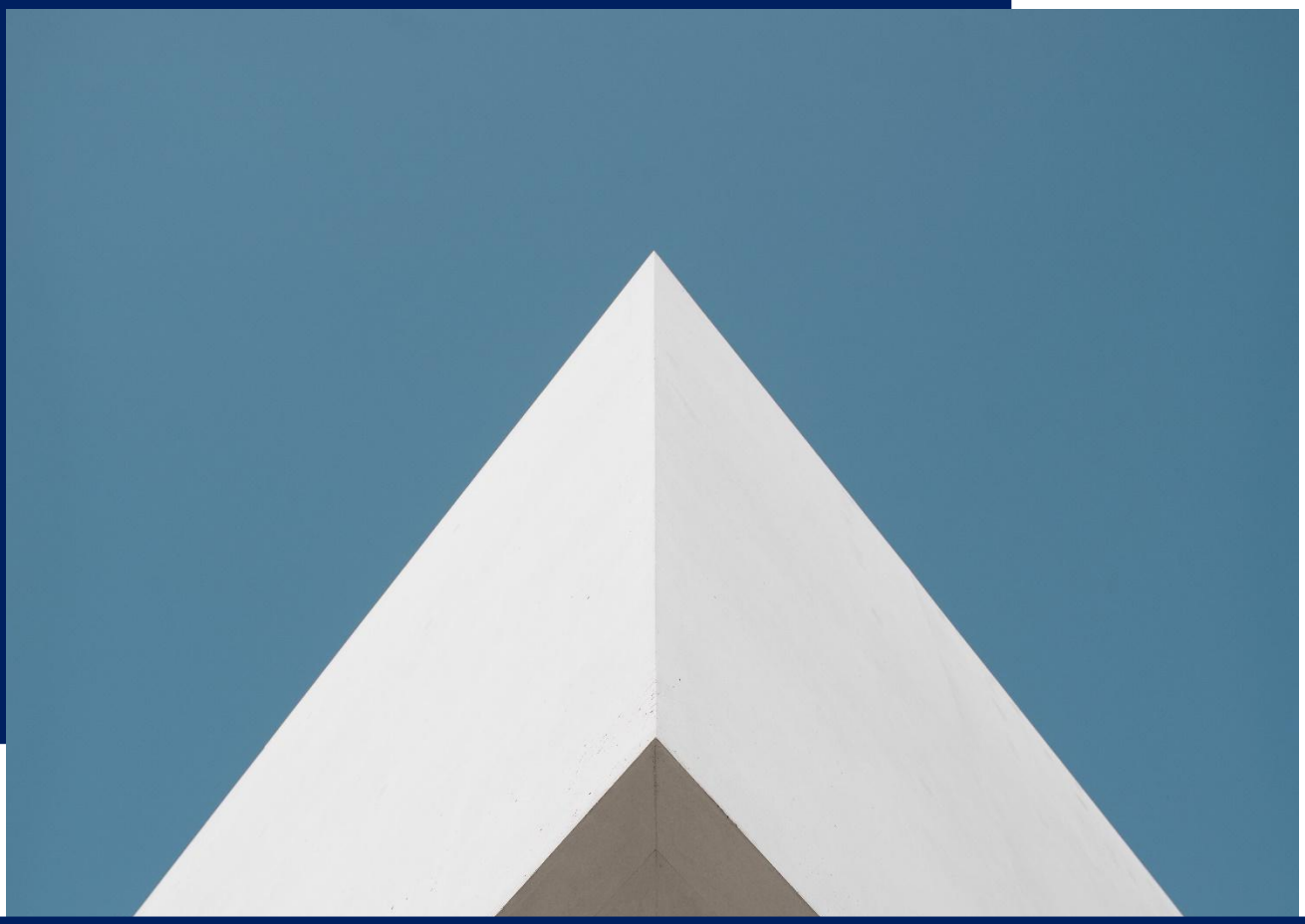
CardinalCare
Virginia's Medicaid Program



MONTHLY COMPLIANCE REPORT

NOVEMBER 2025 · CARDINAL CONTRACT

Office of Compliance

December 15, 2025

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

MONTHLY COMPLIANCE REPORT

INCLUDING OCTOBER 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	0	1	3	FINDINGS NONE CONCERNS NONE
Anthem	19	0	2	17	FINDINGS NONE CONCERNS MLSS
Molina	6	0	0	6	FINDINGS NONE CONCERNS NONE
Sentara	14	1	2	13	FINDINGS LTSS CONCERNS NONE
United	6	0	1	5	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
Aetna	0	2	0	2	FINDINGS SERVICE AUTH DATA SUBMISSION CONCERNS NONE
Anthem	1	4	0	5	FINDINGS SERVICE AUTH DATA SUBMISSION OTHER CONCERNS CLAIMS
Humana	0	0	0	0	FINDINGS NONE CONCERNS REPORTING ERROR
Sentara	1	2	0	3	FINDINGS SERVICE AUTH CONCERNS NONE
United	2	2	0	4	FINDINGS SERVICE AUTH 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 November 5, 2025. The Committee reviewed compliance referrals and deliverables received in October 2025. The meeting 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 contractual thresholds and requirements related to reporting errors, claims processing, service authorizations, and waiver enrollment issues.

The CRC voted to issue twelve (12) Notices of Non-Compliance (NONCs) related to managed care compliance issues. These NONCs included eleven (11) compliance points, and one (1) assessment of CPS liquidated damages.

Each MCO's compliance findings and concerns are detailed below. The Department communicated the CRC's findings in letters and emails distributed to the MCOs on November 24, 2025.

AETNA BETTER HEALTH OF VIRGINIA

Findings:

- **Reporting Error**: Aetna Better Health timely submitted the Monthly Enrollment and Care Management Report. However, the report submitted contained incorrect member caseload data for September 2025.

  Section 17.2.2 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, Aetna Better Health be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point,** no CPS Liquidated Damages, and no MIP or CAP.

  The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** in response to this issue**. (CES # 6898 – 25/26 CC Contract)**

- **Contract Adherence:** Aetna Better Health incorrectly approved multiple service authorizations, failing to apply the correct criteria in approving service authorizations for respite care.

  This included the approval of three (3) service authorizations in which the member's primary caregiver was not identified, one (1) service authorization in which no justification was provided to authorize hours exceeding the 56-hour soft cap, and one (1) service authorization without appropriate documentation.

  Section 6.1 of the Cardinal Care contract states that in accordance with 42 CFR § 438.210(b)(1), the Contractor's authorization process for initial and continuing authorizations of services must follow written policies and procedures and must include effective mechanisms to ensure consistent application of medical necessity review criteria for authorization decisions.

  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 no MIP or CAP.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** in response to this issue**. (CES # 6920 – 25/26 CC Contract)**

Concerns:

- No concerns

MIP/CAP Update:

- Aetna Better Health submitted the requested MCO Improvement Plan (MIP) for **CES # 6688** on September 8, 2025. The MIP was approved on November 17, 2025.
- Aetna Better Health submitted the requested Corrective Action Plan (CAP) for **CES # 6706** on September 19, 2025. The CAP was approved on November 17, 2025.

Request for Reconsideration:

- A Request for Reconsideration for **CES # 6920** was submitted on December 2, 2025. The request is currently under review by the Department.

Expiring Points:

- **CES # 6242:** November 2024 – Service Authorizations. No related points
- **CES # 6301**: November 2024 – Member Benefits and Services. One (1) point removed from Aetna's point total for 2024-2025 contract
- **CES # 6302**: November 2024 – LTTS Issue. No related points

Summary:

- For deliverables and referrals submitted in October 2025, Aetna Better Health showed a **moderate** level of compliance. Aetna Better Health submitted 15 of the 16 required monthly reporting deliverables accurately and on time. Aetna failed to submit an accurate Monthly Enrollment and Care Management Report (as addressed above in **CES # 6898**) and received a Notice of Non-Compliance (NONC) with one (1) compliance point. Additionally, Aetna incorrectly approved multiple respite service authorizations (as addressed above in **CES # 6920**) and received a Notice of Non-Compliance (NONC) with one (1) compliance point.

ANTHEM HEALTHKEEPERS PLUS

Findings:

- **Reporting Error:** Anthem HealthKeepers Plus failed to submit an accurate monthly Pharmacy Report for October 2025. The report did not include two of the five required sections.

  Section 17.2.2 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, Anthem HealthKeepers Plus be issued a **Notice of Non-Compliance (NONC)** with **one (1) compliance point,** no CPS Liquidated Damages, and no MIP or CAP.

  The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point. (CES # 6925 – 25/26 CC Contract)**

- **Contract Adherence:** Anthem HealthKeepers Plus incorrectly approved a Service Authorization for Respite Care. While the member's primary caregiver is her husband, the service authorization incorrectly identified her grandson as the primary caregiver and her husband as the paid respite caregiver. The member's husband cannot serve as both primary and respite caregiver.

  Section 6.1 of the Cardinal Care contract states, "the Contractor's authorization process for initial and continuing authorizations of services must follow written policies and procedures and must include effective mechanisms to ensure consistent application of medical necessity review criteria for authorization decisions."

  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**, no CPS Liquidated Damages, and no MIP or CAP.

  The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** in response to this issue**. (CES # 6918 – 25/26 CC Contract)**

- **Contract Adherence:** Anthem HealthKeepers Plus failed to timely process three (3) Personal Care Service Authorizations within the required 14-day timeframe, with no request for an extension.

  Section 6.1.1, Standard Authorization Decisions, of the Cardinal Care contract states, "for standard authorization decisions, the Contractor must 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."

  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,** no CPS Liquidated Damages, and no MIP or CAP.

  The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** in response to this issue**. (CES # 6917 – 25/26 CC Contract)**

- **Contract Adherence:** Anthem HealthKeepers Plus failed to enter a waiver enrollment within the required 5-day timeframe. The provider submitted completed paperwork via fax on May 1, 2025. However, the member's waiver enrollment was not entered until August 20, 2025.

  As provided by the MCO Guidance Memorandum dated August 7, 2025, the contract requires entry of CCC Plus HCBS Waiver Enrollments directly into the Virginia Medicaid Web Portal. Such admission and change transactions must be entered by the Contractor no later than five (5) business days after the notification of the initiation of Waiver services.

  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,** no CPS Liquidated Damages, and no MIP or CAP.

  The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** in response to this issue**. (CES # 6919 – 25/26 CC Contract)**

Concerns:

- **Contract Adherence:** Anthem HealthKeepers Plus failed to timely adjudicate 209 Nursing Facility claims within the 30-day timeframe.

Section 12.2.4 of the Cardinal Care contract requires that 100% of clean claims from Nursing Facilities/LTSS, MHS, ARTS, and early intervention providers shall be processed within thirty (30) calendar days of receipt. The Contractor must also ensure one hundred percent (100%) of clean claims from these providers are adjudicated within thirty (30) calendar days of receipt.

The Compliance Team recommended that in response to the issue identified above, Anthem HealthKeepers Plus be issued a **Notice of Non-Compliance (NONC)**. As Anthem is currently under an MCO Improvement Plan (MIP) related to this issue, no additional points or liquidated damages will be assessed at this time.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance** in response to this issue**. (CES # 6897 – 25/26 CC Contract).**

MIP/CAP Update:

- Anthem HealthKeepers Plus submitted the requested MCO Improvement Plan (MIP) for **CES # 6798** on October 9, 2025. The MIP was approved on November 17, 2025.
- Anthem HealthKeepers Plus submitted the requested Corrective Action Plan (CAP) for **CES # 6687** on August 26, 2025. The CAP was approved on November 17, 2025.
- Anthem HealthKeepers Plus submitted the requested Corrective Action Plan (CAP) for **CES # 6508** on October 2, 2025. The CAP was approved on November 17, 2025.

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- **CES # 6241:** November 2024 – Appeals and Grievances. One (1) point was removed from Anthem's total for 2024-2025 contract.
- **CES # 6243:** November 2024 – Service Authorizations. No related points.
- **CES # 6303:** November 2024 – LTSS Issue. One (1) point was removed from Anthem's total for 2024-2025 contact.
- **CES # 6341:** November 2024 – Data submission error. No related points.

Summary:

- For deliverables and referrals submitted in October 2025, Anthem HealthKeepers Plus showed a **low** level of compliance. Anthem HealthKeepers Plus submitted all 16 required monthly reporting deliverables

on time. However, Anthem HealthKeepers failed to submit an accurate Monthly Pharmacy Report (as addressed above in **CES # 6925**) and received a Notice of Non-Compliance (NONC) with one (1) compliance point. Anthem also failed to timely process 209 Nursing Facility claims (as addressed above in **CES # 6897**) and received a Notice of Non-Compliance (NONC). Additionally, Anthem inappropriately approved an authorization for respite care (as addressed above in **CES # 6918**) and failed to timely process several personal care service authorizations (as addressed above in **CES # 6917**) receiving a Notice of Non-Compliance (NONC) with one (1) compliance point for each. Lastly, Anthem failed to enter a waiver enrollment within the appropriate timeframe (as addressed above in **CES # 6919**) and received a Notice of Non-Compliance (NONC) with one (1) compliance point.

HUMANA HEALTHY HORIZONS

Findings:

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

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 October 2025, Humana Healthy Horizons showed a **very high** level of compliance. Humana Healthy Horizons submitted all 16 required monthly reporting deliverables accurately and on time. Humana Healthy Horizons complied with all applicable regulatory and contractual requirements for the month.

SENTARA COMMUNITY PLAN

Findings:

- **Contract Adherence:** Sentara Community Plan failed to process a personal care service authorization within the required 14 days. The service authorization was submitted on July 30, 2025, but the authorization decision was not made until August 29, 2025. No extension was requested.

  Section 6.1.1, Standard Authorization Decisions, of the Cardinal Care contract states, "for standard authorization decisions, the Contractor must 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."

  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,** no CPS Liquidated Damages, and no MIP or CAP.

  The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** in response to this issue. **(CES # 6923 – 25/26 CC Contract).**

- **Contract Adherence:** Sentara Community Plan failed to apply the correct criteria in approving a service authorization for respite care. A recent audit found a service authorization that was approved incorrectly, in which the primary caregiver was also listed as the paid attendant. A member's primary caregiver cannot also serve as the respite caregiver.

  Section 6.1 of the Cardinal Care contract states, "the Contractor's authorization process for initial and continuing authorizations of services must follow written policies and procedures and must include effective mechanisms to ensure consistent application of medical necessity review criteria for authorization decisions."

  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,** no CPS Liquidated Damages, and no MIP or CAP.

The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** in response to this issue. **(CES # 6924 – 25/26 CC Contract).**

- **Contract Adherence:** Sentara Community Plan and Kaiser Permanente failed to enter a waiver enrollment within the required 5-day timeframe. The provider submitted a service authorization request on January 10, 2025. However, the service authorization and waiver enrollment were not approved until January 31, 2025.

  Section 7.2.14 of the Cardinal Care contract provides that LTSS services must be made available as expeditiously as the Member's condition requires and within no more than five (5) business days from the Contractor's determination that coverage criteria is met.

  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 **$15,000 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 CPS Liquidated Damages** in response to this issue. **(CES # 6838 – 24/25 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 was approved on November 17, 2025.

Request for Reconsideration:

- A Request for Reconsideration for **CES # 6923** was received on December 3, 2025. The request is currently under review by the Department.
- A Request for Reconsideration for **CES # 6924** was received on December 3, 2025. The request is currently under review by the Department.

Expiring Points:

- **CES # 6281:** November 2024 – NCQA accreditation lapse. One (1) point was removed from Sentara's total for 2024-2025 contract.

- **CES # 6282:** November 2024 – Provider relations issue. One (1) point was removed from Sentara's total for 2024-2025 contract.

Summary:

- For deliverables and referrals submitted in October 2025, Sentara Community Plan showed a **low** level of compliance. Sentara Community Plan submitted all 16 required monthly reporting deliverables accurately and on time. However, Sentara Community Plan failed to timely approve a Personal Care Services Service Authorization (as addressed above in **CES # 6923**) and received a Notice of Non-Compliance (NONC) with one (1) point, and failed to apply the appropriate criteria in approving a Respite Service Authorization (as addressed above in **CES # 6924**) and received a Notice of Non-Compliance (NONC) with one (1) point. Additionally, Sentara failed to timely process a CCC Plus Waiver enrollment (as addressed above in **CES # 6838**) and received a Notice of Non-Compliance (NONC) with one (1) compliance point and $15,000 CPS liquidated damages, for the 2024-2025 contract. Despite these issues, Sentara Community Plan complied with most regulatory and contractual requirements.

UNITEDHEALTHCARE

Findings:

- **Contract Adherence:** UnitedHealthcare failed to process a personal care service authorization within the required 14 days, with no request for an extension. The service authorization was submitted on May 10, 2025, but the authorization decision was not made until August 6, 2025.

  Section 6.1.1, Standard Authorization Decisions, of the Cardinal Care contract states, "for standard authorization decisions, the Contractor must 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."

  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 no MIP or CAP.

  The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** in response to this issue**. (CES # 6922 – 25/26 CC Contract).**

- **Contract Adherence:** United Healthcare failed to enter a waiver enrollment within the required 5-day timeframe. The waiver enrollment request was submitted on May 10, 2025. However, the waiver enrollment was not entered until August 6, 2025.

  As provided by the MCO Guidance Memorandum dated August 7, 2025, the contract requires entry of CCC Plus HCBS Waiver Enrollments directly into the Virginia Medicaid Web Portal. Such admission and change transactions must be entered by the Contractor no later than five (5) business days after the notification of the initiation of Waiver services.

  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 no MIP or CAP.

  The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** with **one (1) compliance point** in response to this issue**. (CES # 6921 – 25/26 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 was approved on November 17, 2025.

Request for Reconsideration:

- No request for reconsideration

Expiring Points:

- **CES # 6261:** November 2024 – Service Authorizations. No related points.
- **CES # 6321:** November 2024 – LTSS Issue. One (1) point was removed from United's total for 2024-2025 contract.

Summary:

- For deliverables and referrals submitted in October 2025, UnitedHealthcare showed a **moderate** level of compliance. UnitedHealthcare submitted all 16 required monthly reporting deliverables accurately and on time. However, UnitedHealthcare failed to timely approve a personal care service authorization (as addressed above in **CES # 6922**) and received a Notice of Non-Compliance (NONC) with one (1) point. Additionally, UnitedHealthcare failed to enter a waiver enrollment timely (as addressed above in **CES # 6921**) and received a Notice of Non-Compliance (NONC) with one (1) 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, *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.