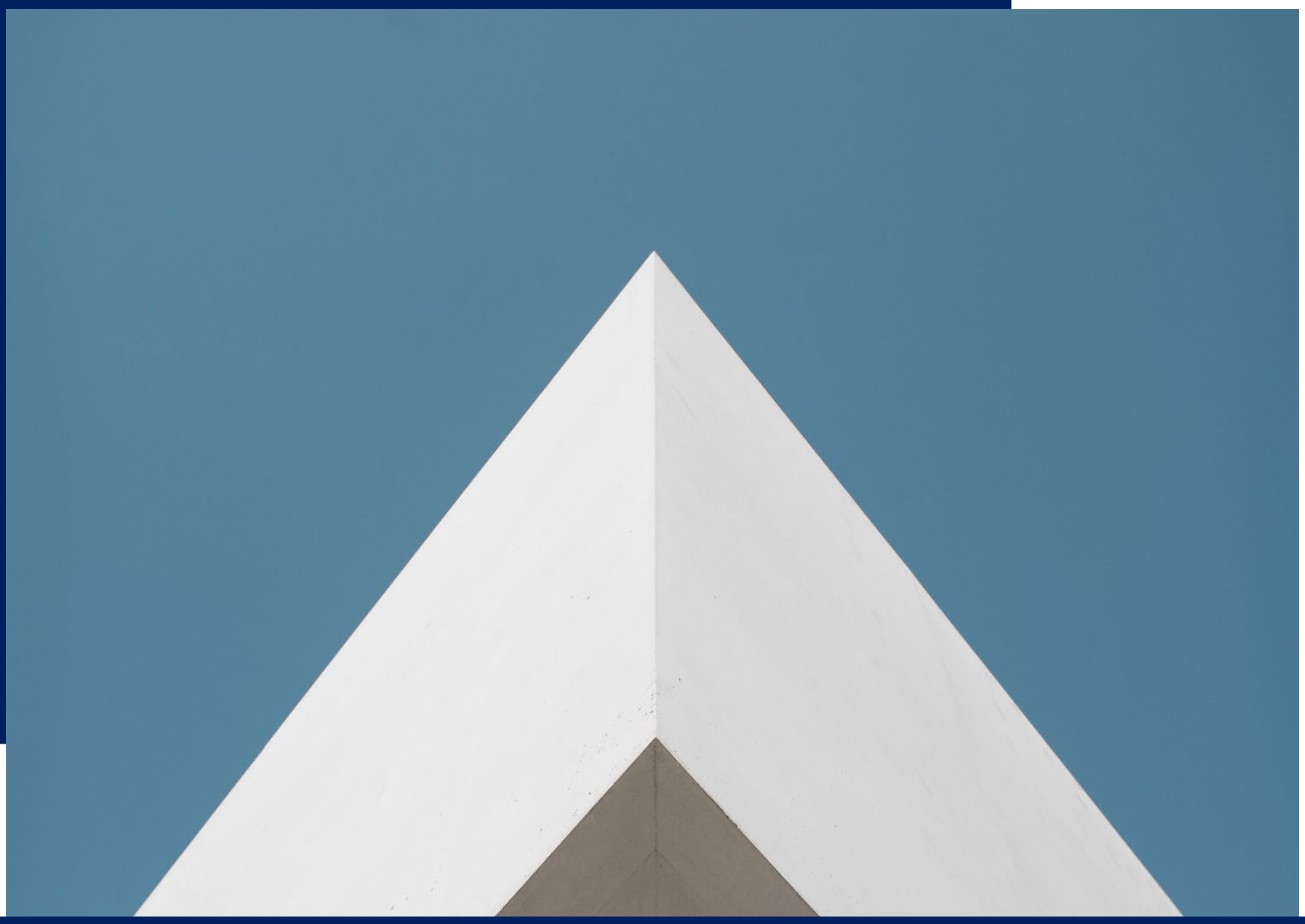
CardinalCare
Virginia's Medicaid Program



MONTHLY COMPLIANCE REPORT

FEBRUARY 2025 · CARDINAL CONTRACT

Office of Compliance

February 17, 2025

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

MONTHLY COMPLIANCE REPORT

INCLUDING JANUARY 2025 DELIVERABLES + REFERRALS

CONTENTS

COMPLIANCE POINTS OVERVIEW

MCO	Prior Month Point Balance	Point(s) Incurred for Current Month*	Point(s) Expiring or Rescinded	Final Point Balance*	Area of Violation: Finding or Concern
Aetna	16	0	0	16	**FINDINGS** NONE **CONCERNS** MHS SA
Anthem	13	1	1	13	**FINDINGS** MLTSS **CONCERNS** MHS SA PHARM PA MLTSS
Molina	17	1	1	17	**FINDINGS** MLTSS **CONCERNS** NONE
Sentara	20	1	1	20	**FINDINGS** MLTSS **CONCERNS** MHS SA
United	18	1	0	19	**FINDINGS** APPEALS **CONCERNS** MHS SA

**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 February 5, 2025. The Committee reviewed compliance referrals and deliverables received in January 2025. The meeting's agenda covered all identified and referred issues of non-compliance, including failures to meet contract thresholds and requirements related to pharmacy prior authorizations, mental health service authorizations, member appeals, as well as other contract requirements.

The CRC voted to issue eleven (11) Notices of Non-Compliance (NONC) related to managed care compliance issues. These NONCs included four (4) compliance points, one (1) request for a Corrective Action Plan (CAP), four (4) financial sanctions, and two (2) issues resulting in liquidated damages.

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 February 7, 2025.

AETNA BETTER HEALTH OF VIRGINIA

Findings:

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

Concerns:

- **Contract Adherence:** Aetna Better Health failed to process all Mental Health Services (MHS) Service Authorizations within the required timeframe. Per the December 2024 data, Aetna failed to process two (2) standard service authorization request within 14 days. No supplemental information was required. Aetna's overall timeliness for processing MHS Service Authorization requests for the month of December was 99.92%.

  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.

  The Compliance Team recommended that in response to the issue identified above, Aetna be issued a **Notice of Non-Compliance (NONC)** with no compliance points or financial penalty, and no MIP/CAP. The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** in response to this issue**. (CES # 6443)**

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- No points

Summary:

- For deliverables measuring performance for December 2024, Aetna Better Health showed a **high** level of compliance. Aetna Better Health submitted all

16 required monthly reporting deliverables on time. However, Aetna Better Health failed to meet contractual requirements related to the timely processing of MHS service authorization requests (as addressed above in **CES # 6443**) and received a Notice of Non-Compliance with no compliance points or financial penalty. Despite this issue, Aetna Better Health complied with most applicable regulatory and contractual requirements.

ANTHEM HEALTHKEEPERS PLUS

Findings:

- **Contract Adherence:** Anthem HealthKeepers Plus failed to meet portal entry requirements. Anthem entered a CCC Plus Waiver line with a begin date prior to the actual start of services.

  Section 5.12.8 of the contract states that the Contractor must enter hospice, NF specialized care and LSH hospital admissions, discharges and changes, admissions into excluded NFs, and CCC Plus Waiver admissions directly into the Virginia Medicaid Web Portal (LTC Tab). The Contractor must not enter LOC benefit information until the applicable services (NF, specialized care, LSH, CCC Plus Waiver, and Hospice) have started.

  The Compliance Team recommended that in response to the issue identified above, Anthem HealthKeepers Plus be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** and a **$15,000 financial penalty**. 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 a **$15,000 financial penalty** in response to this issue. **(CES # 6463)**

- **Contract Adherence:** Anthem HealthKeepers Plus failed to meet waiver enrollment requirements. Anthem did not complete a valid LTSS screening prior to waiver enrollment date.

  Section 5.12.1 of the Cardinal Contract states that the Contractor must not reimburse a NF or CCC Plus Waiver services provider for services to any of its members who are newly admitted to a NF or the CCC Plus Waiver until the LTSS screening has been completed for the Member by an appropriate screening team (described below); Screening Manual – Chapter 4, p. 91.

  Additionally, Virginia Administrative Code: 12VAC30-120-920-C-4 states that "Medicaid shall not pay for any home and community-based care services delivered prior to the individual establishing Medicaid eligibility and prior to the date of the preadmission screening by the Preadmission Screening Team or DMAS-enrolled hospital provider and the physician signature on the Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96)."

  The Compliance Team recommended that in response to the issue identified above, Anthem HealthKeepers Plus be issued a **Notice of Non-Compliance**

(NONC) with **$25,000 in 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 **$25,000 in liquidated damages** in response to this issue. **(CES # 6421)**

Contract Adherence: Anthem HealthKeepers Plus failed to meet waiver enrollment requirements. Anthem did not complete a valid LTSS screening prior to waiver enrollment date. **(CES # 6461)**

Section 5.12.1 of the Cardinal Contract states that the Contractor must not reimburse a NF or CCC Plus Waiver services provider for services to any of its members who are newly admitted to a NF or the CCC Plus Waiver until the LTSS screening has been completed for the Member by an appropriate screening team (described below); Screening Manual – Chapter 4, p. 91

Additionally, Virginia Administrative Code: 12VAC30-120-920-C-4 states that "Medicaid shall not pay for any home and community-based care services delivered prior to the individual establishing Medicaid eligibility and prior to the date of the preadmission screening by the Preadmission Screening Team or DMAS-enrolled hospital provider and the physician signature on the Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96)."

The Compliance Team recommended that in response to the issue identified above, Anthem HealthKeepers be issued a **Notice of Non-Compliance (NONC)** with **$25,000 in 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 **$25,000 in liquidated damages** in response to this issue. **(CES # 6461)**

Concerns:

- **Contract Adherence:** Anthem HealthKeepers Plus failed to process all Pharmacy Prior Authorization Requests timely. Per December 2024 data, Anthem failed to process three (3) requests within 24 hours, with an average untimely processing of 101 hours. Anthem's overall timeliness for processing Pharmacy Prior Authorization requests for the month of December was 99.98%.

  Section 5.15.4 of the Cardinal Care contract states that in accordance with 42 CFR §438.3 and 438.210(d), the Contractor must provide responses for all covered outpatient drug authorizations by telephone or other telecommunication device within twenty-four (24) hours of a request for authorization, in accordance with Section 1927(d)(5)(A) of the Social Security Act.

The Compliance Team recommended that in response to the issue identified above, Anthem be issued a **Notice of Non-Compliance (NONC)** with no points or financial penalty. The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** in response to this issue**. (CES # 6441)**

- **Contract Adherence:** Anthem HealthKeepers Plus failed to process all Mental Health Services (MHS) Service Authorization Requests timely. Per December 2024 data, Anthem failed to process three (3) standard requests within fourteen (14) days, with a maximum processing of twenty-one (21) days. Anthem's overall timeliness for processing MHS Service Authorization requests for the month of December was 99.77%.

  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.

  The Compliance Team recommended that in response to the issue identified above, Anthem be issued a **Notice of Non-Compliance (NONC)** with no points or financial penalty. The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** in response to this issue**. (CES # 6445)**

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- **CES # 5794**: February 2024 – Claims payment issue. 1 point was removed from Anthem's total by closing case

Summary:

- For deliverables measuring performance for December 2024, Anthem HealthKeepers Plus showed a **low** level of compliance. Anthem submitted all 16 required monthly reporting deliverables on time. However, Anthem failed

to submit an accurate portal entry (as addressed above in **CES # 6463**) and received a Notice of Non-Compliance with compliance points and financial penalty. Additionally, Anthem failed to accurately complete two waiver enrollments (as addressed above in **CES # 6421 and CES # 6461**) and each received a Notice of Non-Compliance with liquidated damages. Anthem also failed to meet contractual requirements related to the timely processing of Pharmacy Prior Authorization requests (as addressed above in **CES # 6441**) and MHS service authorization requests (as addressed above in **CES # 6445**) and received a fourth and fifth Notice of Non-Compliance. As a result, Anthem HealthKeepers Plus failed to comply with many regulatory and contractual requirements.

MOLINA HEALTHCARE

Findings:

- **Contract Adherence:** Molina Healthcare failed to complete a face-to-face LOCERI as required by the Cardinal Care contract. On January 16, 2025, Molina Healthcare submitted a LOCERI with an assessment date of January 16, 2025. Upon review, it was determined that the submitted LOCERI was not conducted face-to-face. Instead, the information was gathered via a phone call with the member's daughter. As the review was not conducted face-to-face, no LOCERI should have been submitted in this case.

  Section 5.12.2.2 of the Cardinal Care contract states: All LOC reviews for Members in CCC Plus Waiver must: 1. Be conducted face-to-face.

  The Compliance Team recommended that in response to the issue identified above, Molina Healthcare be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** and a **$15,000 financial penalty**. The Department also recommended that Molina Healthcare submit a **Corrective Action Plan (CAP)**. The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC), one (1) compliance point,** a **$15,000 financial penalty** and a **CAP** in response to this issue. **(CES # 6462)**

Concerns:

- No concerns

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- **CES # 5773**: February 2024 – Claims payment issue. 1 point was removed from Molina's total by closing case

Summary:

- For deliverables measuring performance for December 2024, Molina Healthcare showed a **moderate** level of compliance. Molina submitted all 16 required monthly reporting deliverables on time. However, it was identified that Molina failed to submit an accurate LOCERI (as addressed above in **CES**

 # 6462) and received a Notice of Non-Compliance with one compliance point, and a financial penalty, and a CAP. Despite this issue, Molina complied with most applicable regulatory and contractual requirements.

SENTARA COMMUNITY PLAN

Findings:

- **Contract Adherence:** Sentara Community Plan failed to meet portal entry requirements. December 2024's Waiver Portal Entry Review determined a waiver entry was five months out of compliance.

  Section 5.12.8.2 of the Cardinal Care contract states that the Contractor must enter CCC Plus Waiver enrollments directly into the Virginia Medicaid Web Portal. Such admission and change transactions must be entered by the Contractor no later than two (2) business days of notification of the initiation of Waiver services, often the date the initial service authorization is processed.

  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 a **$15,000 financial penalty**. No MIP/CAP was recommended 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 a **$15,000 financial penalty** in response to this issue**. (CES # 6422)**

Concerns:

- **Contract Adherence:** Sentara Community Plan failed to process all Mental Health Services (MHS) Service Authorization Requests timely. Per December 2024 data, Sentara failed to process two (2) standard requests within fourteen (14) days, with a maximum processing of fifteen (15) days. Sentara's overall timeliness for processing MHS Service Authorization requests for the month of December was 99.95%.

  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.

  The Compliance Team recommended that in response to the issue identified above, Sentara be issued a **Notice of Non-Compliance (NONC)** with no

compliance points or financial penalty. Sentara is currently under a CAP related to MHS Service Authorization requests. The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** in response to this issue**. (CES # 6442)**

MIP/CAP Update:

- CAP received on 12/24/2024 for CES # 6281 and currently under review.
- CAP received on 12/24/2024 for CES # 6282 and currently under review.

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- **CES # 5834**: February 2024 – Call Center Statistics issue. 1 point was removed from Sentara's total by closing case

Summary:

- For deliverables measuring performance for December 2024, Sentara Community Plan showed a **moderate** level of compliance. Sentara submitted all 16 required monthly reporting deliverables accurately and on time. However, Sentara failed to meet contractual requirements related to portal entry requirements (as addressed above in **CES # 6422**) and received a Notice of Non-Compliance with one compliance point and a financial penalty. Additionally, Sentara failed to meet contractual requirements related to the timely processing of Mental Health Services (MHS) Service Authorization requests (as addressed above in **CES # 6442**) and received a Notice of Non-Compliance. Despite these issues, Sentara complied with most applicable regulatory and contractual requirements.

UNITEDHEALTHCARE

Findings:

- **Contract Adherence:** UnitedHealthcare failed to timely process two (2) internal appeals within the required thirty (30) day timeframe without a request for an extension.

  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. By processing the appeal after 30 days, UnitedHealthcare failed to timely meet the contract standard.

  The Compliance Team recommended that in response to the issues identified above, UnitedHealthcare be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** and a **$15,000 financial penalty**. 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 a **$15,000 financial penalty** in response to this issue**. (CES # 6446)**

Concerns:

- **Contract Adherence:** UnitedHealthcare failed to process all Mental Health Services (MHS) Service Authorization Requests timely. Per December 2024 data, UnitedHealthcare failed to process three (3) standard requests within the required fourteen (14) days and three (3) expedited requests within 72 hours. UnitedHealthcare's overall timeliness for processing MHS Service Authorization requests for the month of December was 99.59%.

  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.

The Compliance Team recommended that in response to the issue identified above, UnitedHealthcare be issued a **Notice of Non-Compliance (NONC)** with no points or financial penalty. UnitedHealthcare is currently under a CAP related to MHS Service Authorization requests. The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** in response to this issue**. (CES # 6444)**

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- No points

Summary:

- For deliverables measuring performance for December 2024, UnitedHealthcare showed a **moderate** level of compliance. UnitedHealthcare submitted all 16 required monthly reporting deliverables accurately. However, UnitedHealthcare failed to timely process two (2) internal appeals within the required timeframe (as addressed above in **CES # 6446)** and received a Notice of Non-Compliance with one compliance point and a financial penalty. Additionally, UnitedHealthcare failed to meet contractual requirements related to the timely processing of Mental Health Services (MHS) Service Authorization requests (as addressed above in **CES # 6444**) and received a Notice of Non-Compliance. Despite these issues, UnitedHealthcare complied with most applicable 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.