Managed Care Program Annual Report (MCPAR) for California: Dental Managed Care

Due date	Last edited	Edited by	Status
06/29/2025	10/01/2025	Farrah Samimi	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected
	Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If “No”, please complete the following questions under each plan.	Plan to submit on 10/01/2025

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	California
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Dana Durham
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	dana.durham@dhcs.ca.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Sabrina Wisdom
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	sabrina.wisdom@dhcs.ca.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	10/01/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2024
A6	**Program name** Auto-populated from report dashboard.	Dental Managed Care

Add plans (A.7)

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

	Indicator	Response
	Plan name	Access Dental Plan, Inc. Health Net of California, Inc. LIBERTY Dental Plan of California, Inc.

Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	Maximus

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

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

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

Indicator	Response
ILOS name	Not answered

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	14,980,562
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	14,000,060

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.	The State's program integrity activities involve reviewing encounter data and claims for anomalies and questionable billing patterns under both the managed care plan (MCP) model and fee-for-service (FFS) model. The State performs data analytics to detect fraudulent activities, suspicious providers, and emerging fraud trends within the Medi-Cal program. Actionable leads generated from data analytics and case development efforts are then prioritized and investigated for suspected fraud, waste and abuse. The conclusion of these investigations may result in criminal referrals to the State's Medicaid Fraud Control Unit (MFCU) and/or administrative actions (e.g., educational letter, sanctions, penalties, overpayment recovery) taken against the provider. Recent cases involve prescription drugs and hospice services. In addition to requiring each MCP to maintain a comprehensive program integrity plan to combat fraud, waste and abuse; the State conducts annual managed care contract compliance audits. The results of these audits are used in part by the State to achieve its managed care contract oversight and monitoring objectives. Audit results are used to pursue Corrective Action Plans (CAP) from MCPs, and support sanctions and penalties imposed on non-compliant plans when warranted.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	https://www.dhcs.ca.gov/services/Documents/APL-22-003E.pdf

BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard selected in indicator B.X.2.	The DMC Plan shall retain all overpayment recoveries less than $1 million. For overpayments of $1 million or more, the State and the MCP will share the recovery amount equally. In addition, for other health coverage, DMC Plans must remit warrants, payable to DHCS, for all recovered monies that are 13 months or older from the date of payment of a service, unless the payment meets the criteria of an active repayment plan.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	DMC Plans report overpayment data to the State annually. In addition, plans have 60 days to report an overpayment to the State if the overpayment to a provider is $1 million or more, and within 10 days of the plans' knowledge of suspected fraud. The state monitors the reporting requirements of this section via self-reporting, date of reports, and periodic audits.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	There is a file exchange that occurs between the State and the plans to ensure that the plans have the most current and accurate information the State has. This includes residence address information, plan enrollment information, death record updates, and incarceration status. In addition to the information that the state obtains and shared with the plans, the plans also have contractual agreements with all contractors per Exhibit E, Provision 28 a.3. Changes in Eligibility requires that the "Contractor shall promptly report to DHCS in accordance with Exhibit E, Additional Provisions, Provision 28, Fraud, Waste, and Abuse Reporting when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including all of the following: a) Changes in the Member's residence; and b) The death of a Member".
BX.7a	**Changes in provider circumstances: Monitoring plans**	Yes

	Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	The state uses a template that is completed by the plans to monitor the plan performance - this data is trended to determine if there are any fluctuations within monitoring and how the plan compares to other similar plan models.
BX.8a	**Federal database checks: Excluded person or entities** During the state’s federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	Yes
BX.9b	**Website posting of 5 percent or more ownership control: Link** What is the link to the website? Refer to 42 CFR 602(g)(3).	https://dental.dhcs.ca.gov/Members/Dental_Managed_Care/PlanOwnershipInformation

BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	Mercer (contractor) performs periodic audits of financial data submitted by each MCP, pursuant to 42 CFR 438.602(e) on DHCS' behalf. DHCS is fully compliant with both 42 CFR 438.602(e) and 438.602.(g)(4). DHCS has continued to perform Rate Develpment Template audits on a rolling basis to ensure that the requirements set forth in 42 CFR 438.602(e) are met. Location of Periodic Audits: https://www.dhcs.ca.gov/dataandstats/reports/Pages/CY-2022-CMS-Periodic-Audit-Reports.aspx

Topic XIII. Prior Authorization

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

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Yes
BXIII.1a	**Timeframes for standard prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and within state-established timeframes. For rating periods that start before January 1, 2026, a state's time frame may not exceed 14 calendar days after receiving the request. For rating periods that start on or after January 1, 2026, a state's time frame may not exceed 7 calendar days after receiving the request. Does the state set timeframes shorter than these maximum timeframes for standard prior authorization requests?	No
BXIII.2a	**Timeframes for expedited prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for service. Does the state set timeframes shorter than the maximum timeframe for expedited prior authorization requests?	No

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Access GMC 12-89341, 12/20/2012 Access PHP 13-90115, 6/20/2013 Health Net GMC 12/20/2012 Health Net PHP 13-90116, 6/20/2013 Liberty GMC 12-89343, 12/20/2012 Liberty PHP 13-90117, 6/20/2013 All ongoing and updated for terms on an annual basis.
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	12/20/2012
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.dhcs.ca.gov/services/Pages/DMCContractsAllPlanLetters.aspx
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Other, specify – PAHP - Special Benefit Type (Dental)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Dental
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter “N/A” if not applicable.	Yes, there are additional benefits available for members with special needs through Medi-Cal Dental's Manual of Criteria
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this	974,639

	managed care program per month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter “There were no major changes to the population or benefits during the reporting year” as your response. “N/A” is not an acceptable response.	In accordance with 1915(b) Special Terms and Conditions, all plans were compared with Medi-Cal dental Fee-for-Service (FFS) performance measures for Calendar Year 2022. All plans did not achieve parity when compared to specific measures. As a result, DHCS allowed members in Sacramento County to disenroll from their plan and enroll in the dental FFS delivery system, and also cease automatically enrolling new members in a managed care plan and instead began automatically enrolling the members in the dental FFS delivery system. As part of a settlement agreement, one plan (Liberty) resumed 1/3 member default enrollment in February 2024.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Other, specify – Exhibit A, Attachment 4(B) and APL 18-011. The state evaluates managed care plan performance encounter data submission and correction by reviewing the Post Adjudication Claims and Encounter Data Systems (PACES) file and the Encounter Data Submission Reconciliation Form (EDSRF) submitted by each plan. The plan must resubmit corrected data if deemed insufficient or inaccurate within fifteen (15) calendar days of receipt of DHCS' notice.
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Exhibit A, Attachment 4(B) and APL 18-011, the state evaluates managed care plan performance encounter data submission and correction by reviewing the Post Adjudication Claims and Encounter Data Systems (PACES) file and the Encounter Data Submission Reconciliation Form (EDSRF) submitted by each plan. The plan must resubmit corrected data if deemed insufficient or inaccurate within fifteen (15) calendar days of receipt of DHCS' notice. Exhibit A, Attachment 5(4)(C) APL 22-002 (https://www.dhcs.ca.gov/services/Documents/APL-22-002.pdf)
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of	https://www.dhcs.ca.gov/services/Documents/APL-22-009.pdf

	failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with “N/A” if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter “The state did not experience any barriers to collecting or validating encounter data during the reporting year” as your response. “N/A” is not an acceptable response.	Plans identified that some encounters were erroneously being denied as duplicate services because the State's encounter data system does not differentiate by tooth quadrants.

Topic IV. Appeals, State Fair Hearings & Grievances

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

C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	No later than 30 days

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	Recruiting providers in rural areas in the outer limits of the counties where plans operate. Recruiting providers on the only island located in Los Angeles County (Avalon, CA).
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	Exhibit A, Attachment 5(N), Quality Improvement System Corrective Action Plan (CAP). The State also has two State Directed Payment programs to encourage increased contracting between plans and providers.

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	HCO Website: https://www.healthcareoptions.dhcs.ca.gov/
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Beneficiary support systems is accessible by phone, internet, and in person through DHCS Health Care Options (HCO) enrollment broker, Maximus. Beneficiary support systems includes a Telephone Call Center (TCC), HCO website (https://www.healthcareoptions.dhcs.ca.gov), and In-Person support services. The TCC assists applicants or beneficiaries in understanding, selecting, and enrolling in a Medi-Cal managed care plan. The TCC is accessible through a statewide toll-free helpline and staffed to provide information and assistance in all threshold languages. TCC provides a Telecommunications Device for the Deaf (TDD)/Teletypewriter (TTY) telephone line with a messaging system for the hearing impaired that is available during normal business hours and has a call back option available after normal business hours. The HCO website provides health care options program information and answers to frequently asked questions. HCO website also provides access to informing materials, choice forms, in-person presentation schedules, lists of health plans and links to health plan websites, Provider Information Network, eligibility status and Beneficiary enrollment information. The website also provides help page and a link to request assistance, email questions and comments online. HCO CSP website is in compliance with the California Web Accessibility Standards and applicable provisions the Americans with Disability Act (ADA). In Person support is provided by Enrollment Service Representatives (ESRs) who provide education and outreach through face-to-face presentations, including in-person choice counseling, and outreach events. ESRs assist applicants and beneficiaries in understanding, selecting, and using managed care health plans. Presentation Site locations and schedules can be found on the HCO website or by calling the Telephone Call Center

		(TCC). ESR/Presentation Site locations ensure disabled, hearing and/or visually impaired applicants or beneficiaries understand their health care options by providing presentations and informing materials in alternate formats that comply with the Americans with Disability Act (ADA). Presentation Site facilities are physically accessible to individuals with disabilities pursuant to section 1557 of the Patient Protection and Affordable Care Act (45 CFR 92.203). Beneficiary support systems assist disabled, hearing and/or visually impaired applicants or beneficiaries to understand their health care options by providing presentations and informing materials in alternate formats that comply with ADA. Mailings are mailed to beneficiaries in all threshold languages, as well as in Alternative Formats for persons with disabilities i.e. Braille, Large Print, and Audio CD. Additionally, in-person support can be scheduled with sign language interpreters for beneficiaries who need it. TCC provides auxiliary aids such as TTY/TDD.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	LTSS is not applicable to Dental Managed Care Plans.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	DHCS monitors activities objectively and systematically, measuring and reporting on operation performance, as well as reviewing operations policies and procedures for the purpose of providing recommendations for improvements in the performance of BSS. DHCS ensures BSS performance standards are regularly monitored, evaluated, and revised to ensure compliance of the Telephone Call Center, Educations and Outreach, Informing Materials, Enrollment/Disenrollment Processing, Complaints and Grievance Resolution, Quality Management Program, Reports Reporting, Records Retention and Retrieval, Security and Confidentiality. In addition to the BSS being required to maintain an ISO 9001 certified Quality Management System, the BSS is required to meet stringent SLAs, which is monitored by DHCS. Additionally,

		BSS performance is monitored and evaluated by beneficiary feedback on the quality of service provided by the BSS. Data is collected and reviewed through a Caller Satisfaction Evaluation Tool. DHCS monitors activities objectively and systematically, measuring and reporting on operation performance, as well as reviewing operations policies and procedures for the purpose of providing recommendations for improvements in the performance of BSS. DHCS ensures BSS performance standards are regularly monitored, evaluated, and revised to ensure compliance of the Telephone Call Center, Educations and Outreach, Informing Materials, Enrollment/Disenrollment Processing, Complaints and Grievance Resolution, Quality Management Program, Reports Reporting, Records Retention and Retrieval, Security and Confidentiality. In addition to the BSS being required to maintain an ISO 9001 certified Quality Management System, the BSS is required to meet stringent service level agreements, which is monitored by DHCS. Additionally, BSS performance is monitored and evaluated by beneficiary feedback on the quality of service provided by the BSS. Data is collected and reviewed through a Caller Satisfaction Evaluation Tool.

Topic X: Program Integrity

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

Topic XII. Mental Health and Substance Use Disorder Parity

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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Access Dental Plan, Inc.** 269,117 **Health Net of California, Inc.** 390,582 **LIBERTY Dental Plan of California, Inc.** 314,940
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid enrollment (B.I.1)	**Access Dental Plan, Inc.** 1.8% **Health Net of California, Inc.** 2.6% **LIBERTY Dental Plan of California, Inc.** 2.1%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Access Dental Plan, Inc.** 1.92% **Health Net of California, Inc.** 2.79% **LIBERTY Dental Plan of California, Inc.** 2.25%
D1I.4: Parent	**Organization: The name of the parent entity that controls the Medicaid Managed Care Plan.** If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Access Dental Plan, Inc.** 68.12% **Health Net of California, Inc.** 75.01% **LIBERTY Dental Plan of California, Inc.** 86.83%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Access Dental Plan, Inc.** Program-specific statewide **Health Net of California, Inc.** Program-specific statewide **LIBERTY Dental Plan of California, Inc.** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter “N/A” if not applicable. See glossary for the regulatory definition of MLR.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Access Dental Plan, Inc.** Yes **Health Net of California, Inc.** Yes

		LIBERTY Dental Plan of California, Inc. Yes
N/A	Enter the start date.	**Access Dental Plan, Inc.** 01/01/2022 **Health Net of California, Inc.** 01/01/2022 **LIBERTY Dental Plan of California, Inc.** 01/01/2022
N/A	Enter the end date.	**Access Dental Plan, Inc.** 12/31/2022 **Health Net of California, Inc.** 12/31/2022 **LIBERTY Dental Plan of California, Inc.** 12/31/2022

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Access Dental Plan, Inc.** Monthly, 15 days **Health Net of California, Inc.** Monthly, 15 days **LIBERTY Dental Plan of California, Inc.** Monthly, 15 days
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Access Dental Plan, Inc.** 100% **Health Net of California, Inc.** 100% **LIBERTY Dental Plan of California, Inc.** 100%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Access Dental Plan, Inc.** 100% **Health Net of California, Inc.** 100% **LIBERTY Dental Plan of California, Inc.** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year.An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Access Dental Plan, Inc.** 394 **Health Net of California, Inc.** 537 **LIBERTY Dental Plan of California, Inc.** 774
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	**Access Dental Plan, Inc.** 285 **Health Net of California, Inc.** 310 **LIBERTY Dental Plan of California, Inc.** 617
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	**Access Dental Plan, Inc.** 12 **Health Net of California, Inc.** 74 **LIBERTY Dental Plan of California, Inc.** 40
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	**Access Dental Plan, Inc.** 97 **Health Net of California, Inc.** 153 **LIBERTY Dental Plan of California, Inc.** 117
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 16

LIBERTY Dental Plan of California, Inc.

32

D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable.An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”.Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”.The appeal and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A

	reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year.See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Access Dental Plan, Inc.** 358 **Health Net of California, Inc.** 483 **LIBERTY Dental Plan of California, Inc.** 458
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year.See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 30 **LIBERTY Dental Plan of California, Inc.** 314
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Access Dental Plan, Inc.** 56 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 547
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 0

	termination of a previously authorized service.	
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Access Dental Plan, Inc.** 240 **Health Net of California, Inc.** 7 **LIBERTY Dental Plan of California, Inc.** 15
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 1
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability**	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.**

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	0 **LIBERTY Dental Plan of California, Inc.** 0

Appeals by Service

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

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

	substance use services. If the managed care plan does not cover outpatient behavioral health services, enter “N/A”.	N/A
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter “N/A”.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter “N/A”.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter “N/A”.	**Access Dental Plan, Inc.** 394 **Health Net of California, Inc.** 537 **LIBERTY Dental Plan of California, Inc.** 774

D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter “N/A”.	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 0
D1IV.7k:	**Resolved appeals related to durable medical equipment (DME) & supplies** Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter “N/A”.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.7l:	**Resolved appeals related to home health / hospice** Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter “N/A”.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.7m:	**Resolved appeals related to emergency services / emergency department** Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter “N/A”.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.7n:	**Resolved appeals related to therapies** Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A

	occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.	**LIBERTY Dental Plan of California, Inc.** N/A
D1IV.7o	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter “N/A”.	**Access Dental Plan, Inc.** 98 **Health Net of California, Inc.** 530 **LIBERTY Dental Plan of California, Inc.** 211

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	**Access Dental Plan, Inc.** 10 **Health Net of California, Inc.** 60 **LIBERTY Dental Plan of California, Inc.** 55
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Access Dental Plan, Inc.** 1 **Health Net of California, Inc.** 16 **LIBERTY Dental Plan of California, Inc.** 6
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Access Dental Plan, Inc.** 7 **Health Net of California, Inc.** 22 **LIBERTY Dental Plan of California, Inc.** 32
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Access Dental Plan, Inc.** 1 **Health Net of California, Inc.** 17 **LIBERTY Dental Plan of California, Inc.** 16
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 0

	not offer an external medical review process, enter “N/A”.External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter “N/A”.External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 0

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.A grievance is “resolved” when it has reached completion and been closed by the plan.	**Access Dental Plan, Inc.** 755 **Health Net of California, Inc.** 1,372 **LIBERTY Dental Plan of California, Inc.** 1,563
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Access Dental Plan, Inc.** 2 **Health Net of California, Inc.** 35 **LIBERTY Dental Plan of California, Inc.** 118
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users.An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A

	grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.If the managed care plan does not cover LTSS, the state should enter “N/A” in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter “N/A” in this field.To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year.See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Access Dental Plan, Inc.** 709 **Health Net of California, Inc.** 1,372 **LIBERTY Dental Plan of California, Inc.** 1,563

Grievances by Service

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

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

	were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	**LIBERTY Dental Plan of California, Inc.** N/A
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter “N/A”.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter “N/A”.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter “N/A”.	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter “N/A”.	**Access Dental Plan, Inc.** 754 **Health Net of California, Inc.** 1,372 **LIBERTY Dental Plan of California, Inc.** 1,549

D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Access Dental Plan, Inc.** 1 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 14
D1IV.15k	**Resolved grievances related to durable medical equipment (DME) & supplies** Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.15l	**Resolved grievances related to home health / hospice** Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.15m	**Resolved grievances related to emergency services / emergency department** Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A **LIBERTY Dental Plan of California, Inc.** N/A
D1IV.15n	**Resolved grievances related to therapies** Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or	**Access Dental Plan, Inc.** N/A **Health Net of California, Inc.** N/A

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

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service.Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Access Dental Plan, Inc.** 94 **Health Net of California, Inc.** 434 **LIBERTY Dental Plan of California, Inc.** 368
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management.Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 0
D1IV.16c	**Resolved grievances related to network adequacy or access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Access Dental Plan, Inc.** 138 **Health Net of California, Inc.** 216 **LIBERTY Dental Plan of California, Inc.** 205
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care.Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Access Dental Plan, Inc.** 163 **Health Net of California, Inc.** 268 **LIBERTY Dental Plan of California, Inc.** 293
D1IV.16e	**Resolved grievances related to plan communications**	**Access Dental Plan, Inc.** 14

	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications.Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Health Net of California, Inc.** 3 **LIBERTY Dental Plan of California, Inc.** 20
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Access Dental Plan, Inc.** 218 **Health Net of California, Inc.** 249 **LIBERTY Dental Plan of California, Inc.** 321
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud.Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Access Dental Plan, Inc.** 28 **Health Net of California, Inc.** 2 **LIBERTY Dental Plan of California, Inc.** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation.Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 1 **LIBERTY Dental Plan of California, Inc.** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)**	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 0

	Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**LIBERTY Dental Plan of California, Inc.** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal.Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** 0 **LIBERTY Dental Plan of California, Inc.** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Access Dental Plan, Inc.** 99 **Health Net of California, Inc.** 199 **LIBERTY Dental Plan of California, Inc.** 342

Topic VII: Quality & Performance Measures

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

Quality & performance measure total count: 38

Complete

D2.VII.1 Measure Name: Annual Dental Visits (ADV)

1 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who had at least one (1) dental visit during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any dental procedure (D0100-D9999 or CPT 99188) or dental encounter at a Safety Net Clinic (SNC) (e.g., Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs); and Indian Health Services/Memorandum of Agreement Clinics (community health centers)) during the period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

30.41%

Health Net of California, Inc.

28.12%

LIBERTY Dental Plan of California, Inc.

33.69%

Complete

D2.VII.1 Measure Name: Use of Preventive Services

2 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received any preventive dental service during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any preventive dental service (D1000-D1999 or CPT 99188 or ICD 10: K023 K0251 K0261 K036 K0500 K0501 K051 K0510 K0511 Z012 Z0120 Z0121 Z293 Z299 Z98810 in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

16.88%

Health Net of California, Inc.

19.12%

LIBERTY Dental Plan of California, Inc.

24.74%

Complete

D2.VII.1 Measure Name: Use of Sealants (6-9)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries ages 6-9 and 10-14 who received a dental sealant on at least one permanent molar during the measurement period. Numerator: 1.) Number of beneficiaries ages 6-9 with at least 90 days continuous enrollment in the same plan within the measurement year who received a dental sealant (D1351) on a permanent first molar (tooth number = 3, 14, 19, 30) or a SNC dental encounter with ICD 10: Z98810. 2) Number of beneficiaries ages 10-14 with at least 90 days continuous enrollment in the same plan within the measurement year who received a dental sealant(D1351) on a permanent second molar(tooth number=2,15,18,31) or a SNC dental encounter with ICD 10: Z98810. Denominator: Number of beneficiaries ages 6-9 and 10-14, respectively, with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

12.24%

Health Net of California, Inc.

14.69%

LIBERTY Dental Plan of California, Inc.

16.22%

Complete

D2.VII.1 Measure Name: Use of Sealants (10-14)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries ages 6-9 and 10-14 who received a dental sealant on at least one permanent molar during the measurement period. Numerator: 1.) Number of beneficiaries ages 6-9 with at least 90 days continuous enrollment in the same plan within the measurement year who received a dental sealant (D1351) on a permanent first molar (tooth number = 3, 14, 19, 30) or a SNC dental encounter with ICD 10: Z98810. 2) Number

of beneficiaries ages 10-14 with at least 90 days continuous enrollment in the same plan within the measurement year who received a dental sealant(D1351) on a permanent second molar(tooth number=2,15,18,31) or a SNC dental encounter with ICD 10: Z98810. Denominator: Number of beneficiaries ages 6-9 and 10-14, respectively, with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

6.93%

Health Net of California, Inc.

7.76%

LIBERTY Dental Plan of California, Inc.

9.53%

Complete

D2.VII.1 Measure Name: Use of Diagnostic Services

5 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received any diagnostic dental service during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any diagnostic dental service (D0100-D0999) or dental encounter at a SNC with ICD 10 on List 1 and M2620 M26211 M26212 M26213 M2632 M264 M2660 M2662 M2663 M2669 R6884 in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

21.84%

Health Net of California, Inc.

25.19%

LIBERTY Dental Plan of California, Inc.

30.40%

Complete

D2.VII.1 Measure Name: Treatment/Prevention of Caries

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received either treatment for caries or a caries-preventive procedure during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received a treatment for caries (D2000-D2999) or dental encounter at a SNC with ICD 10: K0262 K029 K0252 K0263 K0253 K0381 Z98811 K027 K08531 K0850 K0851 K08530 K08539 K0859 K0852 K0856 K025 or a caries-preventive procedure (D1203-D1208, D1310, D1330, or D1351) or dental encounter at a SNC with ICD 10: K036, Z293 or Z98810 during the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

17.61%

Health Net of California, Inc.

19.41%

LIBERTY Dental Plan of California, Inc.

25.23%

Complete

D2.VII.1 Measure Name: Exams/Oral Health Evaluations

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

The percentage of beneficiaries who received a comprehensive or periodic oral health evaluation or, for beneficiaries under 3 years of age, who received an oral evaluation and counseling with the primary care giver, during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received a comprehensive or period exam (D0120, D0150) or dental encounter at a SNC with ICD 10 on List 1 below or, for beneficiaries under three (3) years of age, who received an oral evaluation and counseling with the primary caregiver (D0145), during the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

19.68%

Health Net of California, Inc.

22.97%

LIBERTY Dental Plan of California, Inc.

27.89%

Complete

D2.VII.1 Measure Name: Use of Dental Treatment Services

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received any dental treatment service during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any dental treatment service (D2000-D9999) or dental encounter at a SNC with ICD 10 on List 2 below in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

19.39%

Health Net of California, Inc.

18.07%

LIBERTY Dental Plan of California, Inc.

19.54%

Complete

D2.VII.1 Measure Name: Preventive Services to Fillings

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received one (1) or more fillings in the measurement period who also received preventive services (topical fluoride application, sealant, preventive resin restoration, education) during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received one (1) or more fillings (D2000-D2999) or dental encounter at a SNC with ICD 10: K0262 K029 K0252 K0263 K0253 K0381 Z98811 K027 K08531 K0850 K0851 K08530 K08539 K0859 K0852 K0856 K025 in the measurement period and who also received one (1) or more topical fluoride applications (D1203, D1204, D1206, or D1208) or dental encounter at a SNC with ICD10: K036 or Z293, dental sealants (D1351) or dental encounter at a SNC with ICD 10: Z98810, preventive resin restorations (D1352) or dental encounter at a SNC with ICD 10: K023 K0251 K0261 Z98810 or education to prevent caries (D1310 or D1330) in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year, who received one (1) or more fillings (D2000-D2999) or ICD 10: K0262 K029 K0252 K0263 K0253 K0381 Z98811 K027 K08531 K0850 K0851 K08530 K08539 K0859 K0852 K0856 K025 in the measurement period.

Measure results

Access Dental Plan, Inc.

64.97%

Health Net of California, Inc.

63.70%

LIBERTY Dental Plan of California, Inc.

69.56%

Complete

D2.VII.1 Measure Name: Overall Utilization of Dental Services 1 year

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries continuously enrolled for the measurement period who received any dental service during that period. Numerator: Number of beneficiaries continuously enrolled for one (1) year with no gap in coverage who received any dental service (D0100-D9999) or dental encounter at a SNC during that period. Denominator: Number of beneficiaries continuously enrolled for one (1) year with no gap in coverage.

Measure results

Access Dental Plan, Inc.

30.75%

Health Net of California, Inc.

27.65%

LIBERTY Dental Plan of California, Inc.

34.01%

Complete

D2.VII.1 Measure Name: Overall Utilization of Dental Services 2 years

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

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

Dental Specific Measures for Dental Specific Model | Yes

D2.VII.8 Measure Description

Percentage of beneficiaries continuously enrolled for the measurement period who received any dental service during that period. Numerator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage who received any dental service (D0100-D9999) or dental encounter at a SNC during that period. Denominator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage.

Measure results

Access Dental Plan, Inc.

40.74%

Health Net of California, Inc.

38.31%

LIBERTY Dental Plan of California, Inc.

45.54%

Complete

D2.VII.1 Measure Name: Overall Utilization of Dental Services 3 years

12 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries continuously enrolled for the measurement period who received any dental service during that period. Numerator: Number of beneficiaries continuously enrolled for three (3) years with no gap in coverage who received any dental service (D0100-D9999) or dental encounter at a SNC during that period. Denominator: Number of beneficiaries continuously enrolled for three (3) years with no gap in coverage.

Measure results

Access Dental Plan, Inc.

46.91%

Health Net of California, Inc.

45.17%

LIBERTY Dental Plan of California, Inc.

52.93%

Complete

D2.VII.1 Measure Name: Continuity of Care

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

The percentage of beneficiaries continuously enrolled for two (2) years with no gap in coverage who received a comprehensive oral evaluation or a prophylaxis in both the year prior to the measurement year and in the measurement year. Numerator: Number of beneficiaries in the denominator who also received a comprehensive oral evaluation (D0120, D0150) or dental encounter at a SNC with ICD 10 on List 1 below, or a prophylaxis (D1110, D1120) or dental encounter at a SNC with ICD 10: K036 K0500 K0501 K051 K0510 K0511 Z293 Z299 Z012 Z0120 Z0121 in the measurement year. Denominator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage who received a comprehensive oral evaluation (D0120, D0150) or dental encounter at a SNC with ICD 10 on List 1 below, or a prophylaxis (D1110, D1120) or dental encounter at a SNC with ICD 10: K036 K0500 K0501 K051 K0510 K0511 Z293 Z299 Z012 Z0120 Z0121 in the year prior to the measurement year.

Measure results

Access Dental Plan, Inc.

50.66%

Health Net of California, Inc.

54.97%

LIBERTY Dental Plan of California, Inc.

60.18%

Complete

D2.VII.1 Measure Name: Usual Source of Care

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

The percentage of beneficiaries who received any dental service each year for two (2) consecutive years. Numerator: Number of members in the same plan for two years during the measurement period with no gap who received at least one (1) dental service (D0100-D9999) or dental encounter at a SNC in each of those years. Denominator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage.

Measure results

Access Dental Plan, Inc.

16.07%

Health Net of California, Inc.

17.59%

LIBERTY Dental Plan of California, Inc.

23.16%

Complete

D2.VII.1 Measure Name: Annual Dental Visits (ADV) (age 0-20)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who had at least one (1) dental visit during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any dental procedure (D0100-D9999 or CPT 99188) or dental encounter at a Safety Net Clinic (SNC) (e.g., Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs); and Indian Health Services/Memorandum of Agreement Clinics (community health centers)) during the period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

41.81%

Health Net of California, Inc.

41.84%

LIBERTY Dental Plan of California, Inc.

47.44%

Complete

D2.VII.1 Measure Name: Use of Preventive Services (age 0-20)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received any preventive dental service during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any preventive dental service (D1000-D1999 or CPT 99188 or ICD 10: K023 K0251 K0261 K036 K0500 K0501 K051 K0510 K0511 Z012 Z0120 Z0121 Z293 Z299 Z98810 in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

33.36%

Health Net of California, Inc.

37.69%

LIBERTY Dental Plan of California, Inc.

43.58%

Complete

D2.VII.1 Measure Name: Use of Diagnostic Services (age 0-20)

17 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received any diagnostic dental service during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any diagnostic dental service (D0100-

D0999) or dental encounter at a SNC with ICD 10 on List 1 and M2620 M26211 M26212 M26213 M2632 M264 M2660 M2662 M2663 M2669 R6884 in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

33.58%

Health Net of California, Inc.

37.81%

LIBERTY Dental Plan of California, Inc.

43.39%

Complete

D2.VII.1 Measure Name: Treatment/Prevention of Caries (age 0-20)

18 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received either treatment for caries or a caries-preventive procedure during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received a treatment for caries (D2000-D2999) or dental encounter at a SNC with ICD 10: K0262 K029 K0252 K0263 K0253 K0381 Z98811 K027 K08531 K0850 K0851 K08530 K08539 K0859 K0852 K0856 K025 or a caries-preventive procedure (D1203-D1208, D1310, D1330, or D1351) or dental encounter at a SNC with ICD 10: K036, Z293 or Z98810 during the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

32.35%

Health Net of California, Inc.

35.87%

LIBERTY Dental Plan of California, Inc.

41.92%

Complete

D2.VII.1 Measure Name: Exams/Oral Health Evaluations (age 0-20)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

The percentage of beneficiaries who received a comprehensive or periodic oral health evaluation or, for beneficiaries under 3 years of age, who received an oral evaluation and counseling with the primary care giver, during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received a comprehensive or period exam (D0120, D0150) or dental encounter at a SNC with ICD 10 on List 1 below or, for beneficiaries under three (3) years of age, who received an oral evaluation and counseling with the primary caregiver (D0145), during the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

30.96%

Health Net of California, Inc.

34.65%

LIBERTY Dental Plan of California, Inc.

40.46%

Complete

D2.VII.1 Measure Name: Use of Dental Treatment Services (age 0-20)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received any dental treatment service during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any dental treatment service (D2000-D9999) or dental encounter at a SNC with ICD 10 on List 2 below in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

20.13%

Health Net of California, Inc.

23.73%

LIBERTY Dental Plan of California, Inc.

22.64%

Complete

D2.VII.1 Measure Name: Preventive Services to Fillings (age 0-20)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received one (1) or more fillings in the measurement period who also received preventive services (topical fluoride application, sealant, preventive resin restoration, education) during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received one (1) or more fillings (D2000-D2999) or dental encounter at a SNC with ICD 10: K0262 K029 K0252 K0263 K0253 K0381 Z98811 K027 K08531 K0850 K0851 K08530 K08539 K0859 K0852 K0856 K025 in the measurement period and who also received one (1) or more topical fluoride applications (D1203, D1204, D1206, or D1208) or dental encounter at a SNC with ICD10: K036 or Z293, dental sealants (D1351) or dental encounter at a SNC with ICD 10: Z98810, preventive resin restorations (D1352) or dental encounter at a SNC with ICD 10: K023 K0251 K0261 Z98810 or education to prevent caries (D1310 or D1330) in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year, who received one (1) or more fillings (D2000-D2999) or ICD 10: K0262 K029 K0252 K0263 K0253 K0381 Z98811 K027 K08531 K0850 K0851 K08530 K08539 K0859 K0852 K0856 K025 in the measurement period.

Measure results

Access Dental Plan, Inc.

84.93%

Health Net of California, Inc.

87.02%

LIBERTY Dental Plan of California, Inc.

87.56%

Complete

D2.VII.1 Measure Name: Overall Utilization of Dental Services 1 year (age 0-20)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries continuously enrolled for the measurement period who received any dental service during that period. Numerator: Number of beneficiaries continuously enrolled for one (1) year with no gap in coverage who received any dental service (D0100-D9999) or dental encounter at a SNC during that period. Denominator: Number of beneficiaries continuously enrolled for one (1) year with no gap in coverage.

Measure results

Access Dental Plan, Inc.

41.44%

Health Net of California, Inc.

41.37%

LIBERTY Dental Plan of California, Inc.

48.87%

Complete

D2.VII.1 Measure Name: Overall Utilization of Dental Services 2 years (age 0-20)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries continuously enrolled for the measurement period who received any dental service during that period. Numerator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage who received any dental service (D0100-D9999) or dental encounter at a SNC during that period. Denominator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage.

Measure results

Access Dental Plan, Inc.

54.81%

Health Net of California, Inc.

55.18%

LIBERTY Dental Plan of California, Inc.

62.67%

Complete

D2.VII.1 Measure Name: Overall Utilization of Dental Services 3 years (age 0-20)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries continuously enrolled for the measurement period who received any dental service during that period. Numerator: Number of beneficiaries continuously enrolled for three (3) years with no gap in coverage who received any dental service (D0100-D9999) or dental

encounter at a SNC during that period. Denominator: Number of beneficiaries continuously enrolled for three (3) years with no gap in coverage.

Measure results

Access Dental Plan, Inc.

62.49%

Health Net of California, Inc.

63.50%

LIBERTY Dental Plan of California, Inc.

71.28%

Complete

D2.VII.1 Measure Name: Continuity of Care (age 0-20)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

The percentage of beneficiaries continuously enrolled for two (2) years with no gap in coverage who received a comprehensive oral evaluation or a prophylaxis in both the year prior to the measurement year and in the measurement year. Numerator: Number of beneficiaries in the denominator who also received a comprehensive oral evaluation (D0120, D0150) or dental encounter at a SNC with ICD 10 on List 1 below, or a prophylaxis (D1110, D1120) or dental encounter at a SNC with ICD 10: K036 K0500 K0501 K051 K0510 K0511 Z293 Z299 Z012 Z0120 Z0121 in the measurement year. Denominator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage who received a comprehensive oral evaluation (D0120, D0150) or dental encounter at a SNC with ICD 10 on List 1 below, or a prophylaxis (D1110, D1120) or dental encounter at a SNC with ICD 10: K036 K0500 K0501 K051 K0510 K0511 Z293 Z299 Z012 Z0120 Z0121 in the year prior to the measurement year.

Measure results

Access Dental Plan, Inc.

60.96%

Health Net of California, Inc.

67.15%

LIBERTY Dental Plan of California, Inc.

71.15%

Complete

D2.VII.1 Measure Name: Usual Source of Care (age 0-20)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

The percentage of beneficiaries who received any dental service each year for two (2) consecutive years. Numerator: Number of members in the same plan for two years during the measurement period with no gap who received at least one (1) dental service (D0100-D9999) or dental encounter at a SNC in each of those years. Denominator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage.

Measure results

Access Dental Plan, Inc.

26.93%

Health Net of California, Inc.

30.75%

LIBERTY Dental Plan of California, Inc.

37.49%

Complete

D2.VII.1 Measure Name: Annual Dental Visits (ADV) (age 21+)

27 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who had at least one (1) dental visit during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any dental procedure (D0100-D9999 or CPT 99188) or dental encounter at a Safety Net Clinic (SNC) (e.g., Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs); and Indian Health Services/Memorandum of Agreement Clinics (community health centers)) during the period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

25.11%

Health Net of California, Inc.

22.26%

LIBERTY Dental Plan of California, Inc.

26.03%

Complete

D2.VII.1 Measure Name: Use of Preventive Services (age 21+)

28 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received any preventive dental service during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any preventive dental service (D1000-D1999 or CPT 99188 or ICD 10: K023 K0251 K0261 K036 K0500 K0501 K051 K0510 K0511 Z012 Z0120 Z0121 Z293 Z299 Z98810 in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

9.23%

Health Net of California, Inc.

11.19%

LIBERTY Dental Plan of California, Inc.

14.24%

Complete

D2.VII.1 Measure Name: Use of Diagnostic Services (age 21+)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received any diagnostic dental service during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any diagnostic dental service (D0100-D0999) or dental encounter at a SNC with ICD 10 on List 1 and M2620 M26211 M26212 M26213 M2632 M264 M2660 M2662 M2663 M2669 R6884 in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

16.39%

Health Net of California, Inc.

19.80%

LIBERTY Dental Plan of California, Inc.

23.16%

Complete

D2.VII.1 Measure Name: Treatment/Prevention of Caries (age 21+)

30 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received either treatment for caries or a caries-preventive procedure during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received a treatment for caries (D2000-D2999) or dental encounter at a SNC with ICD 10: K0262 K029 K0252 K0263 K0253 K0381 Z98811 K027 K08531 K0850 K0851 K08530 K08539 K0859 K0852 K0856 K025 or a caries-preventive procedure (D1203-D1208, D1310, D1330, or D1351) or dental encounter at a SNC with ICD 10: K036, Z293 or Z98810 during the measurement period. Denominator:

Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

10.76%

Health Net of California, Inc.

12.38%

LIBERTY Dental Plan of California, Inc.

15.93%

Complete

D2.VII.1 Measure Name: Exams/Oral Health Evaluations (age 21+) 31 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

The percentage of beneficiaries who received a comprehensive or periodic oral health evaluation or, for beneficiaries under 3 years of age, who received an oral evaluation and counseling with the primary care giver, during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received a comprehensive or period exam (D0120, D0150) or dental encounter at a SNC with ICD 10 on List 1 below or, for beneficiaries under three (3) years of age, who received an oral evaluation and counseling with the primary caregiver (D0145), during the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

14.44%

Health Net of California, Inc.

17.99%

LIBERTY Dental Plan of California, Inc.

20.89%

Complete

D2.VII.1 Measure Name: Use of Dental Treatment Services (age 21+)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received any dental treatment service during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received any dental treatment service (D2000-D9999) or dental encounter at a SNC with ICD 10 on List 2 below in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year.

Measure results

Access Dental Plan, Inc.

19.05%

Health Net of California, Inc.

15.65%

LIBERTY Dental Plan of California, Inc.

17.81%

Complete

D2.VII.1 Measure Name: Preventive Services to Fillings (age 21+)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who received one (1) or more fillings in the measurement period who also received preventive services (topical fluoride application, sealant, preventive resin restoration, education) during the measurement period. Numerator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year who received one (1) or more fillings (D2000-D2999) or dental encounter at a SNC with ICD 10: K0262 K029 K0252 K0263 K0253 K0381 Z98811 K027 K08531 K0850 K0851 K08530 K08539 K0859 K0852 K0856 K025 in the measurement period and who also received one (1) or more topical fluoride applications (D1203, D1204, D1206, or D1208) or dental encounter at a SNC with ICD10: K036 or Z293, dental sealants (D1351) or dental encounter at a SNC with ICD 10: Z98810, preventive resin restorations (D1352) or dental encounter at a SNC with ICD 10: K023 K0251 K0261 Z98810 or education to prevent caries (D1310 or D1330) in the measurement period. Denominator: Number of beneficiaries with at least 90 days continuous enrollment in the same plan within the measurement year, who received one (1) or more fillings (D2000-D2999) or ICD 10: K0262 K029 K0252 K0263 K0253 K0381 Z98811 K027 K08531 K0850 K0851 K08530 K08539 K0859 K0852 K0856 K025 in the measurement period.

Measure results

Access Dental Plan, Inc.

48.82%

Health Net of California, Inc.

47.37%

LIBERTY Dental Plan of California, Inc.

53.77%

Complete

D2.VII.1 Measure Name: Overall Utilization of Dental Services 1 year (age 21+)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries continuously enrolled for the measurement period who received any dental service during that period. Numerator: Number of beneficiaries continuously enrolled for one (1) year with no gap in coverage who received any dental service (D0100-D9999) or dental encounter at a SNC during that period. Denominator: Number of beneficiaries continuously enrolled for one (1) year with no gap in coverage.

Measure results

Access Dental Plan, Inc.

25.49%

Health Net of California, Inc.

21.44%

LIBERTY Dental Plan of California, Inc.

25.28%

Complete

D2.VII.1 Measure Name: Overall Utilization of Dental Services 2 years (age 21+)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries continuously enrolled for the measurement period who received any dental service during that period. Numerator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage who received any dental service (D0100-D9999) or dental encounter at a SNC during that period. Denominator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage.

Measure results

Access Dental Plan, Inc.

33.22%

Health Net of California, Inc.

30.29%

LIBERTY Dental Plan of California, Inc.

34.90%

Complete

D2.VII.1 Measure Name: Overall Utilization of Dental Services 3 years (age 21+)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries continuously enrolled for the measurement period who received any dental service during that period. Numerator: Number of beneficiaries continuously enrolled for three (3) years with no gap in coverage who received any dental service (D0100-D9999) or dental encounter at a SNC during that period. Denominator: Number of beneficiaries continuously enrolled for three (3) years with no gap in coverage.

Measure results

Access Dental Plan, Inc.

38.28%

Health Net of California, Inc.

36.25%

LIBERTY Dental Plan of California, Inc.

41.12%

Complete

D2.VII.1 Measure Name: Continuity of Care (age 21+)

37 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

The percentage of beneficiaries continuously enrolled for two (2) years with no gap in coverage who received a comprehensive oral evaluation or a prophylaxis in both the year prior to the measurement year and in the measurement year. Numerator: Number of beneficiaries in the denominator who also received a comprehensive oral evaluation (D0120,

D0150) or dental encounter at a SNC with ICD 10 on List 1 below, or a prophylaxis (D1110, D1120) or dental encounter at a SNC with ICD 10: K036 K0500 K0501 K051 K0510 K0511 Z293 Z299 Z012 Z0120 Z0121 in the measurement year. Denominator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage who received a comprehensive oral evaluation (D0120, D0150) or dental encounter at a SNC with ICD 10 on List 1 below, or a prophylaxis (D1110, D1120) or dental encounter at a SNC with ICD 10: K036 K0500 K0501 K051 K0510 K0511 Z293 Z299 Z012 Z0120 Z0121 in the year prior to the measurement year.

Measure results

Access Dental Plan, Inc.

37.29%

Health Net of California, Inc.

41.78%

LIBERTY Dental Plan of California, Inc.

44.68%

Complete

D2.VII.1 Measure Name: Usual Source of Care (age 21+)

38 / 38

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Dental Specific Measures for Dental Specific Model

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

Yes

D2.VII.8 Measure Description

The percentage of beneficiaries who received any dental service each year for two (2) consecutive years. Numerator: Number of members in the same plan for two years during the measurement period with no gap who received at least one (1) dental service (D0100-D9999) or dental encounter at a SNC in each of those years. Denominator: Number of beneficiaries continuously enrolled for two (2) years with no gap in coverage.

Measure results

Access Dental Plan, Inc.

10.26%

Health Net of California, Inc.

11.33%

LIBERTY Dental Plan of California, Inc.

14.27%

Topic VIII. Sanctions

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

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

Sanction total count: 3

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 3

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Access Dental Plan, Inc.

D3.VIII.4 Reason for intervention

Plan has not been contractually compliant in accordance with Exhibit A, Attachement 4, Provision 2 (MIS). Additionally, the Plan repeatedly was not in compliance with deliverables due to MIS migration. This included: 1) Member Phone Call Report, 2) Treatment Authorization Request (TAR), 3) Grievances and Appeals, 4) Quality Improvement Project Report, 5) Timely Access and Specialty Referral Report.

Sanction details

D3.VIII.5 Instances of non-compliance

7

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/16/2024

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

Yes, remediated 02/12/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: DHCS Audit

2 / 3

D3.VIII.2 Plan performance issue

Corrective Action Plan

D3.VIII.3 Plan name

Access Dental Plan, Inc.

D3.VIII.4 Reason for intervention

Plan did not meet contract requirements in the following area and was required to present a Corrective Action Plan (CAP). CAP Category 1 - Utilization Management 1.2.1 - Use of Notice of Action Letter Templates 1.2.2 - Prior Authorization Decision and Notification Timeframes 1.2.3 - Prior Authorization Decisions CAP Category 3 - Access and Availability of Care 3.1.1 - Call Center ""P"" Factor CAP Category 4 - Member's Rights 4.1.1 - Grievance Resolutions 4.1.2 - Grievance Resolution Timeframe 4.1.3 -

Grievance Acknowledgment Letters CAP Category 5 - Quality Management 5.1.1 - Provider Participation in Potential Quality Issues 5.2.1 - New Provider Training CAP Category 6 - Administrative and Organization Capacity 6.2.1 - Compliance Officer Reporting Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

10

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/22/2024

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

Yes, remediated 06/18/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: DHCS Audit

3 / 3

D3.VIII.2 Plan performance issue

Corrective Action Plan

D3.VIII.3 Plan name

Health Net of California, Inc.

D3.VIII.4 Reason for intervention

Plan did not provide clear explanations of the decisions for members complaints regarding Quality of Care (QOC) grievance resolution letters

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/07/2024

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

Yes, remediated 07/02/2025

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Access Dental Plan, Inc.** 2 **Health Net of California, Inc.** 14 **LIBERTY Dental Plan of California, Inc.** 14
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Access Dental Plan, Inc.** 7 **Health Net of California, Inc.** 6 **LIBERTY Dental Plan of California, Inc.** 6
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Access Dental Plan, Inc.** 5 **Health Net of California, Inc.** 4 **LIBERTY Dental Plan of California, Inc.** 4
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Access Dental Plan, Inc.** Makes some referrals to the SMA and others directly to the MFCU **Health Net of California, Inc.** Makes referrals to the Medicaid Fraud Control Unit (MFCU) only **LIBERTY Dental Plan of California, Inc.** Makes referrals to the SMA and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals	**Access Dental Plan, Inc.** Not applicable **Health Net of California, Inc.**

	made during the reporting year.	6 **LIBERTY Dental Plan of California, Inc.** Not applicable
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	**Access Dental Plan, Inc.** Not applicable **Health Net of California, Inc.** Not applicable **LIBERTY Dental Plan of California, Inc.** 6
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made to the SMA and the MFCU in aggregate.	**Access Dental Plan, Inc.** 0 **Health Net of California, Inc.** Not applicable **LIBERTY Dental Plan of California, Inc.** Not applicable
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Access Dental Plan, Inc.** 01/01/2024 **Health Net of California, Inc.** 01/01/2024 **LIBERTY Dental Plan of California, Inc.** 01/01/2024
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Access Dental Plan, Inc.** 12/31/2024 **Health Net of California, Inc.** 12/31/2024 **LIBERTY Dental Plan of California, Inc.** 12/31/2024
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**Access Dental Plan, Inc.** $12,488.83 **Health Net of California, Inc.** $100,402.31 **LIBERTY Dental Plan of California, Inc.**

		$256,712.92
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**Access Dental Plan, Inc.** $52,126,029.07 **Health Net of California, Inc.** $74,236,480.14 **LIBERTY Dental Plan of California, Inc.** $64,592,382.64
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Access Dental Plan, Inc.** Quarterly **Health Net of California, Inc.** Monthly **LIBERTY Dental Plan of California, Inc.** Monthly

Topic XI: ILOS

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

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

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Access Dental Plan, Inc.** Not answered **Health Net of California, Inc.** Not answered **LIBERTY Dental Plan of California, Inc.** Not answered

Topic XIII. Prior Authorization

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

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

Topic XIV. Patient Access API Usage

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

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

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus** Enrollment Broker/Choice Counseling Beneficiary Outreach

Section F: Notes

Notes

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

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