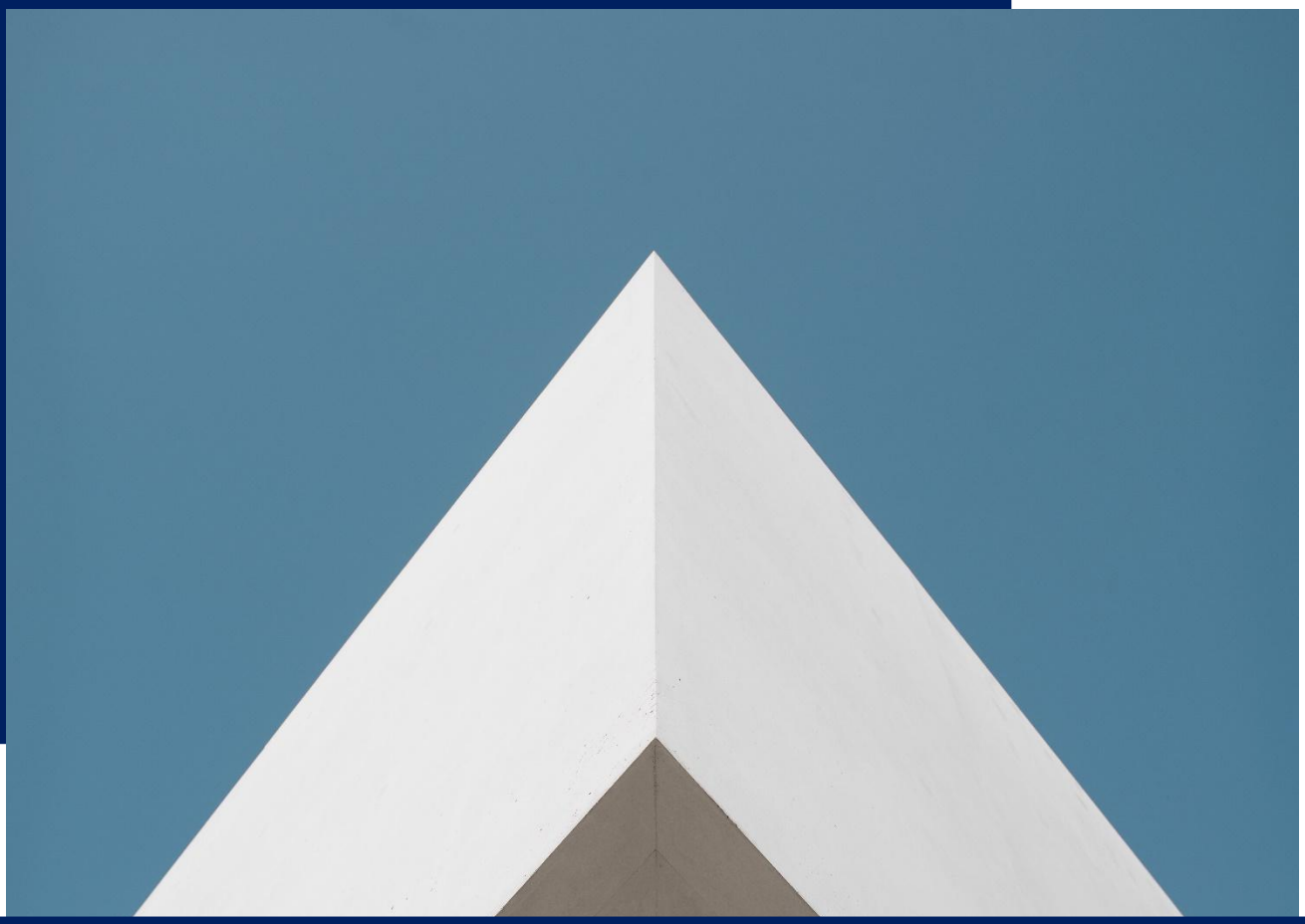
CardinalCare
Virginia's Medicaid Program



MONTHLY COMPLIANCE REPORT

AUGUST 2025 · CARDINAL CONTRACT

Office of Compliance

August 30, 2025

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

MONTHLY COMPLIANCE REPORT

INCLUDING JULY 2025 DELIVERABLES + REFERRALS

CONTENTS

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
Aetna	4	2	2	4	FINDINGS CLAIMS TRANSPORATION CONCERNS NONE
Anthem	12	2	0	14	FINDINGS MEMBER COMMUNICATION CLAIMS CONCERNS NONE
Molina	7	0	0	7	FINDINGS NONE CONCERNS NONE
Sentara	15	1	2	14	FINDINGS CLAIMS CONCERNS NONE
United	7	1	1	7	FINDINGS CLAIMS 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
Aetna	0	0	0	0	FINDINGS NONE CONCERNS NONE
Anthem	0	0	0	0	FINDINGS NONE CONCERNS NONE
Humana	0	0	0	0	FINDINGS NONE CONCERNS NONE
Sentara	0	1	0	1	FINDINGS MEMBER COMMUNICATION CONCERNS NONE
United	0	0	0	0	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.

SUMMARY

The Office of Compliance held their **Compliance Review Committee (CRC)** on August 6, 2025. The Committee reviewed compliance referrals and deliverables received in July 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 member communication materials, claims processing, and transportation.

The CRC voted to issue seven (7) Notices of Non-Compliance (NONC) related to managed care compliance issues. These NONCs included seven (7) compliance points, three (3) CPS Liquidated Damages, as well as four (4) Corrective Action Plans (CAPs) and one (1) MCO Improvement Plan (MIP).

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 August 11, 2025.

AETNA BETTER HEALTH OF VIRGINIA

Findings:

- **Contract Adherence:** Aetna Better Health failed to properly notify Virginia Medicaid members upon the denial of Non-Emergency Medical Transportation services.

  Section 9 of the Cardinal Care contract states, "The Contractor must ensure that Members and providers are sent written notice of any adverse benefit determination or adverse action that informs Members and providers of their rights to appeal through the Contractor as well as their rights to access the Department's State Fair Hearing and provider appeal systems, in accordance with 42 CFR §438.408, after they have exhausted their appeals with the Contractor."

  Additionally, Section 14 of the Cardinal Care contract states that "The Department must hold the Contractor accountable for all actions of the subcontractor and its providers."

  The Compliance Team recommended that in response to the issue identified above, Aetna Better Heath be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point,** no CPS Liquidated Damages, and a request for an **MCO Improvement Plan (MIP).**

  The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point,** no CPS Liquidated Damages, and a **MIP** in response to this issue. **(CES # 6688 – 24/25 CC Contract)**

- **Contract Adherence:** Aetna Better Health failed to timely and accurately process the payment of claims as required by the Cardinal Care contract.

  Aveanna, a Durable Medical Equipment (DME) provider, has reported over 1000 unpaid claims dating from 2023 to the present. Based on the information provided to DMAS, hundreds of claims have been denied or paid incorrectly – requiring repeated resubmission by the provider. Given the extent of this issue, DMAS concludes that Aetna Better Health's current DME claims submission and review process is incompatible with the timely and accurate processing of provider claims

  Section 12.1 of the Cardinal Care contract, states that "with the Claims processing requirements defined in 42 CFR §447.45, the Contractor must comply with the following standards regarding timely Claims processing for

all Providers: 1. Within five (5) days of receipt of a Claim, the Contractor must perform an initial screening, and either reject the Claim, or assign a unique control number and enter it into the system for processing and adjudication. 2. The Contractor must process and pay or deny, as appropriate, ninety (90) percent of all Clean Claims submitted within thirty (30) calendar days of the date of receipt. 3. The Contractor must pay or deny, as appropriate, ninety-nine (99) percent of all Clean Claims submitted within ninety (90) calendar days of the date of receipt. 4. For certain types of Providers and Covered Services, the Contractor must comply with prompter pay requirements as described in Section 12.2.4 NF/LTSS, ARTS, MHS, EI, and Doula Payments. 5. Adjudication (pay or deny) all other Claims within twelve (12) months of the date of receipt (see 42 CFR §447.45 for timeframe exceptions)."

The Compliance Team recommended that in response to the issue identified above, Aetna Better Health be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point,** no CPS Liquidated Damages, and a request for a **Corrective Action Plan (CAP).**

The CRC agreed with the Compliance Team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)**, **one (1) compliance point,** no CPS Liquidated Damages, and a **CAP** in response to this issue. **(CES # 6706 – 24/25 CC Contract)**

Concerns:

- No concerns

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- CES # 6087: August 2024 - Member Communications issue. 1 point was removed from Aetna's total by closing case.
- CES # 6113: August 2024 - Waiver Discharge issue. 1 point was removed from Aetna's total by closing case.

Summary:

- For deliverables and referrals submitted in July 2025, Aetna Better Health showed a **moderate** level of compliance. Aetna Better Health submitted all 16 required monthly reporting deliverables accurately and on time. However, Aetna Better Health failed to meet contractual requirements related to the

proper notice of member adverse benefit determination (as addressed above in **CES # 6688**) and received a Notice of Non-Compliance (NONC) with a compliance point and a MIP. Additionally, Aetna Better Health failed to meet contractual requirements related to the processing of claims payments (as addressed above in **CES # 6706**) and received a second NONC with a compliance point and a CAP. Despite these issues, Aetna Better Health complied with most applicable regulatory and contractual requirements.

ANTHEM HEALTHKEEPERS PLUS

Findings:

- **Contract Adherence:** Anthem HealthKeepers Plus issued inaccurate member communications to Virginia Medicaid members who are patients of Eastern Shore Rural Health. These letters incorrectly stated that the members' primary care providers (PCPs) would no longer participate in Anthem's network.

  Section 4.3 of the Cardinal Care contract states that "All enrollment, disenrollment, informational materials, marketing materials and content for media, social media or websites made available to Members or potential Members by the Contractor must be submitted to the Department for its review prior to use, upon revision, and upon request, unless specified elsewhere in this Contract. The Contractor must submit its member and marketing materials to the Department for review and approval thirty (30) calendar days prior to initial posting and thirty (30) calendar days prior to any substantive changes being made. Materials may not be sent to Members without Department approval."

  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 # 6686 – 24/25 CC Contract)**

- **Contract Adherence:** Anthem HealthKeepers Plus has failed to timely and accurately process the payment of claims as required by the Cardinal Care contract.

  Two Durable Medical Equipment (DME) providers, Aveanna and MediRents, have reported 810 unpaid claims dating from January 1, 2024 to the present. Based on the information provided to DMAS, hundreds of claims have been denied or paid incorrectly – requiring repeated resubmission by the DME providers. Given the extent of this issue, DMAS concludes that Anthem HealthKeepers Plus' current DME claims submission and review process is incompatible with the timely and accurate processing of provider claims.

Section 12.1 of the Cardinal Care contract, states that "with the Claims processing requirements defined in 42 CFR §447.45, the Contractor must comply with the following standards regarding timely Claims processing for all Providers: 1. Within five (5) Days of receipt of a Claim, the Contractor must perform an initial screening, and either reject the Claim, or assign a unique control number and enter it into the system for processing and adjudication. 2. The Contractor must process and pay or deny, as appropriate, ninety (90) percent of all Clean Claims submitted within thirty (30) calendar days of the date of receipt. 3. The Contractor must pay or deny, as appropriate, ninety-nine (99) percent of all Clean Claims submitted within ninety (90) calendar days of the date of receipt. 4. For certain types of Providers and Covered Services, the Contractor must comply with prompter pay requirements as described in Section 12.2.4 NF/LTSS, ARTS, MHS, EI, and Doula Payments. 5. Adjudication (pay or deny) all other Claims within twelve (12) months of the date of receipt (see 42 CFR §447.45 for timeframe exceptions)."

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 CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point, $15,000 in CPS Liquidated Damages**, and a **CAP** in response to this issue**. (CES # 6687 – 24/25 CC Contract)**

Concerns:

- No concerns

MIP/CAP Update:

- Anthem HealthKeepers Plus submitted the requested Corrective Action Plan (CAP) for **CES # 6687** on August 26, 2025. The CAP is now under review by the Department.

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- No points

Summary:

- For deliverables and referrals submitted in July 2025, Anthem HealthKeepers Plus showed a **moderate** level of compliance. Anthem HealthKeepers Plus

submitted all 16 required monthly reporting deliverables accurately and on time. However, Anthem HealthKeepers failed to meet contractual requirements related to the submission of member materials for approved (as addressed above in **CES # 6686**) and received a Notice of Non-Compliance (NONC) with a compliance point. Additionally, Anthem HealthKeepers failed to meet contractual requirements related to the processing of claims payments (as addressed above in **CES # 6687**) and received a second NONC with a compliance point, CPS Liquidated Damages, and a CAP. Despite these issues, Anthem HealthKeepers complied with most applicable regulatory and contractual requirements.

HUMANA HEALTHY HORIZONS

Findings:

- No findings (i.e., no compliance issues severe enough to necessitate the issuance of compliance points).[1]

Concerns:

- No concerns

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- No points

Summary:

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

[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.

SENTARA COMMUNITY PLAN

Findings:

- **Contract Adherence:** The Department of Medical Assistance Services determined that Sentara Community Plan has failed to timely and accurately process the payment of claims as required by the Cardinal Care contract.

  Four Durable Medical Equipment (DME) providers, Aveanna, MediRents, Premier Kids, and National Seating, have reported over 1,000 unpaid claims dating from 2023 to the present. Based on the information provided to DMAS, hundreds of claims have been denied or paid incorrectly – requiring repeated resubmission by the provider. Given the extent of this issue, DMAS concludes that Sentara Community Plan's current DME claims submission and review process is incompatible with the timely and accurate processing of provider claims.

  Section 12.1 of the Cardinal Care contract, states that "with the Claims processing requirements defined in 42 CFR §447.45, the Contractor must comply with the following standards regarding timely Claims processing for all Providers: 1. Within five (5) Days of receipt of a Claim, the Contractor must perform an initial screening, and either reject the Claim, or assign a unique control number and enter it into the system for processing and adjudication. 2. The Contractor must process and pay or deny, as appropriate, ninety (90) percent of all Clean Claims submitted within thirty (30) calendar days of the date of receipt. 3. The Contractor must pay or deny, as appropriate, ninety-nine (99) percent of all Clean Claims submitted within ninety (90) calendar days of the date of receipt. 4. For certain types of Providers and Covered Services, the Contractor must comply with prompter pay requirements as described in Section 12.2.4 NF/LTSS, ARTS, MHS, EI, and Doula Payments. 5. Adjudication (pay or deny) all other Claims within twelve (12) months of the date of receipt (see 42 CFR §447.45 for timeframe exceptions)."

  The Compliance Team recommended that in response to the issue identified above, Sentara Community Plan 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 CRC agreed with the Compliance 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 # 6747 – 24/25 CC Contract).**

- **Contract Adherence:** The Department of Medical Assistance Services has determined that Kaiser Permanente, a subcontractor of Sentara Community Plan, sent letters to Virginia Medicaid members containing inaccurate and inconsistent information regarding services available under the 2025-2026 Cardinal Care contract.

  Section 14 of the Cardinal Care contract states "The Department must hold the Contractor accountable for all actions of the subcontractor and its providers. Additionally, for the purposes of this Contract, the subcontractor's actions and/or providers must also be considered actions and/or providers of the Contractor, as prescribed by 42 CFR §§ 438.230(b)(1) and 438.3(k)."

  Additionally, Section 4.3 of the Cardinal Care contract states that "All enrollment, disenrollment, informational materials, marketing materials and content for media, social media or websites made available to Members or potential Members by the Contractor must be submitted to the Department for its review prior to use, upon revision, and upon request, unless specified elsewhere in this Contract. The Contractor must submit its member and marketing materials to the Department for review and approval thirty (30) calendar days prior to initial posting and thirty (30) calendar days prior to any substantive changes being made. Materials may not be sent to Members without Department approval."

  The Compliance Team recommended that in response to the issue identified above, Sentara Community Plan 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 Compliance 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 # 6727 – 25/26 CC Contract).**

Concerns:

- No concerns

MIP/CAP Update:

- Sentara Community Plan submitted the requested Corrective Action Plan (CAP) for **CES # 6747** on August 25, 2025. The CAP is now under review by the Department.

Request for Reconsideration:

- Sentara Community Plan submitted a request for reconsideration for **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. The request for reconsideration is currently under review by DMAS leadership.

Expiring Points:

- **CES # 6085:** August 2024 – Appeals and Grievances issue. 1 point was removed from Sentara's total by closing case.
- **CES # 6093:** August 2024 – Access to Care issue. 1 point was removed from Sentara's total by closing case.

Summary:

- For deliverables and referrals submitted in July 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 meet the contractual requirements regarding processing claims payments (as addressed above in **CES # 6747**) and received a Notice of Non-Compliance (NONC) with a compliance point, CPS Liquidated Damages, and a CAP. Additionally, Sentara Community Plan failed to meet contractual requirements related to member communications (as addressed above in **CES # 6727**) and received a second NONC with a compliance point. Despite these issues, Sentara Community Plan complied with most regulatory and contractual requirements.

UNITEDHEALTHCARE

Findings:

- **Contract Adherence:** The Department of Medical Assistance Services determined that United Healthcare has failed to timely and accurately process the payment of claims as required by the Cardinal Care contract.

  MediRents, a Durable Medical Equipment (DME) provider, has reported over 950 unpaid claims dating from January 1, 2024 to the present. Based on the information provided to DMAS, hundreds of claims have been denied or paid incorrectly – requiring repeated resubmission by the provider. Given the extent of this issue, DMAS concludes that UnitedHealthcare's current DME claims submission and review process is incompatible with the timely and accurate processing of provider claims.

  Section 12.1 of the Cardinal Care contract, states that "with the Claims processing requirements defined in 42 CFR §447.45, the Contractor must comply with the following standards regarding timely Claims processing for all Providers: 1. Within five (5) Days of receipt of a Claim, the Contractor must perform an initial screening, and either reject the Claim, or assign a unique control number and enter it into the system for processing and adjudication. 2. The Contractor must process and pay or deny, as appropriate, ninety (90) percent of all Clean Claims submitted within thirty (30) calendar days of the date of receipt. 3. The Contractor must pay or deny, as appropriate, ninety-nine (99) percent of all Clean Claims submitted within ninety (90) calendar days of the date of receipt. 4. For certain types of Providers and Covered Services, the Contractor must comply with prompter pay requirements as described in Section 12.2.4 NF/LTSS, ARTS, MHS, EI, and Doula Payments. 5. Adjudication (pay or deny) all other Claims within twelve (12) months of the date of receipt (see 42 CFR §447.45 for timeframe exceptions)."

  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,** no CPS Liquidated Damages, and a request for a **Corrective Action Plan (CAP).**

  The CRC agreed with the Compliance Team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)**, **one (1) compliance point**, no CPS Liquidated Damages, and a **CAP** in response to this issue. **(CES # 6689 – 24/25 CC Contract)**

Concerns:

- No concerns

MIP/CAP Update:

- UnitedHealthcare submitted the requested Corrective Action Plan (CAP) for **CES # 6689** on August 26, 2025. The CAP is now under review by the Department.

Request for Reconsideration:

- UnitedHealthcare submitted a request for reconsideration regarding CES # 6630, concerning the untimely submission of Quarterly ID/D Waiver Reports for the Department of Justice. UnitedHealthcare has provided additional information confirming the report was submitted timely. As a result, the NONC and one (1) compliance point associated with CES # 6630 have been rescinded.

Expiring Points:

- **CES # 6076:** August 2024 – Waiver Entry issue. 1 point was removed from United's total by closing case.

Summary:

- For deliverables and referrals submitted in July 2025, UnitedHealthcare showed a **moderate** level of compliance. UnitedHealthcare submitted all 16 required monthly reporting deliverables accurately. However, UnitedHealthcare failed to meet contractual requirements regarding the processing of claims payments (as addressed above in CES # **6689**) and received a Notice of Non-Compliance with one (1) compliance point and a CAP. 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, *Legend and Non-Legend Drug Coverage: Common Core Formulary*.	$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, *Legend and Non-Legend Drug Coverage: Common Core Formulary*. 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, *Model of Care,* 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, *Provider Network and Access to Care*, 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, *Grievances and Appeals*.	$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, *LTSS Screening Requirements*.	$25,000 per occurrence
Failure to document Member care goals in an ICP, as described in Section 8.6, *Person-Centered Individualized Care Plan*. 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, *Care Management Contact and Format Requirements*.	$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.