groups	**10**	**6**	**3**	**4**	**3**	**4**	**30**
Primary Care Providers	3	2	1	1	1	1	9
Specialists	3	2	1	1	1	1	9
Vison Providers	1	0	0	1	0	1	3
Behavioral Health Care Providers	3	2	1	1	1	1	9
Facilities	**7**	**5**	**5**	**5**	**3**	**5**	**30**
Hospitals	1	1	1	1	0	1	5
Urgent Care Clinics	1	1	0	1	0	1	4
Pharmacies	1	1	0	1	1	1	5
Durable Medical Equipment	1	1	1	0	0	1	4
Laboratory	1	1	1	1	0	0	4
Others	2	0	2	1	2	1	8
Total	**17**	**11**	**8**	**9**	**6**	**9**	**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 B5).

Table B.5. Number of Directory Pages Selected for Review – OCH and OCH-CSP

Provider Type	Okla.	Pott.	Adair	Step.	Hask.	Wood.	Total
Individual (Professionals)	**10**	**6**	**4**	**4**	**3**	**3**	**30**
Primary Care Providers	3	2	1	1	1	1	9
Medical 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	**8**	**6**	**4**	**4**	**4**	**4**	**30**
Hospitals	1	1	1	1	1	1	6
Clinics or Urgent Care	1	0	1	1	1	0	4
Primary Care (FQHCs and RHCs)	0	1	0	0	1	1	3
Pharmacies	1	1	1	1	0	0	4
Medical Equipment	1	1	0	0	0	1	3
Behavioral Health Facility	1	1	0	0	0	0	1
Vision Facility	1	0	0	0	0	0	1
Lab and Other Facility	2	1	1	1	1	1	8
Total	**18**	**12**	**8**	**8**	**7**	**7**	**60**

Downloading directory pages included choosing a category and subcategory. The Medical Professionals category included Primary Care and Medical Specialist subcategories. The Behavioral Health and Vision Categories were subdivided into Professionals and Facilities. The Medical Facilities categories contained Hospitals, Primary Care Facilities (FQHCs and RHCs, but not other primary care clinics), Clinics or Urgent Care and Lab or Other Facility subcategories. FQHCs and RHCs are also listed in the Clinics or Urgent Care subcategory, which is logical since they also offer non-primary care services. Clinics having primary care professionals are listed under "clinic/center: primary care," but the primary care provider indicator was not checked. Examples of services listed under Lab or Other Facility are ambulance and non-emergency transportation, case management, diagnostic imaging, home health and in-home support, nursing care and skilled nursing facilities, and occupational and physical therapy.

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

The Quality Assessment and Performance Improvement section of the SoonerSelect CE contracts were used to assess CE compliance in this review. The following requirements are taken from the QAPI Documentation (Dental 1.10.3.3, Medical/CSP 1.11.3.3) section of Quality Assessment and Performance Improvement (Dental 1.10.3, Medical/CSP 1.11.3).

CE QAPI Requirements

The QAPI program description shall include goals, objectives, structure, and policies and procedures. At a minimum, the QAPI program description shall include the following:

a. Guiding philosophy and strategic direction for the QAPI program;
b. Communication mechanism between the Contractor's executive management team and the QIC;
c. QAPI program committee structure, including specific committees, committee representatives and why the representatives were chosen;
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 Contractor'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 Contractor will ensure that QAPI program activities take place throughout the Contractor's organization and the procedures to document results;
n. The Health Management Information Systems that will support the QAPI program;
o. Process for reporting findings to OHCA, Participating Providers, and Enrollees; and
p. Process for annual program evaluation.

The annual QAPI work plan shall contain the scope, objectives, planned activities, timeframes, and data indicators for tracking performance and other relevant QAPI information.

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

CE EPSDT Requirements

Dental

- 1.7.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Provide Program description
- 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, (e) covered and non-covered services, ESPDT requirements
- 1.20.7.3 Determination of Third-Party Payment, (a) Payment of EPSDT claims
- 1.21.1.10 Covered Benefit Reports (e) EPSDT reports
- Appendix 1F: Deliverable 39, EPSDT Data

Medical

- 1.7.7.2 Non-Emergency Medical Transportation (NEMT) Covered Services
- 1.7.11 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Provide 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
- 1.15.4.2 Provider Manual Content (e) covered and non-covered services, ESPDT requirements
- 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 92, EPSDT Data
- Appendix 1F: Deliverable 92, EPSDT Protocols

CSP

In addition to all of the same EPSDT-related requirements as the Medical contracts, the CSP contract includes contract requirement 1.7.1 Medical and Related Benefits.
The following are associated federal standards:

- *42 CFR §438.206 Availability of services: EPSDT Member Outreach Contacts, Coordinating Services, Provider Referrals, Family Involvement and Accessible services, Member Handbook*
- *42 CFR §438.207 Assurances of adequate capacity and services*
- *42 CFR §438.208 Coordination and Continuity of care: Prenatal and EPSDT appointment assistance, follow up and transportation.*
- *42 CFR §438.210 Coverage and Authorization of services EPSDT Members Rights and Responsibilities*

- *42 CFR §438.228 Grievance and appeal systems EPSDT Non-Discrimination Compliance: Display of Non-Discrimination Information and Non-Discrimination Written materials*
- *42 CFR §441.50 EPSDT Basis and Purpose*
- *42 CFR §441.55 State Plan Requirements EPSDT Services*
- *42 CFR §441.56 Required Activities; §441.57 Discretionary services*
- *42 CFR §441.58 Periodicity schedule*
- *42 CFR §441.59 Treatment of request for EPSDT screening services*
- *42 CFR §441.60 Continuing Care*
- *42 CFR §441.61 Utilizations of providers and coordination with related programs.*
- *42 CFR §441.62 Transportation and scheduling assistance*

CE Documents Reviewed

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

DentaQuest

- *SoonerSelect DentaQuest Member Handbook (Revised 09/30/2024)*
- *DentaQuest Office Reference Manual 2024, ORM_20240223*
- *Sooner Select Members Enjoy No-Cost Dental Benefits Flyer, DQ3320 (7.24)*
- *Oral Health Matters-Flossing Flyer, DQ3141(2.24)*
- *Fluoride can protect your child's teeth against cavities Flyer, DQ3130 (1.24)*
- *Oral Health Matters-How to Keep Healthy Teeth & Gums Flyer, DQ3107 (1.24)*
- *Oral Health Matters-Snack Facts, DQ3105 (1.24)*
- *Oral Health Matters-Baby Teeth are Important Flyer, DQ3104 (1.24)*
- *Oral Health Matters-Seal Out Decay Flyer, DQ3103 (1.24)*
- *Oral Health Matters-Good Health Starts at Birth, DQ3101 (1.24)*
- *Oral Health Matters- Early Warning Signs of Tooth Decay Flyer, DQ3100 (1.24)*
- *Oral Health Matters-Check Your Child's Teeth, DQ3099, (1.24)*
- *Oral Health Matters-Brushing Tips, DQ3098 (1.24)*
- *Oral Health Matters-Calcium is Good for your Teeth, DQ3068 (2.24)*

Liberty

- *SoonerSelect 2024 Member Handbook-LIBERTY Dental (Rev 7/1/2024)*
- *Plan Oklahoma Medicaid Provider Reference Guide Liberty Dental Plan* (4/1/2023)
- *OK SoonerSelect Child Coverage, Limitations and Prior Authorization Requirements (2024)*
- *Liberty Dental Plan Quality Management and Improvement-2024 QMI Program – Oklahoma Medicaid Work Plan*
- *Utilization Management Program Description Liberty Dental,* 2/2025*EPSDT Approvals Dashboard,* Q3 UM Committee
- *Coverage of EPSDT Services Policy and Procedure* (Approval Date: 1/30/2025)

Aetna

- *Aetna SoonerSelect Member Handbook Aetna Better Health of Oklahoma Member Handbook, 2506681-OK-EN (Issued 04/01/24) Rev (10/24)*
- *Aetna Better Health of Oklahoma-Provider Manual (Vol 2 – 9/1/2024)*

- *Aetna Better Health, Smile for Life Oral Health Services for SoonerSelect members 6 months to 5 years old, 4102414-01-01 (10/24)*
- *Aetna Better Health of Oklahoma, See what's covered, Get to know your benefits and rewards (Value-Added Benefits) (Issued 04/24 2803949-01-01 (1/24)*
- *Aetna Better Health of Oklahoma, Claims Adjudication, Policy-Number 2000.10 (Effective 4/1/2024)*
- *Aetna Better Health of Oklahoma-Aetna Medicaid Administrators Policy-Coordination of Benefits, Policy Number 4100.02 (Effective 04/01/2024)*
- *Aetna Better Health of Oklahoma Policy-New, Existing, and Reinstated Member Information, Policy Number 4500.15 (Effective 04/01/2024)*
- *Aetna Better Health of Oklahoma Policy-Emergent and Non-Emergent Transportation, Policy Number 4500.95 (Effective 04/01/2024)*
- *Aetna Better Health of Oklahoma Policy-Provider Manual, Policy Number 6300.13 (Effective date 04/01/2024).*
- *Aetna Better Health of Oklahoma Policy-Member Transition, Policy Number 7000.40 (Effective Date 04/01/2024)*
- *Aetna Better Health of Oklahoma Policy-Transfer of Pediatric Members to an Adult System of Care, Policy Number 7000.44 (Effective Date 04/01/2024)*
- *Aetna Better Health of Oklahoma Policy-Prior Authorization, Policy Number 7100.05 (Effective 04/01/2024)*
- *Aetna Better Health of Oklahoma Policy-Benefit Exception, Policy Number 7100.16 (Effective Date 04/01/2024)*
- *Aetna Better Health of Oklahoma Policy-Concurrent Review, Observation, Policy Number 7200.05 (Effective Date 04/01/2024)*
- *Aetna Better Oklahoma Policy-Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Service, Policy Number 8300.10 (Effective Date 04/01/2024)*
- *Aetna Better Health of Oklahoma-New Member Quick Reference Guide, 2803878-OK-EN (04/24)*
- *Aetna Better Health of Oklahoma-Summer 2024 Member Newsletter, OK-23-07-36-EN (rev 1/24)*
- *Aetna Better Health of Oklahoma-Fall Provider Newsletter, 4061759-01-01 (10/24)*
- *Aetna Better Health of Oklahoma-Covered Benefits (5.1.2)*
- *Aetna Better Health of Oklahoma Fluoride Flyer for Members, 4102414-02-01 (10/24)*
- *Aetna Better Health of Oklahoma-Immunization Grid, 3801072-30-01*

Humana

- *EPSDT Workgroup Meeting Minutes January 21, 2025*
- *EPSDT Team Meeting Minutes January 31, 2025*
- *EPSDT+ cm Meeting on CM education on Immunizations February 4, 2025*
- *Oklahoma Market EPSDT Workgroup November 11, 2024.*
- *December EPSDT Workgroup Meeting Minutes December 12, 2024.*
- *Humana Healthy Horizons in Oklahoma Member Handbook- Plan Year 2024.*
- *HHH 2024 Provider Manual*
- *2024 OK Provider Manual eff 11.15.2024 from Website.pdf*
- *Humana Availity Essentials Training Help Document.pdf*
- *Provider Orientation and Training*
- *2025 Provider Manual*
- *6 Week Postpartum Maternity Assessment*

- *Substance Use Assessment & Treatment.pdf*
- *Links to educational resources for CM within the Guiding Care platform.*
- *HumanaBeginnings rewards you for doing what is best (ENGLISH)*
- *HumanaBeginnings Welcome Letter_2.4.25.pdf*
- *Keep your child's care on time with help from Humana (ENGLISH).pdf*
- *Keep your child's care on time with help from Humana (SPANISH).pdf*
- *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (Effective April 1, 2024)*
- *Quality Performance Measures, (Effective April 1, 2024)*
- *HHH Oklahoma CM EPSDT (12/2023)*
- *HHH Oklahoma Medicaid Value Added Benefits & Go365 Tool*
- *OK Pediatric Comprehensive Assessment*
- *OK Postpartum Maternity Comprehensive Assessment*
- *OK.CLI.009-Covered Benefits*
- *OK.CLI014 _Authorization Decision Notification*
- *OK.CLI.018 -Retrospective Review*
- *GGIJ 2025 Provider Manual HHOK Member Handbook Plan Year 2025*
- *Welcome to Humana Dental Network*

OCH/OCH-CSP (all documents reviewed for both OCH and OCH-CSP)

- *Oklahoma Complete Health SoonerSelect 2024 Provider Manual*
- *Clinical QI Program Immunizations for Adolescents (IMA Combo 2)*
- *Medicaid Child Preventative Care Email-Email Outreach*
- *Clinical QI Program Adolescent Well-Care Visits (AWC) Text-Email Outreach*
- *OCH-Early Periodic Screening, Diagnosis, and Treatment (EPSDT) 0-6 Years Old*
- *OCH-Early Periodic Screening, Diagnosis, and Treatment (EPSDT) 7-21 Years Old*
- *Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Tracking Tool 1.0 Age Group Summary Power BI Dashboard*
- *OCH-Schedule a Well Child exam for your child Today. Child Postcard*
- *OCH-Schedule a Well Child visit for your baby Today. Infant Postcard*
- *Internal Newsletter-Measure of the Month EPSDT*
- *EPSDT Tracking Tool 1.0 EPSDT Measure Rate Trending Power BI Dashboard*
- *EPSDT Measure Summary Power BI Dashboard*
- *EPSDT Required Services Power Point Presentation*
- *OCH-Schedule a yearly exam for your teen today-EPSDT Teen Postcard*
- *Measure of the Month-EPSDT Newsletter-Not approved yet*
- *Measure of the Month EPSDT-Provider Tips Newsletter*
- *Integris Care Gap Example 1 (2.12.25)*
- *OCH Medicaid SoonerSelect and Children's Specialty Program P4P Program 2025*
- *OCH-You can earn My Health Pays Rewards*
- *OCH-You can earn My Health Pays Rewards from Oklahoma Complete Health when you complete healthy activities*
- *Child Wellness Visit (EPSDT) Checklist*
- *State of Oklahoma Contract with Oklahoma Complete Health, Inc (Effective 8/2/2023)*
- *Care Coordination/Care Management Services Policy (Effective 04/01/2024)*

- *Quality Improvement/Quality Management (QI/QM) (Effective 04/01/2024)*
- *Start Smart for your Baby Flyer*
- *Start Smart for Your Baby Dear Member Letter*
- *Oklahoma Complete Health-Member Handbook (Rev 02/29/2024)*
- *Oklahoma Complete Health-Member Handbook (Rev 09/23/2024)*

Appendix C

SoonerSelect Program Annual External Quality Review Technical Report

2024-2025 Reporting Cycle

2024 Recommendations

The following EQR Activity recommendations are included in Appendix C:

- Compliance Review

Regulatory Area	2024 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections	
§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)
	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)
§438.10(f)(1) Information requirements – Information for all enrollees of MCOs, PIHPs, and PAHPs, and PCCM [Primary Care Case Management] 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 [Primary Care Dentist] 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")
	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") 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") 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")

Regulatory Area	2024 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections *(Continued)*	
§438.10(g)(2)(ii) 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") **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")
§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) 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) 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. 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]) 8. Review and revise the member responsibilities listed in the *SoonerSelect Member Handbook* and *ORM* (and any additional applicable documents) to be consistent.

Regulatory Area	2024 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections *(Continued)*	
§438.10(g)(2)(ix) Information requirements – Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook (Continued)	**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) 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])
§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])
	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])
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])

Regulatory Area	2024 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
2024 Review Recommendations	
Subpart D – MCO, PIHP and PAHP Standards (Continued)	
	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])
§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]) 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]) 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")

Regulatory Area	2024 Compliance Review Recommendations
Common Among the SoonerSelect Dental CEs	
2024 Review Recommendations	
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)	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]) 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])
§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)." 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."
	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") 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."

Regulatory Area	2024 Compliance Review Recommendations
DentaQuest	
2024 Review Recommendations (Continued)	
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)
Subpart C – Enrollee Rights and Protections	
§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)
§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."
§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")
LIBERTY	
2024 Review Recommendations	
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)

Regulatory Area	2024 Compliance Review Recommendations
LIBERTY	
2024 Review Recommendations	
Subpart B – State Responsibilities (Continued)	
§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, **or during the ninety (90) days following the date OHCA sends the SoonerSelect Dental Enrollees notice of that Enrollment, whichever is later**." b. Number 2: "At least once every 12 months, **during the Open Enrollment Period**." (State Contract Section 1.6.4 "Enrollment Lock-In Period")
Subpart C – Enrollee Rights and Protections	
§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")
	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")
§438.10(d)(4) Information Requirements – Language and format	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")
§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.

Regulatory Area	2024 Compliance Review Recommendations
LIBERTY	
***2024 Review Recommendations* (Continued)**	
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."
	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])
	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."
	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.

Regulatory Area	2024 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections	
§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) 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")
	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) 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)
	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) 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)

Regulatory Area	2024 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections (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) 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)
	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. 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)
	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)

Regulatory Area	2024 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections (Continued)	
§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) 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) 7. To the *SoonerSelect Member Handbook*, in the list of member rights, add the member right to file a grievance and appeal. 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])
	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. 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])

Regulatory Area	2024 Compliance Review Recommendations
Common Among the SoonerSelect Medical CEs	
2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections (Continued)	
§438.10(g)(2)(ix) Information requirements: Information for enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Enrollee handbook (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." 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)
	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) 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." 6. Review and revise the "Member Rights and Responsibilities" listed in policies and procedures C*C.MBRS.25 Member Rights & Responsibilities* and *OK.MRKT.06 Member Handbook,* the *Member Handbook*, and the *Provider Manual to be consistent across documents*.

Regulatory Area	2024 Compliance Review Recommendations
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2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections (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	**Aetna** 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." **Humana** 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]) 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]) 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])

Regulatory Area	2024 Compliance Review Recommendations
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Subpart C – Enrollee Rights and Protections (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)	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." 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]) 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])

Regulatory Area	2024 Compliance Review Recommendations
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2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections (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."
Subpart D – MCO, PIHP and PAHP Standards Compliance Results	
§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) 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)
	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."
	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)

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Subpart D – MCO, PIHP and PAHP Standards Compliance Results (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") 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")
	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." 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."
	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") 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")

Regulatory Area	2024 Compliance Review Recommendations
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Subpart D – MCO, PIHP and PAHP Standards Compliance Results (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") **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." 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." **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") 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")
Aetna	
2024 Review Recommendations	
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")

Regulatory Area	2024 Compliance Review Recommendations
Aetna	
2024 Review Recommendations (Continued)	
Subpart C – Enrollee Rights and Protections	
§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)
Subpart D – MCO, PIHP and PAHP Standards Compliance Results	
§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." (State Contract Section 1.18.6.4 "Termination, Suspension, or Reduction of Previously Authorized Covered Services," letters a and b[i-viii])

Regulatory Area	2024 Compliance Review Recommendations
Aetna	
2024 Review Recommendations	
Subpart D – MCO, PIHP and PAHP Standards Compliance Results (Continued)	
§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")
Humana	
2024 Review Recommendations	
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")
	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")
§438.56(b)(1) Disenrollment – Requirements and limitations: Disenrollment requested by the MCO, PIHP, PAHP, PCCM, or PCCM entity	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, "**Humana** may request disenrollment **of an enrollee** for reasons known as just cause reasons."

Regulatory Area	2024 Compliance Review Recommendations
Humana	
2024 Review Recommendations	
Subpart B – State Responsibilities (Continued)	
§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")
§438.56(f)(1) Disenrollment – Requirements and limitations: Notice and appeals	24. 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")
§438.56(f)(2) and (g) Disenrollment – Requirements and limitations: (f) Notice and appeals and (g) Automatic reenrollment: Contract requirement	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, "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")
438.56(e)(2) Disenrollment: Requirements and limitations – Timeframe for disenrollment determinations	26. 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")

Regulatory Area	2024 Compliance Review Recommendations
Humana	
2024 Review Recommendations (Continued)	
Subpart C – Enrollee Rights and Protections	
§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."
	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."
§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")
§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.
§438.10(i) Information requirements: Information for all enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Formulary	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")

Regulatory Area	2024 Compliance Review Recommendations
Humana	
2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections (Continued)	
§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)
§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)

Regulatory Area	2024 Compliance Review Recommendations
OCH	
2024 Review Recommendations	
Subpart C – Enrollee Rights and Protections	
§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")

Appendix D

SoonerSelect Program Annual External Quality Review Technical Report

2024-2025 Reporting Cycle

List of Abbreviations and Acronyms

List of Abbreviations and Acronyms	
Abbreviation/Acronym	***Description***
Aetna or ABH	Aetna Better Health of Oklahoma
CE	Contracted Entities
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program (Title XXI)
CMS	Centers for Medicare & Medicaid Services
CSP	Children's Specialty Program
CY	Calendar Year
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FM	Fully Met
FQHC	Federally Qualified Health Centers
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
Humana	Humana Healthy Horizons
ISCA	Information Systems Capabilities Assessment
KFMC	KFMC Health Improvement Partners
LIBERTY	LIBERTY Dental Plan
MCO	Managed Care Organization
MM	Minimally Met
NCQA	National Committee for Quality Assurance
NM	Not Met
NPI	National Program Identifier
OCH	Oklahoma Complete Health
OCH-CSP	Oklahoma Complete Health - Children's Specialty Program
OHCA	Oklahoma Health Care Authority
OHS	Oklahoma Human Services
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
QS	Quality Strategy
RHC	Rural Health Center
SM	Substantially Met
URAC	Utilization Review Accreditation Commission

List of Abbreviations and Acronyms	
Abbreviation/Acronym	***Description***
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCD	Primary Care Dentist
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Partially Met
PPL	Patient Pay Liability
QAPI	Quality Assessment and Performance Improvement
SDOH	Social Determinants of Health
SM	Substantially Met