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

Due date	Last edited	Edited by	Status
12/27/2023	12/14/2023	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.	12/21/2023

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2023
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 Complete Care Optima Health Community Care United Healthcare Virginia Premier Elite Plus

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 438.71. See 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

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.	1,931,725
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.	1,931,185

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.	Program Integrity meets quarterly with the Manage Care Plans to discuss and share fraud, waste and abuse identified in Medicaid services. The collaboration has proven effective, sharing information across Plans, with so many providers in multiple Plan networks. Fraud and Detection System - Analytics 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 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 GDRG
BX.2	**Contract standard for overpayments** Does the state allow plans to retain	State has established a hybrid system

	overpayments, require the return of overpayments, or has established a hybrid system? Select one.	
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	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

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 pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	on ensuring compliance with the Medallion and CCC+ contracts. 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 CCC Plus and Medallion contracts 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. This unit is like “the APA of the MCO Program Integrity Units;” 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	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 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

	payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	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** Describe the metric or indicator that the state uses.	DMAS requests that the MCO identify providers whose terminations were associated 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. The quarterly report is how PI tracks timely reporting of provider termination “for cause”. 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** Does the state post on its website the	No

	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, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	https://www.dmas.virginia.gov/data/financial-reports/

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; July 1, 2022-June 30, 2023
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	07/01/2022
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/managed-care/historical-information/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, Developmental Disabilities 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).	301,146
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.	Doula services were launched by managed care plans on August 2022.

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.	Section 18, Oversight - MCO rates are based on the encounter data, this increasing commitment to data quality and completeness
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 period.	When a MCO converts to a new claim system there is a period of testing that happens to ensure compliance on the encounters. This takes a lot of resources at DMAS.

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.	As expeditiously as the Member's health condition requires and not to exceed 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 standards.	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?	Developed a standard and increased education to the MCOs regarding their compliance to quality data submissions.

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: 67

Complete

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

1 / 67

C2.V.2 Measure standard

Adult 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

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

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C2.V.2 Measure standard

Adult 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

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 / 67

C2.V.2 Measure standard

Adult Day Care

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	MLTSS

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 / 67

C2.V.2 Measure standard

Adult Day Care

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider
LTSS-adult day care

C2.V.5 Region
Urban

C2.V.6 Population
MLTSS

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 5 / 67

C2.V.2 Measure standard
Assistive Technology

C2.V.3 Standard type
Service fulfillment

C2.V.4 Provider
LTSS assistive technology

C2.V.5 Region
Statewide

C2.V.6 Population
MLTSS

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 / 67

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	statewide	MLTSS

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

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	MLTSS

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

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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	MLTSS

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

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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

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

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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

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

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C2.V.2 Measure standard

Outpatient Mental 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

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C2.V.2 Measure standard

Outpatient Mental 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: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Psychosocial Rehab

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

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C2.V.2 Measure standard

Psychosocial Rehab

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: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Psychosocial Rehab

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: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

CMHRS--Behavioral Therapy

C2.V.3 Standard type

Minimum number of network providers

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

Behavioral health	statewide by FIPS	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

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C2.V.2 Measure standard

CMHRS--Crisis Intervention

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	statewide by FIPS	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

18 / 67

C2.V.2 Measure standard

CMHRS--Crisis Stabilization

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	statewide by FIPS	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

19 / 67

C2.V.2 Measure standard

CMHRS--Intensive community treatment

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	statewide by FIPS	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

C2.V.2 Measure standard

CMHRS--Intensive In-Home Treatment

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	statewide by FIPS	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

C2.V.2 Measure standard

CMHRS--Mental Health Case Management

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	statewide by FIPS	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

22 / 67

C2.V.2 Measure standard

CMHRS--Skill Building

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	statewide by FIPS	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

23 / 67

C2.V.2 Measure standard

CMHRS--Peer support services, group mental health

C2.V.3 Standard type

Minimum number of network providers

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

Behavioral health	statewide by FIPS	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

24 / 67

C2.V.2 Measure standard

CMHRS--Peer support services, individual mental health

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	statewide by FIPS	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

25 / 67

C2.V.2 Measure standard

LTSS--Environmental Modifications

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS assistive technology	statewide by FIPS	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

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

LTSS--Personal Emergency Response Systems

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS assistive technology	statewide by FIPS	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

C2.V.2 Measure standard

Urgent Care

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent 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: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Urgent Care

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent 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

29 / 67

C2.V.2 Measure standard

Home Health Agency

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Home Health Agency	Statewide by FIPS	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

30 / 67

C2.V.2 Measure standard

Transportation

C2.V.3 Standard type

Minimum number of network providers

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

Transportation	statewide by FIPS	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

31 / 67

C2.V.2 Measure standard

Durable Medical Equipment

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Durable Medical Equipment	statewide by FIPS	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

32 / 67

C2.V.2 Measure standard

Vision

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Vision	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

33 / 67

C2.V.2 Measure standard

Vision

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Vision	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

34 / 67

C2.V.2 Measure standard

OB/GYN

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Rural	Adult

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

35 / 67

C2.V.2 Measure standard

OB/GYN

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Urban	Adult

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

C2.V.2 Measure standard

Laboratory

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Laboratory	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

C2.V.2 Measure standard

Laboratory

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Laboratory	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

38 / 67

C2.V.2 Measure standard

Pharmacy

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	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

39 / 67

C2.V.2 Measure standard

Pharmacy

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	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

40 / 67

C2.V.2 Measure standard

Outpatient Rehab

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
POT/OT/ST	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

41 / 67

C2.V.2 Measure standard

Outpatient Rehab

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
PT/OT/ST	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

42 / 67

C2.V.2 Measure standard

Radiology

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Radiology	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

43 / 67

C2.V.2 Measure standard

Radiology

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Radiology	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

44 / 67

C2.V.2 Measure standard

Specialist Adult

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Urban	Adult

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

45 / 67

C2.V.2 Measure standard

Specialist Adult

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Rural	Adult

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

C2.V.2 Measure standard

Early Intervention

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Early Intervention	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

C2.V.2 Measure standard

Early Intervention

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Early Intervention	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

48 / 67

C2.V.2 Measure standard

ASAM 2.1 Intensive Outpatient

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ARTS	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

49 / 67

C2.V.2 Measure standard

ASAM 2.1 Intensive Outpatient

C2.V.3 Standard type

Minimum number of network providers

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

ARTS	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

50 / 67

C2.V.2 Measure standard

ASAM 2.5 Partial Hospitalization

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ARTS	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

51 / 67

C2.V.2 Measure standard

ASAM 2.5 Partial Hospitalization

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ARTS	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

52 / 67

C2.V.2 Measure standard

ASAM 3.1, 3.3, 3.5, 3.7 Residential Treatment

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ARTS	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

C2.V.2 Measure standard

ASAM 4 Inpatient Detox

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ARTS	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

C2.V.2 Measure standard

ASAM 4 Inpatient Detox

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ARTS	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

55 / 67

C2.V.2 Measure standard

Substance Use Case Management

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ARTS	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

56 / 67

C2.V.2 Measure standard

Substance Use Case Management

C2.V.3 Standard type

Minimum number of network providers

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

ARTS	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

57 / 67

C2.V.2 Measure standard

Opioid Treatment - Office based

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ARTS	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

58 / 67

C2.V.2 Measure standard

Opioid Treatment - Office Based

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ARTS	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

59 / 67

C2.V.2 Measure standard

ASAM 3.1, 3.3, 3.5, 3.7 Residential Treatment

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ARTS	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

60 / 67

C2.V.2 Measure standard

Hospital (Psychiatric)

C2.V.3 Standard type

Minimum number of network providers

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

61 / 67

C2.V.2 Measure standard

Hospital (Psychiatric)

C2.V.3 Standard type

Minimum number of network providers

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

62 / 67

C2.V.2 Measure standard

Hospital (Rehab)

C2.V.3 Standard type

Minimum number of network providers

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

63 / 67

C2.V.2 Measure standard

Hospital (Rehab)

C2.V.3 Standard type

Minimum number of network providers

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

64 / 67

C2.V.2 Measure standard

Pediatric Primary Care

C2.V.3 Standard type

Minimum number of network providers

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

65 / 67

C2.V.2 Measure standard

Pediatric Primary Care

C2.V.3 Standard type

Minimum number of network providers

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

66 / 67

C2.V.2 Measure standard

Pediatric Specialist

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Urban	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 67 / 67

C2.V.2 Measure standard

Pediatric Specialist

C2.V.3 Standard type

Minimum number of network providers

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

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** 47,221 **Anthem Healthkeepers Plus** 86,528 **Molina Complete Care** 29,425 **Optima Health Community Care** 48,934 **United Healthcare** 40,786 **Virginia Premier Elite Plus** 50,387
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** 2.4% **Anthem Healthkeepers Plus** 4.5% **Molina Complete Care** 1.5%

Optima Health Community Care

2.5%

United Healthcare

2.1%

Virginia Premier Elite Plus

2.6%

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

2.4%

Anthem Healthkeepers Plus

4.5%

Molina Complete Care

1.5%

Optima Health Community Care

2.5%

United Healthcare

2.1%

Virginia Premier Elite Plus

2.6%

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.	**Aetna Better Health of Virginia** 89% **Anthem Healthkeepers Plus** 88% **Molina Complete Care** 88% **Optima Health Community Care** 89% **United Healthcare** 85% **Virginia Premier Elite Plus** 89%
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** Program-specific statewide **Anthem Healthkeepers Plus** Program-specific statewide **Molina Complete Care** Program-specific statewide

		Optima Health Community Care Program-specific statewide **United Healthcare** Program-specific statewide **Virginia Premier Elite Plus** Program-specific statewide
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 Complete Care** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **Optima Health Community Care** Separate calculations for Base Medicaid members and Group

VIII Medicaid Expansion members.

United Healthcare

Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members.

Virginia Premier Elite Plus

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 Complete Care

Yes

Optima Health Community Care

Yes

United Healthcare

Yes

Virginia Premier Elite Plus

		Yes
N/A	Enter the start date.	**Aetna Better Health of Virginia** 07/01/2021 **Anthem Healthkeepers Plus** 07/01/2021 **Molina Complete Care** 07/01/2021 **Optima Health Community Care** 07/01/2021 **United Healthcare** 07/01/2021 **Virginia Premier Elite Plus** 07/01/2021
N/A	Enter the end date.	**Aetna Better Health of Virginia** 06/30/2022 **Anthem Healthkeepers Plus** 06/30/2022 **Molina Complete Care** 06/30/2022

Optima Health Community Care

06/30/2022

United Healthcare

06/30/2022

Virginia Premier Elite Plus

06/30/2022

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 Complete Care** 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

Optima Health Community Care

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

United Healthcare

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

Virginia Premier Elite 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

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 period) met state requirements for timely submission?
If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.

Aetna Better Health of Virginia

99%

Anthem Healthkeepers Plus

99%

Molina Complete Care

88%

Optima Health Community Care

97%

United Healthcare

99%

Virginia Premier Elite Plus

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 period) 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

Aetna Better Health of Virginia

100%

Anthem Healthkeepers Plus

100%

Molina Complete Care

100%

Optima Health Community Care

care plan for the reporting period.	100% **United Healthcare** 100% **Virginia Premier Elite Plus** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

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** 468 **Anthem Healthkeepers Plus** 2,227 **Molina Complete Care** 6,871 **Optima Health Community Care** 193 **United Healthcare** 310 **Virginia Premier Elite Plus** 1,242
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** 67 **Anthem Healthkeepers Plus** 229 **Molina Complete Care** 728

Optima Health Community Care

15

United Healthcare

34

Virginia Premier Elite Plus

138

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 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).

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

109

Molina Complete Care

873

Optima Health Community Care

98

United Healthcare

297

Virginia Premier Elite Plus

528

D1IV.4

Number of critical incidents filed during the reporting

Aetna Better Health of Virginia

period 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 period 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 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.

0

Anthem Healthkeepers Plus

0

Molina Complete Care

9

Optima Health Community Care

2

United Healthcare

4

Virginia Premier Elite Plus

4

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 during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Aetna Better Health of Virginia** 356 **Anthem Healthkeepers Plus** 1,844 **Molina Complete Care** 6,693 **Optima Health Community Care** 191 **United Healthcare** 132 **Virginia Premier Elite Plus** 882
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 during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Aetna Better Health of Virginia** 110 **Anthem Healthkeepers Plus** 316 **Molina Complete Care** 95 **Optima Health Community Care**

11

United Healthcare

170

Virginia Premier Elite Plus

442

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

465

Anthem Healthkeepers Plus

2,227

Molina Complete Care

534

Optima Health Community Care

121

United Healthcare

310

Virginia Premier Elite Plus

448

D1IV.6b

Resolved appeals related to reduction, suspension, or termination of a previously authorized service

Aetna Better Health of Virginia

0

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.

Anthem Healthkeepers Plus

1,243

Molina Complete Care

46

Optima Health Community Care

0

United Healthcare

0

Virginia Premier Elite Plus

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

1,101

Molina Complete Care

5,431

Optima Health Community Care

0

United Healthcare

0

Virginia Premier Elite Plus

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 Complete Care** 0 **Optima Health Community Care** 0 **United Healthcare** 0 **Virginia Premier Elite Plus** 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	**Aetna Better Health of Virginia** 1 **Anthem Healthkeepers Plus** 190

§438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

Molina Complete Care

0

Optima Health Community Care

0

United Healthcare

0

Virginia Premier Elite Plus

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

6

Anthem Healthkeepers Plus

7

Molina Complete Care

0

Optima Health Community Care

0

United Healthcare

0

Virginia Premier Elite Plus

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 Complete Care** 0 **Optima Health Community Care** 0 **United Healthcare** 0 **Virginia Premier Elite Plus** 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** 14 **Anthem Healthkeepers Plus** 604 **Molina Complete Care** 887 **Optima Health Community Care** 2 **United Healthcare** 18 **Virginia Premier Elite Plus** 8
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	**Aetna Better Health of Virginia** 467 **Anthem Healthkeepers Plus** 671 **Molina Complete Care** 2,265

	cover general outpatient services, enter "N/A".	**Optima Health Community Care** 9 **United Healthcare** 48 **Virginia Premier Elite Plus** 516
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** 2 **Anthem Healthkeepers Plus** 62 **Molina Complete Care** 44 **Optima Health Community Care** 0 **United Healthcare** 3 **Virginia Premier Elite Plus** 11
D1IV.7d	**Resolved appeals related to outpatient behavioral health**	**Aetna Better Health of Virginia**

	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".	6 **Anthem Healthkeepers Plus** 123 **Molina Complete Care** 3 **Optima Health Community Care** 50 **United Healthcare** 19 **Virginia Premier Elite Plus** 86
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** 174 **Anthem Healthkeepers Plus** 279 **Molina Complete Care** 166 **Optima Health Community Care** 63

United Healthcare

171

Virginia Premier Elite Plus

704

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

2

Molina Complete Care

1

Optima Health Community Care

0

United Healthcare

0

Virginia Premier Elite Plus

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

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

	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 LTSS services, enter "N/A".	35 **Molina Complete Care** 237 **Optima Health Community Care** 64 **United Healthcare** 14 **Virginia Premier Elite Plus** 234
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 Complete Care** N/A **Optima Health Community Care** 0 **United Healthcare** 0

Virginia Premier Elite Plus

N/A

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

0

Anthem Healthkeepers Plus

2

Molina Complete Care

0

Optima Health Community Care

0

United Healthcare

0

Virginia Premier Elite Plus

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, enter "N/A".

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

633

Molina Complete Care

311

Optima Health Community Care

20

United Healthcare

37

Virginia Premier Elite Plus

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** 10 **Anthem Healthkeepers Plus** 51 **Molina Complete Care** 7 **Optima Health Community Care** 0 **United Healthcare** 33 **Virginia Premier Elite Plus** 11
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** 8 **Anthem Healthkeepers Plus** 20 **Molina Complete Care** 0

Optima Health Community Care

0

United Healthcare

0

Virginia Premier Elite Plus

3

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

2

Anthem Healthkeepers Plus

19

Molina Complete Care

5

Optima Health Community Care

0

United Healthcare

11

Virginia Premier Elite Plus

4

D1IV.8d

State Fair Hearings retracted prior to reaching a decision

Aetna Better Health of Virginia

	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.	0 **Anthem Healthkeepers Plus** 5 **Molina Complete Care** 1 **Optima Health Community Care** 0 **United Healthcare** 19 **Virginia Premier Elite Plus** 0
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** 0 **Anthem Healthkeepers Plus** 0 **Molina Complete Care** 0 **Optima Health Community Care** 0

		United Healthcare 0 **Virginia Premier Elite Plus** N/A
D1IV.9b	**External Medical Reviews resulting in an adverse 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 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).	**Aetna Better Health of Virginia** 0 **Anthem Healthkeepers Plus** 0 **Molina Complete Care** 0 **Optima Health Community Care** 0 **United Healthcare** 0 **Virginia Premier Elite Plus** 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** 1,668 **Anthem Healthkeepers Plus** 2,606 **Molina Complete Care** 1,825 **Optima Health Community Care** 28 **United Healthcare** 1,067 **Virginia Premier Elite Plus** 267
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** 359 **Anthem Healthkeepers Plus** 188 **Molina Complete Care** 191

Optima Health Community Care

1

United Healthcare

161

Virginia Premier Elite Plus

14

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

912

Molina Complete Care

163

Optima Health Community Care

16

United Healthcare

916

Virginia Premier Elite Plus

83

D1IV.13

Number of critical incidents filed during the reporting

Aetna Better Health of Virginia

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 period by (or on behalf of) LTSS users who 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

0

Anthem Healthkeepers Plus

0

Molina Complete Care

9

Optima Health Community Care

8

United Healthcare

12

Virginia Premier Elite Plus

0

	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.	
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 period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Aetna Better Health of Virginia** 1,660 **Anthem Healthkeepers Plus** 2,604 **Molina Complete Care** 1,822 **Optima Health Community Care** 28 **United Healthcare** 817 **Virginia Premier Elite Plus** 261

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** 41 **Anthem Healthkeepers Plus** 0 **Molina Complete Care** 7 **Optima Health Community Care** 0 **United Healthcare** 3 **Virginia Premier Elite Plus** 1
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	**Aetna Better Health of Virginia** 613 **Anthem Healthkeepers Plus** 1 **Molina Complete Care** 16

	not cover this type of service, enter "N/A".	**Optima Health Community Care** 0 **United Healthcare** 122 **Virginia Premier Elite Plus** 36
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 Complete Care** 1 **Optima Health Community Care** 1 **United Healthcare** 0 **Virginia Premier Elite Plus** 4
D1IV.15d	**Resolved grievances related to outpatient behavioral**	**Aetna Better Health of Virginia**

	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".	3 **Anthem Healthkeepers Plus** 0 **Molina Complete Care** 26 **Optima Health Community Care** 0 **United Healthcare** 11 **Virginia Premier Elite Plus** 5
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** 7 **Anthem Healthkeepers Plus** 38 **Molina Complete Care** 211 **Optima Health Community Care** 0

United Healthcare

8

Virginia Premier Elite Plus

2

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 Complete Care

2

Optima Health Community Care

0

United Healthcare

3

Virginia Premier Elite Plus

0

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

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

	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".	2 **Molina Complete Care** 16 **Optima Health Community Care** 0 **United Healthcare** 9 **Virginia Premier Elite Plus** 5
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** 5 **Anthem Healthkeepers Plus** 0 **Molina Complete Care** 17 **Optima Health Community Care** 0 **United Healthcare** 3

Virginia Premier Elite Plus

0

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 cover this type of service, enter "N/A".

Aetna Better Health of Virginia

1,015

Anthem Healthkeepers Plus

1,178

Molina Complete Care

796

Optima Health Community Care

1,114

United Healthcare

902

Virginia Premier Elite Plus

1

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, enter "N/A".

Aetna Better Health of Virginia

8

Anthem Healthkeepers Plus

2,573

Molina Complete Care

248

Optima Health Community Care

4

United Healthcare

6

Virginia Premier Elite Plus

508

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** 1,243 **Anthem Healthkeepers Plus** 74 **Molina Complete Care** 133 **Optima Health Community Care** 0 **United Healthcare** 0 **Virginia Premier Elite Plus** 1
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.	**Aetna Better Health of Virginia** 2 **Anthem Healthkeepers Plus** 18 **Molina Complete Care** 54

	Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Optima Health Community Care** 0 **United Healthcare** 31 **Virginia Premier Elite Plus** 2
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** 38 **Molina Complete Care** 380 **Optima Health Community Care** 0 **United Healthcare** 13 **Virginia Premier Elite Plus** 3
D1IV.16d	**Resolved grievances related to quality of care**	**Aetna Better Health of Virginia**

	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 provided by a provider or the plan.	0 **Anthem Healthkeepers Plus** 456 **Molina Complete Care** 50 **Optima Health Community Care** 12 **United Healthcare** 450 **Virginia Premier Elite Plus** 48
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** 1 **Anthem Healthkeepers Plus** 32 **Molina Complete Care** 141 **Optima Health Community Care** 0

United Healthcare

43

Virginia Premier Elite Plus

1

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 were filed for a reason related to payment or billing issues.

Aetna Better Health of Virginia

666

Anthem Healthkeepers Plus

392

Molina Complete Care

208

Optima Health Community Care

2

United Healthcare

32

Virginia Premier Elite Plus

504

D1IV.16g

Resolved grievances related to suspected fraud

Enter the total number of grievances resolved by the plan during the reporting year that

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

	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.	21 **Molina Complete Care** 11 **Optima Health Community Care** 0 **United Healthcare** 0 **Virginia Premier Elite Plus** 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 Complete Care** 0 **Optima Health Community Care** 0 **United Healthcare** 0

Virginia Premier Elite Plus

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 Complete Care

25

Optima Health Community Care

0

United Healthcare

0

Virginia Premier Elite Plus

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.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

1

Molina Complete Care

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.

0

Optima Health Community Care

0

United Healthcare

0

Virginia Premier Elite Plus

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

23

Molina Complete Care

250

Optima Health Community Care

9

United Healthcare

498

Virginia Premier Elite Plus

3

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

87.06%

Anthem Healthkeepers Plus

90.86%

Molina Complete Care

77.29%

Optima Health Community Care

87.52%

United Healthcare

90.03%

Virginia Premier Elite Plus

86.53%

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

78.96%

Anthem Healthkeepers Plus

73.33%

Molina Complete Care

64.15%

Optima Health Community Care

58.92%

United Healthcare

75%

Virginia Premier Elite Plus

70.52%

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

49.39%

Anthem Healthkeepers Plus

58.15%

Molina Complete Care

40.63%

Optima Health Community Care

48.42%

United Healthcare

67.40%

Virginia Premier Elite Plus

47.69%

Complete

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

4 / 8

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

33.88%

Anthem Healthkeepers Plus

38.28%

Molina Complete Care

20.80%

Optima Health Community Care

35.70%

United Healthcare

34.92%

Virginia Premier Elite Plus

19.16%

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

Not Required (NQ)

Anthem Healthkeepers Plus

No Benefit (NB)

Molina Complete Care

No Benefit (NB)

Optima Health Community Care

No Benefit (NB)

United Healthcare

No Benefit (NB)

Virginia Premier Elite Plus

N/A

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, Medallion 4.0

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

81%

Anthem Healthkeepers Plus

78%

Molina Complete Care

76%

Optima Health Community Care

83%

United Healthcare

78%

Virginia Premier Elite Plus

81%

Complete

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

7 / 8

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

Yes

D2.VII.8 Measure Description

n/a

Measure results

Aetna Better Health of Virginia

35.61%

Anthem Healthkeepers Plus

27.86%

Molina Complete Care

40.48%

Optima Health Community Care

28.08%

United Healthcare

30%

Virginia Premier Elite Plus

38.09%

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

89.52%

Anthem Healthkeepers Plus

87.89%

Molina Complete Care

92.26%

Optima Health Community Care

83.13%

United Healthcare

89.84%

Virginia Premier Elite Plus

81.83%

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: 14

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 14

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

Failure to submit CCCPlus Technical Manual Quarterly Deliverables by the required due date

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

05/09/2023

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

Yes, remediated 05/16/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 14

D3.VIII.2 Intervention topic

Inappropriate Waiver Enrollment

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Inappropriate waiver enrollment

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

05/09/2023

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

Yes, remediated 10/17/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

3 / 14

D3.VIII.2 Intervention topic

appeals

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Two expedited appeals for a members under 21 were routed as standard appeals. One took 15 days to provide a decision, instead of 72 hours. The second took 18 days to provide a decision, instead of 72 hours.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was

03/30/2023

corrected

Yes, remediated
06/07/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic

care coordination

D3.VIII.3 Plan name

Virginia Premier Elite Plus

D3.VIII.4 Reason for intervention

On 2/24/23, Virginia Premier Elite Plus sent two emails requesting DMAS to update/correct LOC lines. Both requests failed to alert DMAS that untimely NF discharge dates were being added to the system. Virginia Premier Elite Plus Elite Plus had completed all validations of NF members on the January 834 as on 2/6/2023.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

03/02/2023

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

Yes, remediated
04/04/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

5 / 14

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Optima Health Community Care

D3.VIII.4 Reason for intervention

Optima Health Community Care is out of compliance for Payment Cycle Entry Timeliness (85.16% / 98%) and Payment Cycle Certification Timeliness (84.62% / 98%)

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

03/01/2023

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

Yes, remediated
02/07/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

6 / 14

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

United Healthcare

Inappropriate
waiver enrollment

D3.VIII.4 Reason for intervention

Inappropriate waiver enrollment

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

02/15/2023

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

Yes, remediated
03/07/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

7 / 14

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Molina Complete Care

D3.VIII.4 Reason for intervention

Failure to respond to a request for information from DMAS by the set deadline.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

02/15/2023

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

Yes, remediated 02/21/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic

care coordination

D3.VIII.3 Plan name

Molina Complete Care

D3.VIII.4 Reason for intervention

Department of Medical Assistance Services (DMAS) policy allows youth (defined as under age 21) to receive Applied Behavioral Analysis (ABA) services if the youth meet medical necessity criteria (MNC) for the service. Medicaid managed care organizations (MCOs) may not use a definition of medical necessity that is more restrictive than the states definition (Commonwealth Coordinated Care (CCC) Plus 4.1, 4.4.2 and Summary of Covered Services Part 2B. Youth who do not meet medical necessity criteria also require a secondary review by a physician with experience in treating the Member's condition or disease under Early and Periodic Screening and Diagnostic Treatment (EPSDT) prior to a denial (CCC Plus 4.4.2, 6.2.4 M4 8.2.M.b, 8.2.M.n). 1. Molina Complete Care Complete Care Complete Care is using more restrictive MNC criteria in some cases and not using DMAS criteria at all in others. 2. Molina Complete Care Complete Care Complete Care did not complete secondary EPSDT reviews. 3. If EPSDT reviews are not being completed for ABA, validity of other denials is in question

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

01/24/2023

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

Yes, remediated
05/16/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

9 / 14

D3.VIII.2 Intervention topic

claims

D3.VIII.3 Plan name

Virginia Premier Elite Plus

D3.VIII.4 Reason for intervention

Virginia Premier Elite Plus Failed to pay claims within 14 days and was unable to reprocess claims (going back to 7/1/22 DOS) due to interest calculation configuration issue. Estimated figures are at least 46 providers and over 3900 claims.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

01/20/2023

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

Yes, remediated
10/17/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

10 / 14

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Anthem HealthKeepers Plus is out of compliance for: 1) Payment cycle entry timeliness: Target 98%; Actual 78.59% (SFY23Q1) and 89.09% (SFY22Q4) 2) Payment cycle certification timeliness: Target 98%; Actual 81.23%

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

12/13/2022

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

Yes, remediated
06/07/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

11 / 14

D3.VIII.2 Intervention topic

service authorization

D3.VIII.3 Plan name

Virginia Premier Elite Plus

D3.VIII.4 Reason for intervention

Virginia Premier Elite Plus did not provide service authorization for member DME (car seat) within contractual timelines. This caused negative impact and undue risk to the member.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

11/09/2022

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

Yes, remediated 04/04/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

12 / 14

D3.VIII.2 Intervention topic

care coordination

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

LTSS lines added to the portal without valid screenings.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

10/26/2022

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

Yes, remediated 02/07/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

13 / 14

D3.VIII.2 Intervention topic

care coordination

D3.VIII.3 Plan name

Molina Complete Care

D3.VIII.4 Reason for intervention

Two Molina Complete Care Complete Care Complete Care members had waiver lines added in the system with start dates prior to completion (MD signature) of valid LTSS screenings.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was

10/14/2022

corrected

Yes, remediated
03/07/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

14 / 14

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Molina Complete Care

D3.VIII.4 Reason for intervention

The Member's mother contacted Molina Complete Care's Care Coordinator on 8/24/22 about a notice of denial letter. On 8/29/22 the Care Coordinator spoke to the mother, who then had difficulty obtaining medical records. DMAS contacted Molina Complete Care Complete Care Complete Care on 9/12 to ask Molina Complete Care to provide the medical record documentation related to the notice of denial. The completed correct records were received on 9/30/22. Record requests must be acted on no later than 30 days after receipt of request.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$30,000

D3.VIII.7 Date assessed

09/30/2022

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

Yes, remediated
02/21/2023

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** 52 **Anthem Healthkeepers Plus** 39 **Molina Complete Care** 5 **Optima Health Community Care** 20 **United Healthcare** 14.92 **Virginia Premier Elite Plus** 5
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** 28 **Anthem Healthkeepers Plus** 428 **Molina Complete Care** 34

Optima Health Community Care

112

United Healthcare

64

Virginia Premier Elite Plus

107

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 per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?

Aetna Better Health of Virginia

0.6:1

Anthem Healthkeepers Plus

4.8:1

Molina Complete Care

1.1:1

Optima Health Community Care

2.3:1

United Healthcare

1.5:1

Virginia Premier Elite Plus

2.1:1

D1X.4

Count of resolved program integrity investigations

Aetna Better Health of Virginia

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

9

Anthem Healthkeepers Plus

71

Molina Complete Care

25

Optima Health Community Care

120

United Healthcare

29

Virginia Premier Elite Plus

89

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 per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?

Aetna Better Health of Virginia

0.2:1

Anthem Healthkeepers Plus

0.8:1

Molina Complete Care

0.8:1

Optima Health Community Care

2.4:1

United Healthcare

0.7:1

Virginia Premier Elite Plus

1.8:1

D1X.6

Referral path for program integrity referrals to the state

What is the referral path that the plan uses to make program integrity referrals to the state? Select one.

Aetna Better Health of Virginia

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Anthem Healthkeepers Plus

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Molina Complete Care

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Optima Health Community Care

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

United Healthcare

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Virginia Premier Elite Plus

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Aetna Better Health of Virginia** 3 **Anthem Healthkeepers Plus** 14 **Molina Complete Care** 6 **Optima Health Community Care** 48 **United Healthcare** 53 **Virginia Premier Elite Plus** 12

D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.	**Aetna Better Health of Virginia** 0.1:1 **Anthem Healthkeepers Plus** 0.2:1 **Molina Complete Care** 0.2:1 **Optima Health Community Care** 0.04:1 **United Healthcare** 1.3:1 **Virginia Premier Elite Plus** 0.2:1
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue	**Aetna Better Health of Virginia** The most recent MLR data available is for SFY 2022. Rating Period: SFY 2022 Overpayments recovered for SFY 2022: Total: $1,788,977.93 % of Premium Revenue: 0.16% Overpayments recovered for SFY 2023 are based on quarterly Program Integrity Overpayment Recovery Reports and include only unsolicited overpayment

as defined in MLR reporting under 42 CFR 438.8(f)(2).

recoveries. Rating Period: SFY 2023 Total: $,2,309,923.95

Anthem Healthkeepers Plus

The most recent MLR data available is for SFY 2022. Rating Period: SFY 2022 Overpayments recovered for SFY 2022: Total: $2,736,558.23 % of Premium Revenue: 0.12% Overpayments recovered for SFY 2023 are based on quarterly Program Integrity Overpayment Recovery Reports and include only unsolicited overpayment recoveries. Rating Period: SFY 2023 Total: $2,887,434.97

Molina Complete Care

The most recent MLR data available is for SFY 2022. Rating Period: SFY 2022 Overpayments recovered for SFY 2022: Total: $1,270,408.09 % of Premium Revenue: 0.17% Overpayments recovered for SFY 2023 are based on quarterly Program Integrity Overpayment Recovery Reports and include only unsolicited overpayment recoveries. Rating Period: SFY 2023 Total: None reported

Optima Health Community Care

The most recent MLR data available is for SFY 2022. Rating Period: SFY 2022 Overpayments recovered for SFY 2022: Total:

$3,317,252.2 % of Premium Revenue: 0.25% Overpayments recovered for SFY 2023 are based on quarterly Program Integrity Overpayment Recovery Reports and include only unsolicited overpayment recoveries. Rating Period: SFY 2023 Total: $1,086,000.83

United Healthcare

The most recent MLR data available is for SFY 2022. Rating Period: SFY 2022 Overpayments recovered for SFY 2022: Total: $607,506.94 % of Premium Revenue: 0.07% Overpayments recovered for SFY 2023 are based on quarterly Program Integrity Overpayment Recovery Reports and include only unsolicited overpayment recoveries. Rating Period: SFY 2023 Total: $796,498.58

Virginia Premier Elite Plus

The most recent MLR data available is for SFY 2022. Rating Period: SFY 2022 Overpayments recovered for SFY 2022: Total: $3,892,273.26 % of Premium Revenue: 0.29% Overpayments recovered for SFY 2023 are based on quarterly Program Integrity Overpayment Recovery Reports and include only unsolicited overpayment

		recoveries. Rating Period: SFY 2023 Total: $3,620,862.81
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Aetna Better Health of Virginia** Daily **Anthem Healthkeepers Plus** Daily **Molina Complete Care** Daily **Optima Health Community Care** Daily **United Healthcare** Daily **Virginia Premier Elite Plus** Daily

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 was contracted to perform 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