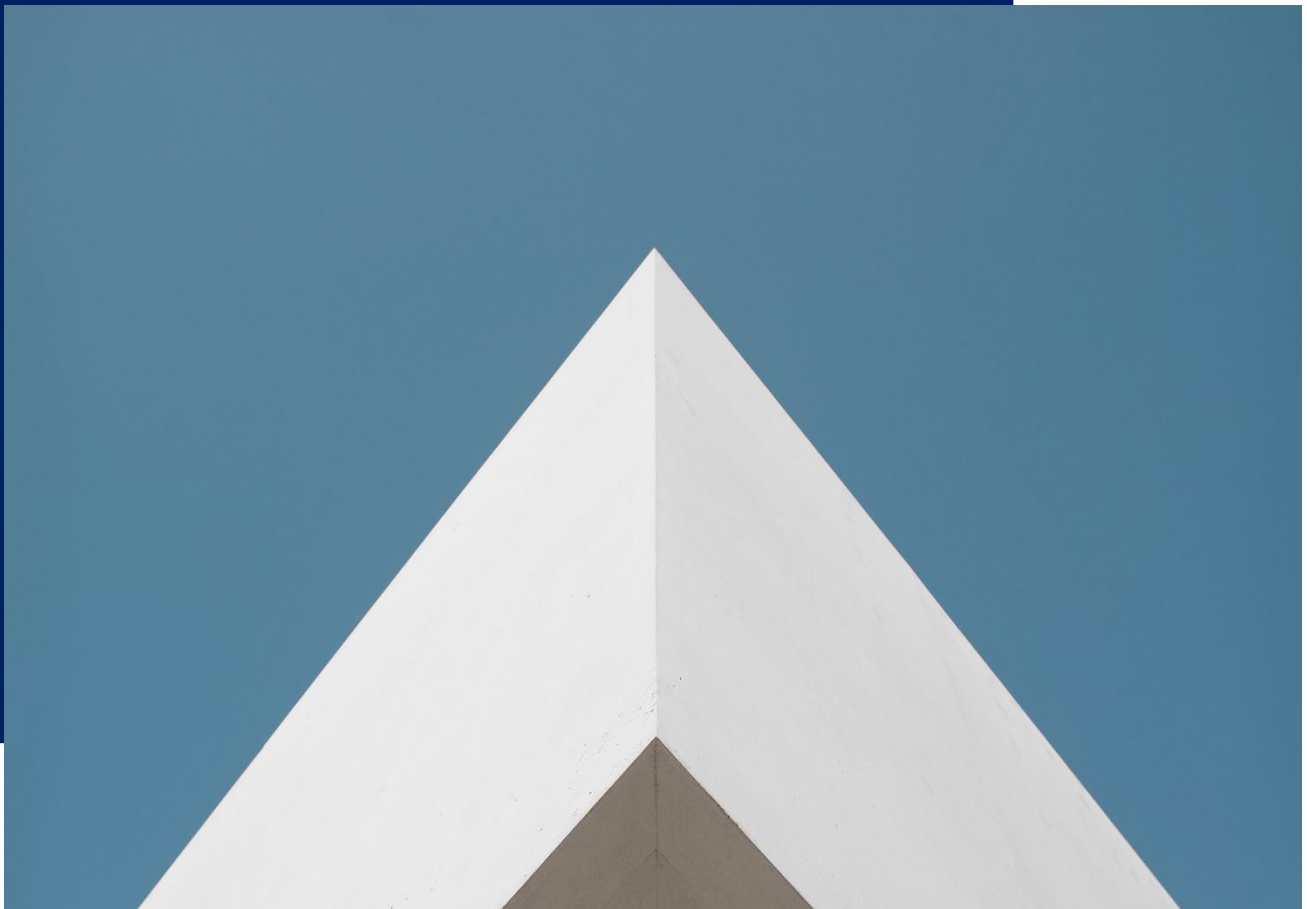




MONTHLY COMPLIANCE REPORT

SEPTEMBER 2025 · CARDINAL CONTRACT

Office of Compliance
September 30, 2025

MONTHLY COMPLIANCE REPORT

INCLUDING AUGUST 2025 DELIVERABLES + REFERRALS

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MCO COMPLIANCE ENFORCEMENT

The Department of Medical Assistance Services (DMAS) actively monitors the performance of all Managed Care Organizations (MCOs) under the Cardinal Care Managed Care (CCMC) contract. The Office of Compliance issues compliance enforcement actions whenever an MCO is found to be out of compliance with the CCMC contract. Section 17 of the CCMC contract provides the Department's Oversight and Compliance Enforcement Process, including the Compliance Point System and escalating Point Violations. (*See Contract References for relevant excerpts from Section 17: Oversight*)

The Department issues enforcement actions under the contract in force when the identified non-compliance occurred. As a result, the Department maintains separate point schedules for points issued under the previous CCMC contract (2024-2025) and the new Virginia Medicaid Cardinal Care Managed Care contract (2025-2026) associated with the reprocurement of the Cardinal Care Managed Care Program under RFP 13330. The new CCMC contract (2025-2026) took effect July 1, 2025. Molina Healthcare was no longer a CCMC MCO after June 30, 2025. Humana Healthy Horizons of Virginia joined the CCMC program as an MCO starting July 1, 2025.

The Department will include both point schedules in the Monthly Compliance Report for the six-month transition period following the implementation of the new contract. All compliance point violations and compliance point system liquidated damages issued by the Department will be applied to the appropriate contract's point schedule.

COMPLIANCE POINTS OVERVIEW

2024-2025 Cardinal Care Contract

Please note: The Department of Medical Assistance Services issues enforcement actions under the contract in force when the non-compliance occurred. The table below reflects compliance points issued under the previous 2024-2025 Cardinal Care Managed Care contract.

MCO	Prior Month Point Balance	Point(s) Incurred for Current Months*	Point(s) Expiring or Rescinded	Final Point Balance*	Area of Violation: Finding or Concern
<u>Aetna</u>	4	0	0	4	FINDINGS NONE CONCERNS NONE
<u>Anthem</u>	14	7	1	20	FINDINGS D-SNP ISSUES (6) MLTSS CONCERNS NONE
<u>Molina</u>	7	0	0	7	FINDINGS NONE CONCERNS NONE
<u>Sentara</u>	14	1	0	15	FINDINGS DATA SUBMISSION CONCERNS NONE
<u>United</u>	7	0	1	6	FINDINGS NONE CONCERNS NONE

**All listed point infractions are pending until the expiration of the 15-day comment period.*

Notes:

Findings – Area(s) of violation; point(s) issued.

Concerns – Area(s) of concern that could lead to potential findings; no points issued.

Expired Points – Compliance points expire 365 days after issuance.

COMPLIANCE POINTS OVERVIEW

2025-2026 Cardinal Care Contract

Please note: The Department of Medical Assistance Services issues enforcement actions under the contract in force when the non-compliance occurred. The table below reflects compliance points issued under the new 2025-2026 Cardinal Care Managed Care contract.

MCO	Prior Month Point Balance	Point(s) Incurred for Current Month/s*	Point(s) Expiring or Rescinded	Final Point Balance*	Area of Violation: Finding or Concern
<u>Aetna</u>	0	0	0	0	FINDINGS NONE CONCERNS NONE
<u>Anthem</u>	0	0	0	0	FINDINGS NONE CONCERNS NONE
<u>Humana</u>	0	0	0	0	FINDINGS NONE CONCERNS NONE
<u>Sentara</u>	1	0	1	0	FINDINGS NONE CONCERNS NONE
<u>United</u>	0	2	0	2	FINDINGS REPORTING ERRORS MEMBER APPEALS CONCERNS NONE

**All listed point infractions are pending until the expiration of the 15-day comment period.*

Notes:

Findings – Area(s) of violation; point(s) issued.

Concerns – Area(s) of concern that could lead to potential findings; no points issued.

Expired Points – Compliance points expire 365 days after issuance.

SUMMARY

The Office of Compliance held their **Compliance Review Committee (CRC)** on September 10, 2025. The Committee reviewed compliance referrals and deliverables received in August 2025. The meeting's agenda covered all identified and referred issues of non-compliance occurring under both the current Cardinal Care 2025-2026 contract and the previous Cardinal Care 2024-2025 contract, including failures to meet contract thresholds and requirements related to data submission, claims processing and reporting, member appeals, and Dual-Eligible Special Needs Plan (D-SNP) related issues.

The CRC voted to issue twelve (12) Notices of Non-Compliance (NONC) related to managed care compliance issues. These NONCs included ten (10) compliance points, eight (8) CPS Liquidated Damages, as well as one (1) Corrective Action Plans (CAP) related to D-SNP compliance issues.

Each MCO's compliance findings and concerns are detailed below. The Department communicated the CRC's findings in letters and emails issued to the MCOs on September 18, 2025.

AETNA BETTER HEALTH OF VIRGINIA

Findings:

- No findings (i.e., no compliance issues severe enough to necessitate the issuance of compliance points).

Concerns:

- No concerns

MIP/CAP Update:

- Aetna Better Health submitted the requested Corrective Action Plan (CAP) for **CES # 6688** on September 8, 2025. The CAP is now under review by the Department.
- Aetna Better Health submitted the requested Corrective Action Plan (CAP) for **CES # 6706** on September 19, 2025. The CAP is now under review by the Department.

Request for Reconsideration:

- A Request for Reconsideration was received on August 26, 2025, for **CES # 6706** regarding untimely processing of DME claims. After careful consideration, Department leadership decided to uphold the initial enforcement action - including the NONC, point, and Corrective Action Plan (CAP). The MCO was notified on September 5, 2025.

Expiring Points:

- No points

Summary:

- For deliverables and referrals submitted in August 2025, Aetna Better Health showed a **very high** level of compliance. Aetna Better Health submitted all 16 required monthly reporting deliverables accurately and on time, complying with all applicable regulatory and contractual requirements.

ANTHEM HEALTHKEEPERS PLUS

Findings:

- **Contract Adherence:** Anthem HealthKeepers Plus incorrectly paid claims for CCC Plus HCBS Waiver services. In February 2025, a Waiver provider determined that Anthem paid a number of claims at the Rest of State (ROS) rate instead of the higher rate required by the members' Northern Virginia FIPS code.

Section 12.2.3 of the Cardinal Care contract states, the Contractor's reimbursement for CCC Plus HCBS Waiver services must include the Northern Virginia differential for qualifying localities, as described on the Provider Portal at this link. The differential reimbursement for Waiver services in Northern Virginia is determined by the Member's FIPS code, except for ADHC services, which are based on the Provider's FIPS code.

The Compliance Team recommended that in response to the issue identified above, Anthem be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages**. No MIP or CAP will be required at this time.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages** in response to this issue. **(CES # 6726 – 24/25 CC Contract)**

- **Contract Adherence:** Anthem HealthKeepers Plus failed to submit an operation system change to DMAS for review and approval as required by the Cardinal Care contract. On January 1, 2025, Anthem merged and consolidated all Dual Eligible Special Needs Plan (D-SNP) member records within their Fully Integrated Dual Eligible (FIDE) system. The implementation of this unapproved system change resulted in several other contract violations and directly impacted members and providers.

Section 2.11.1 of the Cardinal Care contract states that "Any changes to Contractor organizational structure and/or operations that have significant impact on Virginia Medicaid require advance notification to the Department.... The Contractor must ensure, at a minimum, the following at all times: 1. Uninterrupted services and ongoing adequate Access to care and choice for Members; 2. The ability to maintain and support the Contract requirements; 3. Major functions, including anything that may adversely affect a Member, of the Contractor's organization, as well as Department programs and

Members, are not adversely affected; and 4. Compliance with all Commonwealth of Virginia procurement policies to ensure the integrity of a fair, competitive procurement process for Managed Care contract”.

The Compliance Team recommended that in response to the issue identified above, Anthem be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point, \$15,000 in CPS Liquidated Damages**, and a request for a **Corrective Action Plan (CAP)**. The CAP should outline how Anthem has addressed the compliance issues identified in Compliance Enforcement cases # 6508, # 6790, # 6791, # 6793, # 6794, and # 6796.

The CRC agreed with the team’s recommendation and voted to issue a **Notice of Non-Compliance (NONC), one (1) compliance point, \$15,000 in CPS Liquidated Damages**, and a **CAP** in response to this issue. **(CES # 6508 – 24/25 CC Contract)**

- **Contract Adherence:** As addressed in CES Case # 6508, the Department of Medical Assistance Services (DMAS or the Department) has determined that Anthem HealthKeepers Plus failed to submit an operational system change to DMAS for review and approval as required by the Cardinal Care contract. The implementation of this unapproved system change resulted in a number of additional contract violations, including Anthem’s failure to promptly notify providers of the system change.

Anthem’s failure to notify providers of the scheduled system change or provide the impacted members’ new service authorization numbers resulted in thousands of improperly denied and delayed service authorizations. This failure impacted at least 13,417 service authorizations.

Section 7.3.11 of the Cardinal Care contract states, the Contractor must provide written notification to all affected Participating Providers at least sixty (60) days prior to the effective date of changes to any operational process that would affect services to Members, including but not limited to Claims processing, SA requirements, etc. This requirement applies to all services covered under this Contract.

The Compliance Team recommended that in response to the issue identified above, Anthem be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point, and \$15,000 in CPS Liquidated Damages**.

The CRC agreed with the team’s recommendation and voted to issue a **Notice of Non-Compliance (NONC), one (1) compliance point, and \$15,000 in CPS Liquidated Damages** in response to this issue. **(CES # 6790 – 24/25 CC Contract)**

- **Contract Adherence:** As addressed in CES Case # 6508, the Department of Medical Assistance Services has determined that Anthem HealthKeepers Plus failed to submit an operational system change to DMAS for review and approval as required by the Cardinal Care contract. The implementation of this unapproved system change resulted in a number of additional contract violations, including Anthem's failure to comply with contractual reporting requirements.

Anthem failed to comply with multiple reporting requirements due to system and data issues associated with the unapproved merger of member records. DMAS and CRMS reporting was significantly impacted for six months.

Section 1.4 of the Cardinal Care contract states that, to ensure compliance with the terms of this Contract and all applicable Federal and State statutes, regulations and guidance, the Department requires the Contractor to submit reports and other documentation related to the Contractor's performance and operations. Reports and documentation required to be maintained and/or submitted by the Contractor to the Department, or its designee are included in the Cardinal Care Technical Manual, which provides the specific requirements for the content and submission of all required reports. Failure to timely and accurately provide any required reports or documentation will result in compliance enforcement actions, as provided in Section 17, Oversight.

Section 8.11.6 of the Cardinal Care contract states, the Contractor must have systems and operational processes in place for sharing data to and from the Department and other Contractors, including but not limited to Member's Claims and SAs, reviewing the data for Member risks/needs and utilizing the data to support the transition process.

Section 11.11.2 of the Cardinal Care contract states, the Contractor must adhere to data exchange requirements as described in the CRMS and Cardinal Care Technical Manuals, as revised. The Contractor is responsible for submission of all its subcontracted CRMS data.

The Compliance Team recommended that in response to the issue identified above, Anthem be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages**.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)**, **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages** in response to this issue. (**CES # 6791 – 24/25 CC Contract**)

- **Contract Adherence:** As addressed in CES Case # 6508, the Department of Medical Assistance Services has determined that Anthem HealthKeepers Plus failed to submit an operational system change to DMAS for review and approval as required by the Cardinal Care contract. The implementation of this unapproved system change resulted in several additional contract violations, including Anthem's failure to process service authorizations in a timely manner.

Anthem's failure to honor existing service authorizations for members and approve new service authorizations in a timely manner impacted approximately 5,428 members, 1,004 providers, and 13,417 total authorizations.

Section 6.1 of the Cardinal Care contract states for standard authorization decisions, the Contractor shall provide the decision notice as expeditiously as the member's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if (1) the member or the provider requests extension or (2) the Contractor justifies to the Department upon request that the need for additional information per 42 CFR §438.210(d)(1)(ii) is in the member's interest. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member requests an extension or the Contractor justifies to the Department a need for additional information and how the extension is in the member's interest.

Additionally, Section 8.11.2 regarding Continuity of Care upon disenrollment states "The Department, or its designee, must assume responsibility for all Covered Services authorized by the Member's previous MCO within the Department's Provider Network which are rendered after the effective date of Disenrollment to the FFS system, if the Member otherwise remains eligible for the service(s)", as well as "following the transition, the Department, or its designee, or the Member's receiving Health Plan must assume responsibility for all Covered Services authorized by the Contractor during the Continuity of Care period."

The Compliance Team recommended that in response to the issue identified above, Anthem be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages**.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)**, **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages** in response to this issue. **(CES # 6793 – 24/25 CC Contract)**.

- **Contract Adherence:** As addressed in CES Case # 6508, the Department of Medical Assistance Services has determined that Anthem HealthKeepers Plus failed to submit an operational system change to DMAS for review and approval as required by the Cardinal Care contract. The implementation of this unapproved system change resulted in a number of additional contract violations, including Anthem's failure to timely and accurately process claims.

Anthem's failure to timely and accurately process claims was the result of three primary issues associated with the merger of member records:

1. Claims were incorrectly routed to terminated member profiles and incorrectly denied due to lack of coverage, impacting approximately 2,656 members and 9,549 claims.
2. System network issues which delayed claims processing, impacting approximately 64,332 claims between 1/1/2025 and 1/24/2025.
3. Configuration issues which resulted in inappropriate denial of Nursing Facility claims, impacting 216 claims valued at \$1.1 million.

Section 12.1 of the Cardinal Care contract regarding General Provider Payment Processes states that "In accordance with Section 1932(f) of the Social Security Act (42 U.S.C. § 1396a-2), the Contractor must pay all in-and Out-of-Network Providers on a timely basis, consistent with the Claims payment procedure described in 42 CFR §§447.45, 447.46, 448.60, and Section 1902(a)(37), upon receipt of all Clean Claims for Covered Services rendered to covered Members who are enrolled with the Contractor".

The Compliance Team recommended that in response to the issue identified above, Anthem be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages**.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)**, **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages** in response to this issue. **(CES # 6794 – 24/25 CC Contract)**.

- **Contract Adherence:** As addressed in CES Case # 6508, the Department of Medical Assistance Services has determined that Anthem HealthKeepers Plus failed to submit an operational system change to DMAS for review and approval as required by the Cardinal Care contract. The implementation of this unapproved system change resulted in a number of additional contract violations, including Anthem's failure to properly train call center staff regarding the FIDE system or the merger of member records. This failure resulted in numerous members receiving incorrect information regarding their eligibility status and coverage. Anthem reported at least 109 member complaints.

Section 2.12.1.2 of the Cardinal Care contract states that "The Contractor must ensure that both the Member and Provider call centers are staffed adequately to respond to questions and concerns that are specific to the Managed Care Program during the required Cardinal Care Managed Care hours of operation. It is the Contractors' responsibility to maintain up-to-date and accurate program specific information for call center staff to reference at all times".

The Compliance Team recommended that in response to the issue identified above, Anthem be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages**.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)**, **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages** in response to this issue. (CES # 6796 – 24/25 CC Contract).

Concerns:

- No concerns

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- **CES # 6140:** September 2024 – Waiver Entry issue. 1 point was removed from Anthem's total by closing case.

Summary:

- For deliverables and referrals submitted in August 2025, Anthem HealthKeepers Plus showed a **very low** level of compliance. Anthem HealthKeepers Plus submitted all 16 required monthly reporting deliverables accurately and on time. However, Anthem HealthKeepers failed to pay claims at the correct FIPS rate (as addressed above in **CES # 6726**) and received a Notice of Non-Compliance (NONC) with a compliance point and CPS liquidated damages. Additionally, Anthem HealthKeepers implemented an unapproved system change (as addressed above in **CES # 6508**) and received a second NONC with a compliance point, CPS Liquidated Damages, and a CAP. The issue addressed in CES # 6508 was a catalyst for five (5) additional contract violations. These included the failure to (1) notify providers of the system change (**CES # 6790**); (2) comply with reporting requirements due to the system change (**CES # 6791**); (3) process service authorizations timely due to the system change (**CES # 6793**); (4) process claims timely due to the system change (**CES # 6794**); and (5) to train call center staff regarding the system change (**CES # 6796**). Each of these violations included a NONC with a compliance point and CPS Liquidated Damages. As a result, Anthem HealthKeepers failed to comply with many regulatory and contractual requirements.

HUMANA HEALTHY HORIZONS

Findings:

- No findings (i.e., no compliance issues severe enough to necessitate the issuance of compliance points).

Concerns:

- **Reporting Error:** Humana Healthy Horizons provided DMAS with the contractually required Cardinal Care deliverables in a timely manner. However, the Department determined that three (3) monthly reporting deliverables (Mental Health Services (MHS) Service Authorizations and Registrations, Foster Care Barrier Report, and Foster Care Transition Planning Report) submitted by Humana contained data quality errors.

Section 17.1.2 of the Cardinal Care contract states that the Department may assess one (1) compliance point for a Contractor's failure to provide data in a timely or accurate manner, as required by the Cardinal Care contract, and the Cardinal Care Deliverables Technical Manual.

However, the Compliance Team recommended that in response to the issue identified above, Humana be issued a **Notice of Non-Compliance (NONC)** with no compliance points to give Humana the opportunity to bring these deliverables into compliance. No MIP or CAP will be required at this time.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** in response to this issue. **(CES # 6788 – 25/26 CC Contract).**¹

- **Contract Adherence:** Humana Healthy Horizons failed to process ten (10) Early Intervention (EI) clean claims within the required 14 days. Humana's overall timeliness for processing EI claims within 14 days for the month of August was 96.72%.

¹ Humana Healthy Horizons joined the Cardinal Care Managed Care program with the implementation of the new Cardinal Care contract on July 1, 2025. As a new Cardinal Care MCO, a transitional reporting period was provided to support initial implementation, due to data availability and to align with contract reporting requirements and expectations. During this transitional period, Humana Healthy Horizons received Notices of Non-Compliance (NONC) without compliance points for identified compliance issues.

Section 12.2.4 of the Cardinal Care contract requires that 100% of clean claims from MHS, ARTS, and early intervention providers shall be processed within thirty (30) calendar days of receipt. The Contractor must also ensure ninety-nine percent (99%) of clean claims from these providers are adjudicated within fourteen (14) calendar days of receipt.

According to the Cardinal Care contract, the Department may assess one (1) point for failure to timely or accurately adjudicate claims in compliance with Section 12.1, General Provider Payment Processes.

However, the Compliance Team recommended that in response to the issue identified above, Humana be issued a **Notice of Non-Compliance (NONC)** with no compliance points to give Humana the opportunity to bring EI claims processing into compliance. No MIP or CAP will be required at this time.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** in response to this issue. **(CES # 6797 – 25/26 CC Contract)**.²

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- No points

Summary:

- For deliverables and referrals submitted in August 2025, Humana Healthy Horizons showed a **high** level of compliance. Humana Healthy Horizons submitted 13 of the 16 required monthly reporting deliverables accurately and on time. However, three (3) of the required monthly deliverables were submitted inaccurately and contained reporting errors (as addressed above in **CES # 6788**) for which Humana received a Notice of Non-Compliance (NONC). Additionally, Humana Healthy Horizons failed to adjudicate 10 Early

² Humana Healthy Horizons joined the Cardinal Care Managed Care program with the implementation of the new Cardinal Care contract on July 1, 2025. As a new Cardinal Care MCO, a transitional reporting period was provided to support initial implementation, due to data availability and to align with contract reporting requirements and expectations. During this transitional period, Humana Healthy Horizons received Notices of Non-Compliance (NONC) without compliance points for identified compliance issues.

Intervention claims within contractual timeframes (addressed above in **CES # 6797**) and received a second NONC. Despite these issues, Humana Healthy Horizons complied with most applicable regulatory and contractual requirements.

SENTARA COMMUNITY PLAN

Findings:

- **Contract Adherence:** Sentara Community Plan failed to submit complete and accurate Encounters as required by the Cardinal Care contract. Additionally, DMAS determined that Sentara altered Encounters dating back to January 2025 - removing the National Drug Code (NDC) and changing payment status without prior approval or notification to DMAS.

The Department first notified Sentara of this issue on June 30, 2025. After a period of review, Sentara confirmed that Encounters had been altered on July 24, 2025. As the altered Encounters date back to January 2025, Sentara failed to notify DMAS of the changes to Encounter data within two days as required by contract.

Section 11.14 of the Cardinal Care contract states “The Contractor must submit complete, accurate, and timely Encounters for all adjudicated services for all Members for all services regardless of contracted payment type and or payment status. The Contractor must submit Encounters according to the MES Encounters Processing Solution (EPS) Cardinal Care Technical Manual, as well as the Companion Guide.”

Additionally, Section 11.14.2 of the Cardinal Care contract states the Contractor must “Provide notification to the Department within two (2) days of identification of any unanticipated changes that may have an impact on the substance or process of data exchanges between the parties, and must engage with testing before submitting files into EPS production.”

The Compliance Team recommended that in response to the issue identified above, Sentara be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages**. No MIP or CAP will be required at this time.

The CRC agreed with the team’s recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point**, and **\$15,000 in CPS Liquidated Damages** in response to this issue. (**CES # 6766 – 24/25 CC Contract**).

Concerns:

- No concerns

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- Sentara Community Plan submitted a request for reconsideration regarding **CES # 6727** on August 13, 2025. Sentara requested that DMAS reconsider the enforcement action – clarifying that the communication in question was a provider letter and not a member letter. Given the additional information provided by the MCO, the Department rescinded the NONC, one (1) compliance point, and \$15,000 in CPS Liquidated Damages associated with CES # 6727.

Expiring Points:

- No points

Summary:

- For deliverables and referrals submitted in August 2025, Sentara Community Plan showed a **moderate** level of compliance. Sentara Community Plan submitted all 16 required monthly reporting deliverables accurately and on time. However, Sentara Community Plan failed to submit complete and accurate Encounters (as addressed above in **CES # 6766**) and received a Notice of Non-Compliance (NONC) with one (1) compliance point and CPS Liquidated Damages. Despite these issues, Sentara Community Plan complied with most regulatory and contractual requirements.

UNITEDHEALTHCARE

Findings:

- **Reporting Error:** UnitedHealthcare provided DMAS with the contractually required Cardinal Care deliverables in a timely manner. However, the Department of Medical Assistance Services (DMAS or Department) has determined the MCO Claims Report submitted by UnitedHealthcare contained data quality errors.

Section 17.1.2 of the Cardinal Care contract states that the Department may assess one (1) compliance point for a Contractor's failure to provide data in a timely or accurate manner, as required by the Cardinal Care contract, and the Cardinal Care Deliverables Technical Manual.

The Compliance Team recommended that in response to the issue identified above, UnitedHealthcare be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** and no CPS Liquidated Damages. No MIP or CAP will be required at this time.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)**, **one (1) compliance point**, and no CPS Liquidated Damages in response to this issue. **(CES # 6787 – 25/26 CC Contract)**.

- **Contract Adherence:** UnitedHealthcare failed to process one (1) member appeal within 30 days as required by the Cardinal Care contract. No request for an extension was submitted.

According to Section 9.6 of the Cardinal Care contract, the Contractor shall process and must respond in writing to standard internal appeals as expeditiously as the Member's health condition requires and must not exceed thirty (30) calendar days from the initial date of receipt of the internal appeal.

The Compliance Team recommended that in response to the issue identified above, UnitedHealthcare be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point**, and no CPS Liquidated Damages. No MIP or CAP will be required at this time.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** and no CPS Liquidated Damages in response to this issue. **(CES # 6789 – 25/26 CC Contract)**.

Concerns:

- No concerns

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No request for reconsideration

Expiring Points:

- **CES # 6133:** September 2024 EI Claims Payment. One (1) point was removed from UnitedHealthcare's total by closing case.

Summary:

- For deliverables and referrals submitted in August 2025, UnitedHealthcare showed a **moderate** level of compliance. UnitedHealthcare submitted 15 of the 16 required monthly reporting deliverables accurately and on time. However, one (1) of the required monthly deliverable was submitted with reporting errors (as addressed above in CES # **6787**), for which UnitedHealthcare received a Notice of Non-Compliance (NONC) with one (1) compliance point. Additionally, UnitedHealthcare failed to process one (1) member appeal within contractually required timeframes (as addressed above in CES # **6789**) and received a second NONC with one (1) compliance point. Despite these issues, UnitedHealthcare complied with most regulatory and contractual requirements.

NEXT STEPS

The Office of Compliance will continue to host Compliance Review Committee meetings each month. The Compliance Team will track, monitor, and communicate with the MCOs regarding identified compliance issues. The team will also continue to work with other DMAS units and divisions to investigate and address potential compliance issues.

The Office of Compliance remains focused on the MCOs' overall compliance with the Cardinal Care contract - especially those requirements with a direct impact on members and providers.

CONTRACT REFERENCES

17 OVERSIGHT

17.1 Contract Violations

Upon completion of the Readiness Review, as described in Section 2.7, *Contractor Readiness Reviews*, and at the Operational Start Date of this Contract, the Contractor must meet or exceed all the performance standards that are part of this Contract. The Department is responsible for conducting ongoing Contract compliance monitoring and enforcement and reserves the right to impose any and all remedies available under the Contract, law, and regulations. These remedies include, but are not limited to, intermediate sanctions, escalating compliance enforcement actions, liquidated damages, and/or termination of the Contract as described in Section 21.1.62, *Termination of Contract*. In no event will the application of any remedies preclude the Department's right to any other remedy available in law or regulation.

As part of this process, the Department will review the performance of the Contractor in relation to the performance standards outlined in this Contract and those described in the Cardinal Care Technical Manual, Encounters Technical Manual, and in any other applicable DMAS directive. Compliance enforcement actions related to performance standards are described in Section 17.2.2, *Escalating Compliance Enforcement Points Violations* and 17.2.3, *Liquidated Damages*.

The Department's compliance monitoring program includes:

1. Collecting and reviewing standard hard copy and electronic reports and related documentation, including Encounter and other data, which the Contractor is required, under the terms of this Contract, to submit to the Department or otherwise maintain;
2. Conducting Contractor, Network Provider, and Subcontractor site visits; and
3. Reviewing Contractor policies and procedures, and other internal documents.

17.2 Compliance Enforcement Process

A maximum of one (1) compliance enforcement action will be applied by the Department per individual Contract violation and/or failure to meet a performance standard, however, unresolved or ongoing non-compliance may result in the escalation of compliance enforcement actions. The Department reserves the right to impose any applicable compliance enforcement action upon discovery of non-compliance or violation that was not previously known or reported to the Department.

Monetary compliance enforcement actions, including the assessment of liquidated damages or imposition of financial sanctions issued through the Department's compliance enforcement process, will be deducted from the Contractor's monthly Capitation Payment. Deductions will be initiated within thirty (30) calendar days of the end of the comment period described in any issued compliance letters, unless disputed through the process described in Section 20, *MCO Contract Disputes*. Each month is a separate period for measuring the Contractor's performance and any failure to achieve the required performance standards.

If any failure to meet a performance standard is directly and solely attributable to the following, the Department will not take compliance enforcement action(s) against the Contractor:

1. A force majeure event;
2. Actions or omissions of the Department or a breach by the Department of the Contract; or
3. Unforeseeable actions or omissions by a third party outside of the Contractor's reasonable control (any action or inaction taken by a third party that causes an adverse effect on the Contractor's ability to provide the Services to meet the performance standard(s) under the Contract).

The Department has sole discretion in determining if the failure to meet a performance standard directly and solely attributable to the circumstances provided in (1) through (3) of this paragraph. The use of Subcontractors is foreseeable and any actions or omissions by a Subcontractor are within the Contractor's reasonable control.

If the Contractor is unable to meet a performance standard or requirement due to circumstances that are not within its control (i.e. force majeure event, etc.) a written request may be submitted to the Department to temporarily waive any/all or part of a particular day, month, or period of when such occurrence took place. Any such requests must be received within five (5) Days of the occurrence or period, whichever comes first, and detail why the expected standard or requirement could not be met in its entirety. Exceptions must be reviewed on an occurrence-by-occurrence basis by the Department. The Department's approval of an exception request for a performance standard or requirement is not deemed a waiver of any compliance enforcement action or remedy available to the Department under the Contract, law, or regulation.

Each performance standard is unique unto itself. If the failure to meet a performance standard affects another performance standard, each will be treated separately and an appropriate liquidated damages or other remedies will apply.

17.2.1 Compliance Point System

The Department and the Contractor agree that if the Contractor or its Subcontractor violates the Contract or fails to meet a performance standard, the Contractor will be subject to the compliance point system described in this Contract in addition to any remedies the Department may have pursuant to the Contract, law, or regulation. The Department will evaluate non-compliance based on factors that include, without limitation, the severity of the incident, likelihood of incident recurrence, and totality of circumstances surrounding the incident.

The Department will utilize a compliance point system in response to the Contractor's, or its Subcontractor's, non-compliance with the standards and requirements outlined in this Contract and all technical manuals incorporated by reference. Points will be issued for each incident of non-compliance as outlined in Section 17.2.2, *Escalating Compliance Enforcement Points Violations*. Contractor compliance from the previous calendar month will be reviewed by the Department on a monthly basis and any points issued will accumulate over a rolling twelve (12)-month schedule. The failure to resolve a compliance issue in the timeframe specified by the Department will result in a new, escalated compliance action as detailed in Section 17.2.2, *Escalating Compliance Enforcement Points Violations*.

As compliance points accrue, escalating Contract Enforcement Actions will apply. These escalating compliance enforcement actions, including liquidated damages as described in the chart below, will be assessed each month in which the Department issues new points to the Contractor because of any new compliance violations. The liquidated damages assessed will be based on the total number of points the Contractor has accumulated through the current month. For example, if the Contractor has accumulated one (1) point during the previous twelve (12) months and is issued a five (5) point violation, no liquidated damages would be assessed as a result of the new five (5) point violation because the Contractor's accumulated points would total six (6) for the twelve (12)-month period. However, if the Contractor has accumulated ten (10) points during the previous twelve (12) months and is issued a five (5) point violation, \$15,000 in liquidated damages will be assessed in response to the new five (5) point violation because the Contractor would now have accumulated fifteen (15) total points. Compliance enforcement action, including liquidated damages, will not be assessed under this Section if the Contractor is not issued any new points for non-compliance for the current month.

Compliance Point System (CPS) Level	Points Accumulated During Twelve (12)-month Period	Compliance Enforcement Actions
Level 1	0-10	None
Level 2	11-25	\$15,000 liquidated damages
Level 3	26-50	\$30,000 liquidated damages
Level 4	51-70	\$60,000 liquidated damages
Level 5	71-100	\$90,000 liquidated damages
Level 6	101-150	Suspend Enrollment
Level 7	>150	Termination, at the sole option of DMAS

17.2.2 Escalating Compliance Enforcement Points Violations

One (1) Point Violations (each instance):

1. Inaccurate or improperly formatted submissions of a deliverable or report as described in this Contract, the Cardinal Care Technical Manual, or Cardinal Care Encounter Technical Manual. One (1) point will be assessed for each deliverable that is inaccurate or improperly formatted;
2. Failure to submit a report or deliverable in the timeframe established by the Department or in accordance with the Cardinal Care Technical Manual or Cardinal Care Encounter Technical Manual;
3. Failure to provide data to DMAS in a timely or accurate manner, as required by this Contract and any Technical Manuals issued by the Department;
4. Failure to timely or accurately adjudicate Claims in compliance with Section 12.1, *General Provider Payment Processes*;
5. Use of unapproved Marketing or Member materials. Requirements for the approval of Marketing or Member materials are described in Section 4.3, *Member Materials* and Section 4.4 *Marketing Requirements*;
6. Failure to comply with the reporting requirements of the Virginia All-Payer Claims Database per Section 11.17, *All-Payer Claims Database*;
7. Failure to appropriately stratify a Member into the appropriate intensity of Care Management, as required by Department and/or the Contractor's policies described in Section 8.4, *Care Management*;
8. Failure to meet the target set for the Payment Cycle Certification Timeliness, as defined in the Encounters Technical Manual;
9. Failure to meet the target set for Encounter File Certification Timeliness, as defined in the Encounters Technical Manual;
10. Failure to ensure that the Contractor's systems allow the Care Coordination Platform and Triage Algorithm to be continuously updated with ADT feeds

from the Emergency Department Care Coordination solution. Reference Section 5.7.5, *Virginia Emergency Department Care Coordination Program*; 11. Failure to participate in the Compliance Collaborative. Reference Section 17.4.1, *Compliance Collaborative*; and Failure to meet any additional requirement as specified in this Contract that is not specifically identified in this Section.

Five (5) Point Violations (each instance):

1. Failure to provide Member materials to a new Member in a timely manner, as described in Section 4.3, *Member Materials*;
2. Failure to appropriately notify the Department, or Members, of Provider panel terminations as required by Section 7.3.7.2, *Notice to the Department of Provider Termination*;
3. Failure to submit a CAP required by the Department in Section 17.3.3, *Corrective Action Plans*;
4. Failure to actively participate in QIPs or PIPs facilitated by the Department and/or the EQRO as described in Section 10, *Quality Improvement* and Section 10.11, *EQRO Quality Activities*;
5. Failure to achieve quality metrics set forth in Section 10.6, *HEDIS® and CAHPS Quality Measures and Reporting*, and Section 10.7, *Other Department Priority Quality Measures and Reporting*. This compliance enforcement action will not be imposed in addition to the Performance Withhold Program (PWP) should failure to meet performance expectations occur for those identified quality measures in the PWP program;
6. Failure to meet or maintain required ratios for Care Managers to Members as required in Section 8.4.4, *Care Management Staffing Ratios*;
7. Failure to complete a HRA within the timeframes established by Section 8.5.3, *HRA Completion Timeframes* of this Contract for at least ninety-five (95%) of Members in receipt of/eligible for Care Management on a monthly basis;
8. Failure to remedy noncompliance related to a one (1)-point violation in a subsequent, but consecutive measurement period;
9. Failure to disclose ownership and control changes within the timeframes established in Section 2.9, *Ownership and Control Interest*;
10. Failure to meet the target set for Payment Cycle Entry Timeliness, as defined in the Encounters Technical Manual;
11. Failure to meet the target set for Encounter Submission Timeliness, as defined in the Encounters Technical Manual;
12. Failure to meet for the target set for Encounter Completeness Reconciliation, as defined in the Encounters Technical Manual;

13. Failure to meet the target set for General Provider Payment Timeliness, as defined in the Encounters Technical Manual;
 14. Failure to meet the target set for Exception Provider Payment Timeliness, as defined in the Encounters Technical Manual; and
- Failure to comply with requirements set forth in the Encounters Technical Manual for Hospital Claims.

Ten (10) Point Violations (each instance):

1. Failure to maintain and update an Internal Monitoring and Audit Plan, as required by Section 18.2.1, *Monitoring and Auditing Plan*;
2. Failure to notify DMAS of suspected Fraud, Waste or Abuse, allegations of potential improper payments and/or safety concerns of Enrollees, as required by Section 18.8, *Reporting Suspected Fraud and Abuse to the Department*;
3. Failure to suspend payments following receipt of payment suspension notice within the timeframes established in Section 12.1.5, *Notice of Payment Suspension*;
4. Failure to participate in transition of care activities or discharge planning activities as required by Section 8.10, *Transitional Care Management*, Section 8.11, *Administrative Transitions*, and Section 8.13, *Coordination with the Member's Medicare or Other MCO Plan*;
5. Failure to process SA Requests within the prescribed timeframes described in Section 6, *Utilization Management Requirements*;
6. Failure to implement or comply with a CAP as required by Section 17.3.3, *Corrective Action Plan*;
7. The imposition of Cost Sharing on Members that exceed the Cost Sharing limits permitted under the Medicaid and FAMIS programs. Reference Section 13, *Cost Sharing and Coordination of Benefits* and the FAMIS Summary of Covered Services Chart;
8. Failure to remedy noncompliance related to a five (5)-point violation in a subsequent consecutive measurement period;
9. Violation of mental health parity standards. Reference Section 5.6, *Mental Health Parity and Addition Equity Requirements*;
10. Failure to meet network adequacy requirements for any Provider type listed in the Cardinal Care Technical Manual. Ten (10) points will be assessed per Provider type that is deficient and for which the MCO does not have a DMAS approved exception;
11. Failure to monitor network adequacy as required under Section 7.1.8, *Assurances that Access Standards are Being Met*;

12. Failure to appropriately staff the Member clinical triage line/behavioral health crisis line, as required by Section 2.12.2.2, *Clinical Triage Line Requirements*;
13. Failure to meet the requirements for Warm Transfer of Member calls that need immediate attention, as required by Section 2.12.2.2 *Clinical Triage Line Requirements*;
14. Failure to comply with Internal Appeal or Grievance requirements set forth in Section 9, *Grievances and Appeals*;
15. Issuance of an Adverse Benefit Determination that fails to meet the requirements of Section 9.4, *Notice of Adverse Benefit Determination*; and Failure to comply with the requirements for authorization of EPSDT services, as provided in Section 5.8, *Early and Periodic Screening, Diagnostic, and Treatment*.

17.2.3 Liquidated Damages

The Department reserves the right to assess liquidated damages against the Contractor for specific Contract violations, as well as other violations which, in the Department's sole discretion, have resulted in serious or specific harm to Members, the Department, or other parties.

For the specific Contract violations described below, the Department reserves the right to assess liquidated damages in the amount specified.

Liquidated Damages	
Failure to maintain one hundred percent (100%) accuracy for all PDL coding changes based on drug files provided by the Department as required by Section 5.15.1, <i>Legend and Non-Legend Drug Coverage: Common Core Formulary</i> .	\$5,000 per coding error
Failure to maintain a ninety-five percent (95%) compliance rate to the closed classes of the Department PDL as required by Section 5.15.1, <i>Legend and Non-Legend Drug Coverage: Common Core Formulary</i> . The only exception will be for established pharmacological treatment regimens, which must be continued for up to thirty (30) Days when a Member transitions from another plan.	\$25,000 per quarter
Incomplete or insufficient care plans, described in Section 8, <i>Model of Care</i> , as identified during Audits	\$15,000 per occurrence

(certain percentage of sample to be defined in Audit protocols).	
Deficiencies in Provider Access, as required by Section 7, <i>Provider Network and Access to Care</i> , identified by secret shopper surveys.	\$10,000 per occurrence
Failure to notify a Member of his or her right to a state hearing when the Contractor proposes to deny, reduce, suspend or terminate a Medicaid covered service, as described in Section 9, <i>Grievances and Appeals</i> .	\$15,000 per occurrence
Failure to confirm a valid LTSS screening has been completed documenting the Member meets the LOC requirements for Enrollment in the CCC Plus HCBS Waiver or NF admission, as required by Section 5.12.1, <i>LTSS Screening Requirements</i> .	\$25,000 per occurrence
Failure to document Member care goals in an ICP, as described in Section 8.6, <i>Person-Centered Individualized Care Plan</i> . Liquidated damages will be assessed when care goals are not documented in five percent (5%) or more of ICPs reviewed by the Department.	\$25,000 when Threshold is not met
Failure to provide the required number of minimum Care Management Contacts to at least ninety-five percent (95%) of Members, as required under Section 8.4.5, <i>Care Management Contact and Format Requirements</i> .	\$25,000 when Threshold is not met

The Department further reserves the right to assess liquidated damages for any Contract violation not specifically described in this Section.