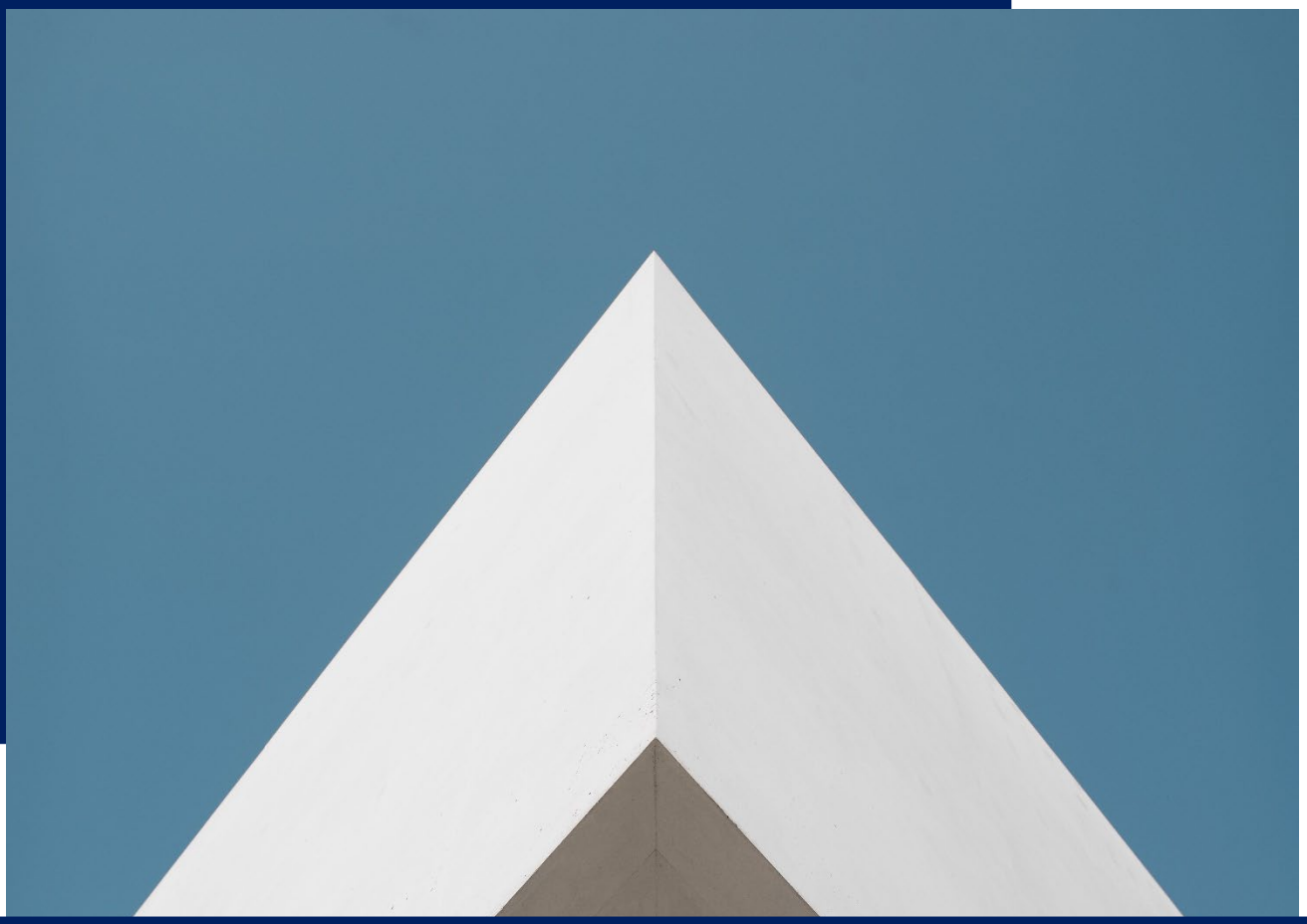
CardinalCare
Virginia's Medicaid Program



MONTHLY COMPLIANCE REPORT

APRIL 2025 · CARDINAL CONTRACT

Office of Compliance

April 30, 2025

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

CardinalCare
Virginia's Medicaid Program

MONTHLY COMPLIANCE REPORT

INCLUDING MARCH 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MCO	Prior Month Point Balance	Point(s) Incurred for Current Month*	Point(s) Expiring or Rescinded	Final Point Balance*	Area of Violation: Finding or Concern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	6	0	1	5	**FINDINGS** NONE **CONCERNS** NONE
Anthem	12	1	0	13	**FINDINGS** MLTSS **CONCERNS** NONE
Molina	17	2	10	9	**FINDINGS** EI CLAIMS MLTSS **CONCERNS** PHARM PA
Sentara	18	1	4	15	**FINDINGS** MLTSS **CONCERNS** PHARM PA
United	8	0	2	6	**FINDINGS** NONE **CONCERNS** MLTSS MLTSS

**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 April 10, 2025. The Committee reviewed compliance referrals and deliverables received in March 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, Early intervention claims, as well as MLTSS issues.

The CRC voted to issue eight (8) Notices of Non-Compliance (NONC) related to managed care compliance issues. These NONCs included four (4) compliance points, two (2) financial sanctions, as well as two (2) requests for an 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 April 15, 2025.

AETNA BETTER HEALTH OF VIRGINIA

Findings:

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

Concerns:

- No concerns

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- Aetna Better Health submitted a request for reconsideration regarding **CES #6486**. Aetna requested that DMAS reconsider the assessment of a NONC letter and a one-point violation, advising that both member appeals were extended at the request of the member. After carefully reviewing the request, DMAS leadership decided to overturn and rescind the NONC, and a one-point violation associated with CES #6486. Aetna was notified of this decision on April 1, 2025.

Expiring Points:

- No points

Summary:

- For deliverables measuring performance for February 2025, Aetna Better Health showed a **very high** level of compliance. Aetna Better Health submitted all 16 required monthly reporting deliverables accurately and on time. Aetna Better Health complied with all applicable regulatory and contractual requirements this month.

ANTHEM HEALTHKEEPERS PLUS

Findings:

- **Data Submission Errors:** Anthem HealthKeepers Plus (Anthem or Contractor) failed to provide an accurate reporting for validation of member waiver services. The Department requested validation of whether specific members were receiving Waiver services. Upon Anthem validating there were no services in place, DMAS terminated the CCC Plus Waivers on that basis. On March 4, 2025, Anthem reached out advising of a system problem and identified 4 members that they had incorrectly reported as no services in place. DMAS reinstated more than 80 members that were terminated from the Waiver based on information provided by Anthem.

  Section 1.4 Required Reporting and Documentation of the Cardinal Contract states Failure to timely and accurately provide any required reports or documentation will result in compliance enforcement actions, as provided in Section 17, Oversight. Notwithstanding the foregoing, the Department has the right to require additional documentation, reports, and information be maintained; and request additional documentation, reports, and information not listed in the Cardinal Care Technical Manual. The Contractor must submit such documentation and reports in the timeframes and manner as requested by the Department.

  Additionally, 5.12 Long-term Services and Supports (LTSS) of the Cardinal Care Contract states, the Contractor is responsible for knowledge of the services within the CCC Plus and DD waivers in order to educate members about these benefits and to assist members in accessing these LTSS services as appropriate.

  The Compliance Team recommended that in response to the issue identified above, Anthem be issued a **Notice of Non-Compliance (NONC)** with **one 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 # 6516)**

Concerns:

- No concerns

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- No points

Summary:

- For deliverables measuring performance for February 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 Plus failed to meet contractual requirements related to the accurate submission of the CCC Plus Waivers (as addressed above in **CES # 6516**) received a Notice of Non-Compliance with compliance point and financial penalty. Despite these issues, Anthem HealthKeepers Plus complied with most applicable regulatory and contractual requirements.

MOLINA HEALTHCARE

Findings:

- **Contract Adherence:** Molina Healthcare failed to process the EI clean claims within the required timeframe. Per February 2025 data, Molina failed to process 99% of EI clean claims within required 14 days (27 clean claims exceeded 14 calendar days to adjudicate, with 98.11% processed timely).

  As described in Section 12.2.4 of the Cardinal Care contract, Molina is required to ensure ninety-nine percent (99%) of clean claims from EI providers to be adjudicated within fourteen (14) calendar days of receipt.

  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.** 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)** and **one (1) compliance point** in response to this issue. **(CES # 6506)**

- **Untimely Filling Issue:** Molina Healthcare failed to report member exemptions within contractual timeframes. On February 18, 2025, Molina Healthcare submitted details regarding 149 incarcerated members with dates from January 2024 through January 2025.

  As described in Section 3.9 of the Cardinal Care contract, Molina must notify the Department within two (2) business days upon learning that a member meets one (1) or more of the Managed Care exclusion criteria. The Contractor must report to the Department and Members it identifies as incarcerated within two (2) business days of knowledge of the incarceration.

  The Compliance Team recommended that in response to the issue identified above, Molina Healthcare be issued a **Notice of Non-Compliance (NONC), one (1) compliance point,** and an **MCO Improvement Plan (MIP)** in response to this issue**.**

  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 **MIP** in response to this issue. **(CES # 6509)**

Concerns:

- **Contract Adherence:** Molina Healthcare failed to process all Pharmacy Prior Authorization Requests timely. Per February 2025 data, Molina failed to process two (2) requests within 24 hours, with an average untimely processing of 28 hours. Molina's overall timeliness for processing Pharmacy Prior Authorization requests for the month of February was 99.94%.

  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, Molina 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 # 6523)**

MIP/CAP Update:

- CAP was received on 2/24/2025 for CES # 6462 was approved on 4/15/2025

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- **CES # 5875**: April 2024 – MHS Service Authorizations and Registrations issue. 10 points were removed from Molina's total by closing case

Summary:

- For deliverables measuring performance for February 2025, Molina Healthcare showed a **low** level of compliance. Molina Healthcare submitted all 16 required monthly reporting deliverables accurately and on time. However, Molina Complete Care failed to process the EI clean claims within the required timeframe (as addressed above in **CES # 6506**) and received a Notice of Non-Compliance with one compliance point. Additionally, Molina reported member exemptions within contractual timeframes (as addressed above in **CES # 6509**) and received a second Notice of Non-Compliance with one compliance point, and request for a MIP. Molina also failed to meet contractual requirements related to the timely processing of Pharmacy Prior Authorization requests (as addressed above in **CES # 6523**) and received a

third Notice of Non-Compliance. As a result, Molina Healthcare failed to comply with many regulatory and contractual requirements.

SENTARA COMMUNITY PLAN

Findings:

- **Data Submission Errors:** During the January 2025 Portal Entry Review, it was discovered that on December 13, 2024, Sentara Community Plan entered a CCCP Waiver line with a begin date of August 1, 2024, for a Medicaid Works (MW) member. The entry was made after Sentara Community Plan was informed twice by DMAS that a member cannot be enrolled in both MW and a CCCP Waiver at the same time.

  As described in Section 4.2.3 of the Cardinal Care contract, "Medicaid Works individuals may not be simultaneously enrolled in a HCBS waiver. Medicaid Works individuals are not required to have a Medicaid LTSS Screening. The Department is solely responsible for determining eligibility for and enrolling Members in Medicaid Works."

  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**, a $**15,000 financial penalty,** 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,** a $**15,000 financial penalty,** and a **MIP** in response to this issue. **(CES # 6517)**

Concerns:

- **Contract Adherence:** Sentara Community Plan failed to process all Pharmacy Prior Authorization Requests timely. Per February 2025 data, Sentara failed to process two (2) requests within 24 hours, with an average untimely processing of 25 hours. Sentara's overall timeliness for processing Pharmacy Prior Authorization requests for the month of February 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, Sentara 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 # 6524)**

MIP/CAP Update:

- CAP for CES # 6281 was received and currently under review
- CAP for CES # 6282 was received and currently under review
- CAP for CES # 6179 was received and currently under review

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- **CES # 5881**: April 2024 – Untimely Data Submission issue. 1 point was removed from Sentara's total by closing case
- **CES # 5882**: April 2024 – Untimely Data Submission. 1 point was removed from Sentara's total by closing case
- **CES # 5893**: April 2024 – PHI Breach issue. 1 point was removed from Sentara's total by closing case
- **CES # 5935**: April 2024 – Call Center Statistics issue. 1 point was removed from Sentara's total by closing case

Summary:

- For deliverables measuring performance for February 2025, 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 provide an accurate data in the CCC Plus Waiver (as addressed above in **CES # 6517**) and received a Notice of Non-Compliance with one compliance point, financial penalty, and a request for a MIP. Additionally, Sentara failed to meet contractual requirements related to the timely processing of Pharmacy Prior Authorization requests (as addressed above in **CES # 6524**) and received a second Notice of Non-Compliance. Despite these issues, Sentara Community Plan complied with most regulatory and contractual requirements.

UNITEDHEALTHCARE

Findings:

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

Concerns:

- **Untimely Portal Entry:** UnitedHealthcare entered three (3) waiver lines in the system that did not meet the required two (2) business-day turnaround time.

  As described in Section 5.12.8.2 of the Cardinal Care contract, UnitedHealthcare must enter CCC Plus Waiver enrollments directly into the Virginia Medicaid Web Portal. Such admission and change transactions must be entered by UnitedHealthcare 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, UnitedHealthcare 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 # 6511)**

- **Contract Adherence:** UnitedHealthcare failed to process thirty-nine (39) Preauthorization Requests from February 10, 2025, to March 7, 2025, timely.

  As described in Section 5.2.1.1 of the Cardinal Care contract, UnitedHealthcare shall honor anesthesia and hospitalization authorizations for medically necessary dental services as determined by the DBA. UnitedHealthcare shall respond in writing via facsimile (262) 834-3575 to the DBA request for authorization within two (2) business days. An authorization shall include a valid date range for the outpatient request. The Contractor shall provide a comprehensive list of routine and escalation contacts. This list should be updated as changes occur. UnitedHealthcare shall adhere to all turnaround times.

  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.

  The CRC agreed with the team's recommendation and voted to issue a **Notice of Non-Compliance (NONC)** in response to this issue**. (CES # 6521)**

MIP/CAP Update:

- No MIP/CAP

Request for Reconsideration:

- No requests for reconsideration

Expiring Points:

- **CES # 5873**: April 2024 – Claims Payment issue. 1 point was removed from UnitedHealthcare's total by closing case
- **CES # 5934**: April 2024 – Claims Payment issue. 1 point was removed from UnitedHealthcare's total by closing case

Summary:

- For deliverables measuring performance for February 2025, UnitedHealthcare showed a **high** level of compliance. UnitedHealthcare submitted all 16 required monthly reporting deliverables accurately. However, UnitedHealthcare failed to meet contractual requirements related to the timely processing of Service Preauthorization requests (as addressed above in **CES # 6521**) and received a Notice of Non-Compliance. Additionally, UnitedHealthcare, UnitedHealthcare failed to meet the required two (2) business-day turnaround time for portal waiver entry. 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.