Managed Care Program Annual Report (MCPAR) for Virginia: CCC Plus

Due date	Last edited	Edited by	Status
03/28/2024	12/18/2024	Ali Faruk	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Virginia
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Ali Faruk
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	ali.faruk@dmas.virginia.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Ali Faruk
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	ali.faruk@dmas.virginia.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/25/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	09/30/2023
A6	**Program name** Auto-populated from report dashboard.	CCC Plus

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Indicator	Response
Plan name	Aetna Better Health of Virginia Anthem Healthkeepers Plus Molina Healthcare of VA Sentara Health Community Plan UnitedHealthcare Community Plan

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

	Indicator	Response
	BSS entity name	Maximus (Enrollment Broker); Virginia Department for Aging and Rehabilitative Services; State Long Term Care Ombudsman

Add In Lieu of Services and Settings (A.9)

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

	Indicator	Response
	ILOS name	

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,909,426
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,708,615

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff EQRO Proprietary system(s) Other, specify – All vendors
BIII.2	**HIPAA compliance of proprietary system(s) for encounter data validation** Were the system(s) utilized fully HIPAA compliant? Select one.	Yes

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter 'No PI activities were performed during the reporting period' as your response. 'N/A' is not an acceptable response.	We use many levels of Program Integrity oversight of the Plans as well as work in conjunction with the Plans - i.e.. Quarterly Collaborative meetings to discuss FWA across all Plans. DMAS PI also conducts data analysis across all Plans and FFS using our Fraud and Detection System - Examples of your analytics are: FADS, or the Fraud and Detection System, has various components and modules. This summary provides a high-level overview of the capabilities of the analytics focused components: 1. Algorithms are analytics custom designed for a specific purpose and deployed by the Optum FADS team quarterly in collaboration with the DMAS PID FADS Analytics team. So far, the following eleven algorithms have been developed and deployed. Excessive Mental Health Services By Servicing NPI (FA207A) - Identifies providers rendering excessive mental health services, excluding mental health centers. The report displays a report with servicing providers that exceed the threshold of services provided per member. LTC Members with No Patient Pay Obligation Amount (FA469B) Detects LTC members with a patient pay obligation amount

of zero. Patient pay obligation is the amount a member in a LTC Facility is responsible for paying toward their Long Term Services and Support (LTSS) bill that is based on their income. Excessive Physician Hours per Day Summary (FA446A) Detects servicing providers who bill an excessive number of hours per day. The hours billed may be distributed across multiple claims by the same physician and are billable by a variety of provider types. Excessive Use of Miscellaneous Codes Servicing Provider Summary (FA065A) Identifies summary information for servicing providers billing 5 or more unlisted procedure codes in a quarter. DRG Inpatient and Readmission /Transfers Summary (FA479A) Detects inpatient facilities that are readmitting/transferring patients within 30 days or less from being discharged. These situations are considered a single admittance rather than two. The first claim should be adjusted to include the payment for both claims. The readmit/transfer claim should be voided. Misuse of Evaluation and Management – New Office Visits and Established office Visits (FA438A) Identifies servicing providers who bill multiple new office visit evaluation and management (E&M) procedure codes or incorrectly use new office visits

evaluation and management procedure codes in place of established office visit E&M procedure codes for the same member within a three-year period. This algorithm also reports on any other evaluation and management services that are billed on the same date of service for the same member as a new or established office visit. Postmortem Services – Member (FA064A) Identifies paid claim lines with a date of service (DOS) that is after a member's date of death (DOD) and excludes certain reinstatement codes to prevent false positives. This algorithm focuses on all services that appear to have been rendered (based on the date of service) after the DOD and subsequently paid. The member's DOD comes from the member file. Time Limited services (FA484A) This algorithm identifies the servicing provider and corresponding claims where a provider has ordered time-limited services that exceeds identified time limits. The provider Summary will quickly identify which providers exceed the limit and how often they are exceeding the identified time limit. COVID-19 Lab Testing (FA482A) This algorithm identifies the billing provider on claims where a provider has ordered additional lab testing for a member in conjunction with a COVID-19

test. The summary report includes claim counts for COVID-19 testing and claim counts for additional lab tests performed on the same DOS for the same member. IDs In Multiple Algorithms This report compiles all of the providers by NPI that have appeared on multiple of the algorithms listed above. It details how many distinct algorithms the provider was found on, and how many times between them. Provider Activity Spike Detection This semi-configurable report allows the user to select a recent time period to view providers with a significant increase/decrease (spike) in billing activity. Long Term Care Facility Review This report compiles a list of facilities and providers that bill Medicaid member's part of a Long Term Care (LTC) facility, where ostensibly the majority of their care should be covered by the LTC facility itself. High Cost Members Report This list compiles the Medicaid members with the highest expenditures. Additional information is included in the report like the member's aid category, how many distinct diagnoses they have, how many providers they see, etc. Top N Reports A number of reports that compile the most commonly occurring data elements among DMAS claims data: ● Top N Diagnosis Codes ● Procedure Codes ● Top

		N NDC Codes ● Top N DRG As well as DMAS PI analytics, each Plan has their own SIU team performing analytics.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 14.14.4 Treatment of Recoveries
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	Generally, MCOs will be permitted to retain recoveries of overpayments identified and established through their own monitoring and investigative efforts. However, any overpayments for claims that were paid more than three years prior to the date that the Contractor formally notified the Department of the overpayment will be retained by the Department. In addition, one year from the date the Contractor is notified that they are permitted to recover an overpayment, the outstanding remainder of that overpayment will revert to the Department for collection and retention.

BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The External Provider and Policy Review Unit (EPAP) was a new Program Integrity Unit in FY18. Each Managed Care Organization (MCO) is required to establish their own internal program integrity unit to guard against fraud, waste, and/or abuse of Medicaid program benefits and resources. The EPAP unit provides oversight to the MCO program integrity units and primarily focuses on ensuring compliance with the Cardinal Care contract. The EPAP unit will perform audits of contractor review documentation to ensure contract requirements are being met. EPAP follows policies and procedures within the Program Integrity section of the Cardinal Care contract that outline the requirements for the contractor to uphold and how EPAP will conduct the review process. We Track timeliness and compliance by review and reconciliation of the quarterly report. Annual Review Process EPAP does not follow an audit plan but will provide direct DMAS oversight of the MCO and contractor Program Integrity Plans. DMAS will select reviews to ensure they were completed in accordance with policies and procedures, contract requirements, and the Code of Virginia. Contractors are required to submit electronically

to DMAS each quarter all activities conducted on behalf of Program Integrity by the Contractor and include findings related to these activities. This report will serve as the annual report of overpayment recoveries required under 42 C.F.R. §§ 438.604(a)(7), 438.606, and 438.608(d)(3). The report must include, but is not limited to, the following: 1. Allegations received and results of preliminary review 2. Investigations conducted and outcome 3. Payment Suspension notices received and suspended payments summary 4. Claims Edits/Automated Review summary 5. Coordination of Benefits/Third-Party Liability savings and recoveries 6. Service Authorization/Medical Necessity savings 7. Provider Education Savings 8. Provider Screening reviews and denials 9. Providers Terminated 10. Unsolicited Refunds (Provider-identified Overpayments) 11. Archived Referrals (Historical Cases) 12. Other Activities Upon submission, DMAS will review the Quarterly Fraud/Waste/Abuse Overpayment Report. This evaluation will examine ongoing reporting as well as the contents of the report to ensure that all contractual requirements are being met. Each MCO is required to complete an Internal

		Monitoring and Audit Plan which identifies the scope of reviews that will be performed during the year. DMAS will evaluate progress towards the Internal Monitoring and Audit Plan required to identify any major changes or shortcomings to projected program integrity activity. DMAS will evaluate this submission and provide feedback to the Contractor. A minimum number of investigations shall be conducted annually based on total dollars in medical claims expenditures. Investigations conducted by the Contractor shall involve the review of medical records for claims representing at least 3 percent of total medical expenditures. Personnel Structure and Experience within EPAP EPAP unit is embedded in the Program Integrity Division. EPAP is comprised of 3 analysts, and one supervisor. Although there are no required certifications or licenses, the EPAP staff have experience in Medicaid auditing and contract compliance.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status	The Department posts an Enrollment Roster to its secure FTP EDI server using the X12 834 HIPAA compliant electronic data interchange (EDI) transaction set. These files will contain full member eligibility data (audit records) for member assignments to the MCOs. The

	(e.g., incarcerated, deceased, switching plans).	834 Enrollment Roster provides the MCOs with ongoing information about its active and disenrolled members. Twice a month throughout the term of the Department's contract with the MCOs, the Department posts an enrollment change file to its secure FTP EDI server using the 834 EDI transaction set. These files contain all changes to the MCO's member eligibility data since the last 834 was produced. These changes will include "add" transactions (member is newly enrolled for the MCO), "terminate" transactions (member is disenrolled or dropped from the MCO), and "audit" information (any information that changed for the current member).
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe metric**	DMAS requests that the MCO identify providers whose terminations were associated

	Describe the metric or indicator that the state uses.	with PI-related findings for the purposes of the quarterly report. As part of the overall MCO oversight conducted by the Program Integrity Division, the MCOs are required to document in their quarterly reports' provider terminations. The provider terminations are documented on the designated tab of the quarterly report. The quarterly report is submitted to the Program Integrity Division for review of the MCOs program integrity efforts. As pursuant to 42 CFR 438.608(a)(4), the quarterly report is used for the timely reporting of provider termination “for cause”.
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control**	No

	Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter 'No such audits were conducted during the reporting year' as your response. 'N/A' is not an acceptable response.	https://dmas.virginia.gov/data-reporting/quality-population-health/studies-and-reporting/

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Commonwealth Coordinated Care Plus MCO Contract for Managed Long Term Services and Supports
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	07/01/2023
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://dmas.virginia.gov/for-providers/cardinal-care/cccplus-and-medallion-4-reference-information/commonwealth-coordinated-care-plus-ccc-plus/program-information/
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Transportation

C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter “N/A” if not applicable.	CCC Plus Waiver, Medicaid Expansion Population
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	300,514
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter 'There were no major changes to the population or benefits during the reporting year' as your response. 'N/A' is not an acceptable response.	There were no major changes to the population or benefits during the reporting year.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support Other, specify – Pharmacy Rebates
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Other, specify – CCC Plus employs a data quality scorecard (DQSC) to measure the MCO's performance in encounter data submission. The DQSC evaluates payment cycle data, certification as well as payment timeliness, reasonableness and accuracy.
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan	Section 16, Information Management Systems

	performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Section 16.9.5, Data Quality Penalties
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with “N/A” if the plan does not use incentives to award encounter data quality.	MCO rates are based on encounter data, so the MCOs are incentivized to submit complete and accurate encounter data
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter 'The state did not experience any barriers to collecting or validating encounter data during the reporting year' as your response. 'N/A' is not an acceptable response.	• Documentation of EDI translator rules (compliance check) • IT turnaround time for MCOs to comply with SMA changes • Restrictions on number of records in EDI files • Issues with submission of adjustments & voids for failed originals • Timeliness of code set updates for encounter edits • Onboarding of new MCO systems and subcontractors requires extensive testing and staff resources.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	A critical incident is any incident that threatens or impacts the well-being of the Member. Critical incidents shall include, but are not limited to, the following incidents: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death of a Member.
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	As expeditiously as the Member's health condition requires and not to exceed thirty (30) calendar days from the initial date of receipt of the internal appeal request.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	Within seventy-two (72) hours from the initial receipt of the appeal.

C1IV.4	**State definition of “timely” resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	As expeditiously as the Member’s health condition requires, within state established timeframes not to exceed ninety (90) calendar days from the date the Contractor receives the grievance in a format and language that meets, at a minimum, the standards described in 42 CFR § 438.10.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter 'No challenges were encountered' as your response. 'N/A' is not an acceptable response.	Having complete and accurate data sent in by the MCOs.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	We are working with MCOs to continue education and technical assistance on network adequacy standards to ensure compliance.

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Access measure total count: 13

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 13

C2.V.2 Measure standard

Primary Care

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 13

C2.V.2 Measure standard

Primary Care

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider 3 / 13

C2.V.2 Measure standard

Adult Day Healthcare

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-adult day care	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider 4 / 13

C2.V.2 Measure standard

Adult Day Healthcare

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-adult day care	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: Exception to quantitative standard

5 / 13

C2.V.2 Measure standard

Assistive Technology

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS assistive technology	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: LTSS-related standard: provider travels to the enrollee

6 / 13

C2.V.2 Measure standard

Private duty Nursing, Respite and Personal Care, and Service Facilitation

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-personal care assistant	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider

7 / 13

C2.V.2 Measure standard

SNF/ICF

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider

8 / 13

C2.V.2 Measure standard

SNF/ICF

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

9 / 13

C2.V.2 Measure standard

Hospital (acute)

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Rural	

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

10 / 13

C2.V.2 Measure standard

Hospital (acute)

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

11 / 13

C2.V.2 Measure standard

Behavioral Health

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

12 / 13

C2.V.2 Measure standard

Behavioral Health

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: LTSS-related standard: provider travels to the enrollee

C2.V.2 Measure standard

Private duty Nursing, Respite and Personal Care, and Service Facilitation

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-personal care assistant	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Monthly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://coverva.dmas.virginia.gov/ and https://www.virginiamanagedcare.com
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Member services are available by phone and website. TTY service is available by phone
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	The state EB is responsible for submitting member complaints to the state and the state submits grievances to the MCO. Member can submit appeals to the state for review and resolution.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the	The state Enrollment Broker provides weekly, monthly and annual reporting to ensure the quality of service for the BSS. The state reviews recorded and

	quality, effectiveness, and efficiency of the BSS entities' performance?	live customer service calls for quality performance.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity

> ⚠ **Beginning December 2024, this section must be completed for programs that include MCOs**

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	No
C1XII.6	**Did the State or MCOs complete the analysis(es)?**	State
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services	01/10/2020

	provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	
C1XII.9	**When was the last parity analysis(es) for this program submitted to CMS?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	01/10/2020
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	No
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report.	Yes

	States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A “Yes” response means that the parity analysis for either the state or for ALL MCOs has been posted.	
C1XII.12b	**Provide the URL link(s).** Response must be a valid hyperlink/URL beginning with “http://” or “https://”. Separate links with commas.	https://dmas.virginia.gov/data-reporting/programs-services/behavioral-health/

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Aetna Better Health of Virginia** 47,841 **Anthem Healthkeepers Plus** 87,154 **Molina Healthcare of VA** 29,347 **Sentara Health Community Plan** 48,217 **UnitedHealthcare Community Plan** 41,380
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Aetna Better Health of Virginia** 2.5% **Anthem Healthkeepers Plus** 4.6% **Molina Healthcare of VA** 1.5% **Sentara Health Community Plan**

		2.5% **UnitedHealthcare Community Plan** 2.2%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Aetna Better Health of Virginia** 2.8% **Anthem Healthkeepers Plus** 5.1% **Molina Healthcare of VA** 1.7% **Sentara Health Community Plan** 2.8% **UnitedHealthcare Community Plan** 2.4%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Aetna Better Health of Virginia** 89% **Anthem Healthkeepers Plus** 91% **Molina Healthcare of VA** 91% **Sentara Health Community Plan** 91.4% **UnitedHealthcare Community Plan** 90.2%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Aetna Better Health of Virginia** Statewide all programs & populations **Anthem Healthkeepers Plus** Statewide all programs & populations **Molina Healthcare of VA** Statewide all programs & populations

		Sentara Health Community Plan Statewide all programs & populations **UnitedHealthcare Community Plan** Statewide all programs & populations
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter “N/A” if not applicable. See glossary for the regulatory definition of MLR.	**Aetna Better Health of Virginia** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **Anthem Healthkeepers Plus** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **Molina Healthcare of VA** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **Sentara Health Community Plan** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members.

		UnitedHealthcare Community Plan Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members.
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Aetna Better Health of Virginia** Yes **Anthem Healthkeepers Plus** Yes **Molina Healthcare of VA** Yes **Sentara Health Community Plan** Yes **UnitedHealthcare Community Plan** Yes
N/A	Enter the start date.	**Aetna Better Health of Virginia** 07/01/2022 **Anthem Healthkeepers Plus** 07/01/2022 **Molina Healthcare of VA**

		07/01/2022 **Sentara Health Community Plan** 07/01/2022 **UnitedHealthcare Community Plan** 07/01/2022
N/A	Enter the end date.	**Aetna Better Health of Virginia** 06/30/2023 **Anthem Healthkeepers Plus** 06/30/2023 **Molina Healthcare of VA** 06/30/2023 **Sentara Health Community Plan** 06/30/2023 **UnitedHealthcare Community Plan** 06/30/2023

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Aetna Better Health of Virginia** Measure Unit: Each encounter submitted to EPS within forty-five calendar days of the end of the quarter with a 'passed' validation status and a payment date between the first day and last day of quarter with a 'passed' validation status and a payment date between the first day and last day of the quarter **Anthem Healthkeepers Plus** Measure Unit: Each encounter submitted to EPS within forty-five calendar days of the end of the quarter with a 'passed' validation status and a payment date between the first day and last day of quarter with a 'passed' validation status and a payment date between the first day and last day of the quarter **Molina Healthcare of VA** Measure Unit: Each encounter submitted to EPS within forty-five calendar days of the end of the quarter with a 'passed' validation status and a payment date between the first day and last day of quarter with a 'passed' validation status and a payment date between the first day and last day of the quarter

Sentara Health Community Plan

Measure Unit: Each encounter submitted to EPS within forty-five calendar days of the end of the quarter with a 'passed' validation status and a payment date between the first day and last day of quarter with a 'passed' validation status and a payment date between the first day and last day of the quarter

UnitedHealthcare Community Plan

Measure Unit: Each encounter submitted to EPS within forty-five calendar days of the end of the quarter with a 'passed' validation status and a payment date between the first day and last day of quarter with a 'passed' validation status and a payment date between the first day and last day of the quarter

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D1III.2

Share of encounter data submissions that met state's timely submission requirements

What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data

Aetna Better Health of Virginia

100%

Anthem Healthkeepers Plus

100%

Molina Healthcare of VA

99%

	submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Sentara Health Community Plan** 100% **UnitedHealthcare Community Plan** 99%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Aetna Better Health of Virginia** 100% **Anthem Healthkeepers Plus** 100% **Molina Healthcare of VA** 100% **Sentara Health Community Plan** 100% **UnitedHealthcare Community Plan** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter “N/A”.

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Aetna Better Health of Virginia** 123 **Anthem Healthkeepers Plus** 865 **Molina Healthcare of VA** 222 **Sentara Health Community Plan** 422 **UnitedHealthcare Community Plan** 77
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Aetna Better Health of Virginia** n/a **Anthem Healthkeepers Plus** n/a **Molina Healthcare of VA** n/a **Sentara Health Community Plan**

n/a

UnitedHealthcare Community Plan

n/a

D1IV.1b

Appeals resolved in partial favor of enrollee

Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.

Aetna Better Health of Virginia

n/a

Anthem Healthkeepers Plus

n/a

Molina Healthcare of VA

n/a

Sentara Health Community Plan

n/a

UnitedHealthcare Community Plan

n/a

D1IV.1c

Appeals resolved in favor of enrollee

Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.

Aetna Better Health of Virginia

n/a

Anthem Healthkeepers Plus

n/a

Molina Healthcare of VA

n/a

Sentara Health Community Plan

n/a

UnitedHealthcare Community Plan

n/a

D1IV.2

Active appeals

Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.

Aetna Better Health of Virginia

77

Anthem Healthkeepers Plus

130

Molina Healthcare of VA

0

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

0

D1IV.3

Appeals filed on behalf of LTSS users

Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not

Aetna Better Health of Virginia

0

applicable.
An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

Anthem Healthkeepers Plus

37

Molina Healthcare of VA

26

Sentara Health Community Plan

212

UnitedHealthcare Community Plan

9

D1IV.4

Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A".
Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A".
The appeal and critical incident

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare of VA

4

Sentara Health Community Plan

3

UnitedHealthcare Community Plan

0

do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.
To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Aetna Better Health of Virginia** 94 **Anthem Healthkeepers Plus** 358 **Molina Healthcare of VA** 191 **Sentara Health Community Plan** 322 **UnitedHealthcare Community Plan** 29
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Aetna Better Health of Virginia** 29 **Anthem Healthkeepers Plus** 56 **Molina Healthcare of VA** 26 **Sentara Health Community Plan** 88

		UnitedHealthcare Community Plan 44
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Aetna Better Health of Virginia** 123 **Anthem Healthkeepers Plus** 415 **Molina Healthcare of VA** 203 **Sentara Health Community Plan** 71 **UnitedHealthcare Community Plan** 77
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 239 **Molina Healthcare of VA** 52

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

0

D1IV.6c

Resolved appeals related to payment denial

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

209

Molina Healthcare of VA

6

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

0

D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 0 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 1 **Molina Healthcare of VA** 0 **Sentara Health Community Plan** 0

UnitedHealthcare Community Plan

0

D1IV.6f

Resolved appeals related to plan denial of an enrollee's right to request out-of-network care

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).

Aetna Better Health of Virginia

3

Anthem Healthkeepers Plus

1

Molina Healthcare of VA

0

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

0

D1IV.6g

Resolved appeals related to denial of an enrollee's request to dispute financial liability

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare of VA

0

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

0

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	**Aetna Better Health of Virginia** 6 **Anthem Healthkeepers Plus** 125 **Molina Healthcare of VA** 15 **Sentara Health Community Plan** 9 **UnitedHealthcare Community Plan** 4
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	**Aetna Better Health of Virginia** 146 **Anthem Healthkeepers Plus** 147 **Molina Healthcare of VA** 16 **Sentara Health Community Plan**

221

UnitedHealthcare Community Plan

11

D1IV.7c

Resolved appeals related to inpatient behavioral health services

Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

9

Molina Healthcare of VA

16

Sentara Health Community Plan

1

UnitedHealthcare Community Plan

2

D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter “N/A”.	**Aetna Better Health of Virginia** 3 **Anthem Healthkeepers Plus** 25 **Molina Healthcare of VA** 28 **Sentara Health Community Plan** 51 **UnitedHealthcare Community Plan** 1
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter “N/A”.	**Aetna Better Health of Virginia** 51 **Anthem Healthkeepers Plus** 44 **Molina Healthcare of VA** 49 **Sentara Health Community Plan** 140

		UnitedHealthcare Community Plan 38
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 3 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 0
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 3 **Molina Healthcare of VA** 29

	plan does not cover LTSS services, enter “N/A”.	**Sentara Health Community Plan** 130 **UnitedHealthcare Community Plan** 9
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter “N/A”.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** n/a **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 0

D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter “N/A”.	**Aetna Better Health of Virginia** 65 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 0 **Sentara Health Community Plan** n/a **UnitedHealthcare Community Plan** 0
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter “N/A”.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 76 **Molina Healthcare of VA** 2 **Sentara Health Community Plan** 0

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Aetna Better Health of Virginia** 3 **Anthem Healthkeepers Plus** 2 **Molina Healthcare of VA** 5 **Sentara Health Community Plan** 10 **UnitedHealthcare Community Plan** 2
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 2 **Sentara Health Community Plan**

		2 **UnitedHealthcare Community Plan** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Aetna Better Health of Virginia** 3 **Anthem Healthkeepers Plus** 1 **Molina Healthcare of VA** 0 **Sentara Health Community Plan** 8 **UnitedHealthcare Community Plan** 1
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 1 **Molina Healthcare of VA**

0

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

1

D1IV.9a

External Medical Reviews resulting in a favorable decision for the enrollee

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Aetna Better Health of Virginia

n/a

Anthem Healthkeepers Plus

n/a

Molina Healthcare of VA

n/a

Sentara Health Community Plan

n/a

UnitedHealthcare Community Plan

n/a

D1IV.9b

External Medical Reviews resulting in an adverse decision for the enrollee

If your state does offer an external medical review

Aetna Better Health of Virginia

n/a

process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A".
External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Anthem Healthkeepers Plus

n/a

Molina Healthcare of VA

n/a

Sentara Health Community Plan

n/a

UnitedHealthcare Community Plan

n/a

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is “resolved” when it has reached completion and been closed by the plan.	**Aetna Better Health of Virginia** 417 **Anthem Healthkeepers Plus** 672 **Molina Healthcare of VA** 668 **Sentara Health Community Plan** 60 **UnitedHealthcare Community Plan** 215
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Aetna Better Health of Virginia** 400 **Anthem Healthkeepers Plus** 214 **Molina Healthcare of VA** 0 **Sentara Health Community Plan**

0

UnitedHealthcare Community Plan

0

D1IV.12

Grievances filed on behalf of LTSS users

Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users.
An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

169

Molina Healthcare of VA

48

Sentara Health Community Plan

16

UnitedHealthcare Community Plan

1

D1IV.13

Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare of VA

previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.
If the managed care plan does not cover LTSS, the state should enter "N/A" in this field.
Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field.
To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

0

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

3

D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Aetna Better Health of Virginia** 417 **Anthem Healthkeepers Plus** 672 **Molina Healthcare of VA** 665 **Sentara Health Community Plan** 26 **UnitedHealthcare Community Plan** 183

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 0 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 2
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 3 **Sentara Health Community Plan**

0

UnitedHealthcare Community Plan

31

D1IV.15c

Resolved grievances related to inpatient behavioral health services

Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare of VA

0

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

0

D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 9 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 6
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 6 **Molina Healthcare of VA** 63 **Sentara Health Community Plan** 0

		UnitedHealthcare Community Plan 3
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter “N/A”.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 5 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 1
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter “N/A”.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 48

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

1

D1IV.15h

Resolved grievances related to dental services

Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter “N/A”.

Aetna Better Health of Virginia

4

Anthem Healthkeepers Plus

0

Molina Healthcare of VA

n/a

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

1

D1IV.15i

Resolved grievances related to non-emergency medical transportation (NEMT)

Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not

Aetna Better Health of Virginia

512

Anthem Healthkeepers Plus

267

	cover this type of service, enter "N/A".	**Molina Healthcare of VA** 224 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 168
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".	**Aetna Better Health of Virginia** 300 **Anthem Healthkeepers Plus** 210 **Molina Healthcare of VA** 0 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 2

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Aetna Better Health of Virginia** 537 **Anthem Healthkeepers Plus** 25 **Molina Healthcare of VA** 8 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 0
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 3 **Molina Healthcare of VA** 28 **Sentara Health Community Plan**

	complaints about the plan or provider care or case management process.	0 **UnitedHealthcare Community Plan** 5
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 9 **Molina Healthcare of VA** 111 **Sentara Health Community Plan** 2 **UnitedHealthcare Community Plan** 8
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 86 **Molina Healthcare of VA**

	provided by a provider or the plan.	31 **Sentara Health Community Plan** 8 **UnitedHealthcare Community Plan** 78
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 6 **Molina Healthcare of VA** 0 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 7
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that	**Aetna Better Health of Virginia** 253

	were filed for a reason related to payment or billing issues.	**Anthem Healthkeepers Plus** 57 **Molina Healthcare of VA** 51 **Sentara Health Community Plan** 50 **UnitedHealthcare Community Plan** 19
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 4 **Molina Healthcare of VA** 5 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 0

D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 0 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 0 **Sentara Health Community Plan** 0

		UnitedHealthcare Community Plan 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Healthcare of VA** 0 **Sentara Health Community Plan** 0 **UnitedHealthcare Community Plan** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 2 **Molina Healthcare of VA** 67

Sentara Health Community Plan

0

UnitedHealthcare Community Plan

98

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 8

Complete

D2.VII.1 Measure Name: Adults' Access to Primary Care Preventive and Ambulatory Health Services-Total*

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

86.67%

Anthem Healthkeepers Plus

89.06%

Molina Healthcare of VA

77.67%

Sentara Health Community Plan

85.29%

UnitedHealthcare Community Plan

90.23%

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care-Timeliness of Prenatal Care

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

71.82%

Anthem Healthkeepers Plus

82.14%

Molina Healthcare of VA

63.79%

Sentara Health Community Plan

64.14%

UnitedHealthcare Community Plan

68.57%

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure 3 / 8

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0018

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

54.99%

Anthem Healthkeepers Plus

52.07%

Molina Healthcare of VA

37.71%

Sentara Health Community Plan

51.58%

UnitedHealthcare Community Plan

67.88%

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up-Total*

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

30.99%

Anthem Healthkeepers Plus

33.57%

Molina Healthcare of VA

22.14%

Sentara Health Community Plan

32.13%

UnitedHealthcare Community Plan

29.58%

Complete

D2.VII.1 Measure Name: Annual Preventive Dental Visits-Total*

5 / 8

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

NR (not reported)

Anthem Healthkeepers Plus

NB (No Benefit)

Molina Healthcare of VA

NB (No benefit)

Sentara Health Community Plan

NB (No Benefit)

UnitedHealthcare Community Plan

NB (No Benefit)

Complete

D2.VII.1 Measure Name: Member Rating of Health Plan (8+9+10)

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

0006

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: CCC Plus (MLTSS), Medallion 4.0 (Acute)

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

80.30%

Anthem Healthkeepers Plus

76.05%

Molina Healthcare of VA

77.15%

Sentara Health Community Plan

82.10%

UnitedHealthcare Community Plan

85.98%

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total

D2.VII.2 Measure Domain

Long-term services and supports

D2.VII.3 National Quality Forum (NQF) number

2800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

n/a

Measure results

Aetna Better Health of Virginia

35.66%

Anthem Healthkeepers Plus

29.83%

Molina Healthcare of VA

46.34%

Sentara Health Community Plan

31.49%

UnitedHealthcare Community Plan

38.20%

Complete

D2.VII.1 Measure Name: Ambulatory Care—Emergency Department Visits

8 / 8

D2.VII.2 Measure Domain

Utilization

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

1083.05 visits

Anthem Healthkeepers Plus

1096.40 visits

Molina Healthcare of VA

1132.40 visits

Sentara Health Community Plan

1063.44 visits

UnitedHealthcare Community Plan

1152.54 visits

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count: 10

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 10

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

failure to complete level of care review face-to-face

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

07/11/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 01/23/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 10

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Sentara Health Community Plan

D3.VIII.4 Reason for intervention

Untimely nursing facility portal entry

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

08/07/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated
10/02/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

3 / 10

D3.VIII.2 Plan performance issue

Financial issues

D3.VIII.3 Plan name

Sentara Health Community Plan

D3.VIII.4 Reason for intervention

Untimely Waiver portal entry resulting in capitation overpayment

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

09/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated
12/26/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

4 / 10

D3.VIII.2 Plan performance issue

Financial issues

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Untimely portal entry

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

09/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 01/23/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

5 / 10

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

failure to submit a corrective action plan

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

09/18/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated
10/03/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

6 / 10

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Sentara Health Community Plan

D3.VIII.4 Reason for intervention

Failure to complete Level of Care assessment face-to-face.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

09/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated
10/14/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

7 / 10

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Aetna Better Health of Virginia

D3.VIII.4 Reason for intervention

Clean-up of rejected Care Review Management System (CRMS) data

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

10/16/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated
04/04/2024

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Corrective action plan

8 / 10

Complete

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Sentara Health Community Plan

D3.VIII.4 Reason for intervention

Clean-up of rejected Care Review Management System (CRMS) data.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

10/16/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 04/04/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

9 / 10

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Sentara Health Community Plan

D3.VIII.4 Reason for intervention

Untimely nursing facility portal entry.

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

1

$0

D3.VIII.7 Date assessed

11/13/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 03/18/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

10 / 10

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Aetna Better Health of Virginia

D3.VIII.4 Reason for intervention

Untimely nursing facility portal entry.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

11/28/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 03/18/2024

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Aetna Better Health of Virginia** 62 **Anthem Healthkeepers Plus** 49 **Molina Healthcare of VA** 10 **Sentara Health Community Plan** 26 **UnitedHealthcare Community Plan** 13
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Aetna Better Health of Virginia** 52 **Anthem Healthkeepers Plus** 221 **Molina Healthcare of VA** 17 **Sentara Health Community Plan**

236

UnitedHealthcare Community Plan

594

D1X.3

Ratio of opened program integrity investigations to enrollees

What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.

Aetna Better Health of Virginia

0.19:1,000

Anthem Healthkeepers Plus

0.82:1,000

Molina Healthcare of VA

0.03:1,000

Sentara Health Community Plan

0.43:1,000

UnitedHealthcare Community Plan

2.65:1,000

D1X.4

Count of resolved program integrity investigations

How many program integrity investigations were resolved by the plan during the reporting year?

Aetna Better Health of Virginia

90

Anthem Healthkeepers Plus

115

Molina Healthcare of VA

		67 **Sentara Health Community Plan** 318 **UnitedHealthcare Community Plan** 177
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Aetna Better Health of Virginia** 0.33:1,000 **Anthem Healthkeepers Plus** 0.43:1,000 **Molina Healthcare of VA** 0.12:1,000 **Sentara Health Community Plan** 0.58:1,000 **UnitedHealthcare Community Plan** 0.79:1,000
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program	**Aetna Better Health of Virginia** Makes referrals to the SMA and MFCU concurrently

	integrity referrals to the state? Select one.	**Anthem Healthkeepers Plus** Makes referrals to the SMA and MFCU concurrently **Molina Healthcare of VA** Makes referrals to the SMA and MFCU concurrently **Sentara Health Community Plan** Makes referrals to the SMA and MFCU concurrently **UnitedHealthcare Community Plan** Makes referrals to the SMA and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	**Aetna Better Health of Virginia** 26 **Anthem Healthkeepers Plus** 43 **Molina Healthcare of VA** 1 **Sentara Health Community Plan** 32

		UnitedHealthcare Community Plan 42
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**Aetna Better Health of Virginia** 0.1:1,000 **Anthem Healthkeepers Plus** 0.16:1,000 **Molina Healthcare of VA** 0:1,000 **Sentara Health Community Plan** 0.06:1,000 **UnitedHealthcare Community Plan** 0.19:1,000
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Aetna Better Health of Virginia** 07/01/2023 **Anthem Healthkeepers Plus** 07/01/2023 **Molina Healthcare of VA** 07/01/2023

Sentara Health Community Plan

07/01/2023

UnitedHealthcare Community Plan

07/01/2023

D1X.9b:

Plan overpayment reporting to the state: End Date

What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?

Aetna Better Health of Virginia

09/30/2023

Anthem Healthkeepers Plus

09/30/2023

Molina Healthcare of VA

09/30/2023

Sentara Health Community Plan

09/30/2023

UnitedHealthcare Community Plan

09/30/2023

D1X.9c:

Plan overpayment reporting to the state: Dollar amount

From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?

Aetna Better Health of Virginia

$471,648.91

Anthem Healthkeepers Plus

$1,216,044.16

Molina Healthcare of VA

NR

Sentara Health Community Plan

$976,706.97

UnitedHealthcare Community Plan

$513,456.71

D1X.9d:

Plan overpayment reporting to the state: Corresponding premium revenue

What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))

Aetna Better Health of Virginia

n/a

Anthem Healthkeepers Plus

n/a

Molina Healthcare of VA

NA

Sentara Health Community Plan

na

UnitedHealthcare Community Plan

na

D1X.10

Changes in beneficiary circumstances

Aetna Better Health of Virginia

Select the frequency the plan reports changes in beneficiary circumstances to the state.	Daily **Anthem Healthkeepers Plus** Daily **Molina Healthcare of VA** Daily **Sentara Health Community Plan** Daily **UnitedHealthcare Community Plan** Daily	

Topic XI: ILOS

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if “Yes”, which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter “0” for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Aetna Better Health of Virginia** No ILOSs were offered by this plan **Anthem Healthkeepers Plus** No ILOSs were offered by this plan **Molina Healthcare of VA** No ILOSs were offered by this plan **Sentara Health Community Plan** No ILOSs were offered by this plan **UnitedHealthcare Community Plan** No ILOSs were offered by this plan

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus (Enrollment Broker); Virginia Department for Aging and Rehabilitative Services; State Long Term Care Ombudsman** Ombudsman Program Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus (Enrollment Broker); Virginia Department for Aging and Rehabilitative Services; State Long Term Care Ombudsman** Enrollment Broker/Choice Counseling LTSS Complaint Access Point LTSS Grievance/Appeals Education LTSS Grievance/Appeals Assistance Review/Oversight of LTSS Data