Managed Care Program Annual Report (MCPAR) for Virginia: Medallion 4.0

Due date	Last edited	Edited by	Status
12/27/2023	12/15/2023	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.	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.	Medallion 4.0

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 Anthem Molina Optima United Healthcare Virginia Premier

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

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)
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. This year we developed an extension of the quarterly collaborative, the BRAVO Workgroup, where Program Integrity meets with Plans monthly to talk about fraud, waste and abuse found in behavioral health services. Specifically, a focus was put on outlier providers providing Community Stabilization and Mobile Crisis services. This joint effort continues as we apply program integrity oversight of the services. 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: 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 overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 11.11.A Formal Initiation of Recovery
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,	The Contractor shall notify the Department prior to formal initiation of a recovery from an investigation by the Contractor on its own network. Submission of the Completed Investigation Form will serve as this notification. The Contractor

	or administers a hybrid system) selected in indicator B.X.2.	shall not proceed with any recoupment or withholding of any program integrity-related funds until the Department confirms that the recoupment or withhold is permissible. The contractor shall submit adjusted encounters reflecting any identified overpayments (regardless of whether they are recovered) and report to the Department via the Quarterly Fraud/Waste/Abuse Report on any overpayments that have not been collected. The Contractor shall notify the Department prior to formal initiation of a recovery from an investigation by the Contractor on its own network. Submission of the Completed Investigation Form will serve as this notification. The Contractor shall not proceed with any recoupment or withholding of any program integrity-related funds until the Department confirms that the recoupment or withhold is permissible. The contractor shall submit adjusted encounters reflecting any identified overpayments (regardless of whether they are recovered) and report to the Department via the Quarterly Fraud/Waste/Abuse Report on any overpayments that have not been collected.
BX.5	**State overpayment reporting monitoring**	Overview The External Provider and Policy Review Unit (EPAP) was a new Program Integrity

Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting?
The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.

Unit in FY18. Each Managed Care Organization (MCO) is required to establish their own internal program integrity unit to guard against fraud, waste, and/or abuse of Medicaid program benefits and resources. The EPAP unit provides oversight to the MCO program integrity units and primarily focuses on ensuring compliance with the 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 payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	"All initial member MCO enrollments and assignments are done in the state MES. All member enrollment and MCO changes are done within MES and communicated to the MCOs via a weekly enrollment roster (EDI 834). Enrollment Broker changes are also done directly in MES. The state MES is always the system of record for member enrollment. PMPM capitation payments are generated by the state MES based on the member enrollment data. Any changes to member data automatically trigger PMPM capitation adjustments which retract/adjust previous payments made to the MCO. In addition, MES does a reconciliation of member enrollment vs capitation payments each quarter to ensure that all historical payments have been made accurately."
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**	Yes

	Does the state use a metric or indicator to assess plan reporting performance? Select one.	
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	No

	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.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
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).	state has a hybrid system

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.	Medallion 4.0 Managed Care Services Agreement
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://www.dmas.virginia.gov/media/4981/medallion-40-sfy23.pdf
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 Transportation

	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.	
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.	N/A
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).	1,630,039

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.	Telehealth and telemedicine services; coverage of mobile vision services; coverage of adult preventive services; doula services went live in Aug 2022 with managed care plans;

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 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).	Timeliness of initial data submissions Timeliness of data certifications Use of correct file formats Overall data accuracy (as determined through data validation)
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 performance on encounter data submission and correction will be measured. Use contract	Section 14 (Encounters) of the Medallion SFY 2023 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.	Sections 13.5.D (Data Quality Penalties) and section 14.2.A (Data Quality Requirements) in the Medallion SFY 2023 contract.
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	MCO rates are based on encounter data, so the MCOs are incentivized to submit complete and accurate encounter data.
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	• Documentation of EDI translator rules (compliance check) • IT turnaround time for MCOs to comply with SMA changes • Restrictions on number of records in EDI files • Issues with submission of adjustments & voids for failed originals • Timeliness of code set updates for encounter edits • Onboarding of new MCO systems and subcontractors requires extensive testing and staff resources.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
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.	Meeting network adequacy time and distinct standards in rural areas or areas where there is only one zip code in the region. Specifically in Bath Co., Highland Co., Fauquier Co., Campbell Co., and Bedford Co.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	Managed Care Organizations(MCO) submit quarterly provider network files based on requirements outlined in the Medallion 4.0 Network Requirements Submission Manual; which outlines the methodology that is used to determine adequacy in specific regions/ FIPS codes as it relates to time and distance standards. The quarterly provider files are analyzed internally, each MCOs strengths and weakness of their individual networks are documented and each plan receives a summarized finding of areas where the MCO does not meet time and distance standards based on contractual standards; along with a summary of the MCOs Network Adequacy Scorecard and Network Adequacy Map. Each MCO is given five business days to submit a Network Adequacy Exemption Request form to the Department. The form allows the MCO to detail the rational for an exception of not meeting adequacy standards for the out-

compliance region, a detail list of providers closest to the out of compliance region and the MCOs plan of action to meet time and distant standards in the out of compliance region. The Department analyzes the each MCOs Network Adequacy Exemption Request form and provides feedback to each MCO.

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: 46

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

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C2.V.2 Measure standard

Primary Care Provider (PCP)

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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

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C2.V.2 Measure standard

Primary Care Provider

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

Pediatrician (Pediatrics)

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pediatrics	Urban	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

Pediatrician (Pediatrics)

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pediatrician (Pediatrics)	Rural	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

OB/GYN (Obstetrics & Gynecology)

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

OB/GYN (Obstetrics & Gynecology)

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN (Obstetrics & Gynecology)	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

Outpatient Mental Health (Behavioral Health & Social Service Providers)

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Outpatient Mental Health (Behavioral Health & Social Service Providers)	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

Outpatient Mental Health (Behavioral Health & Social Service Providers)

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Outpatient Mental Health (Behavioral Health & Social Service Providers)	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

Pharmacy

C2.V.3 Standard type

Maximum time or distance

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

Quarterly

Complete

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

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C2.V.2 Measure standard

Pharmacy

C2.V.3 Standard type

Maximum time or distance

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

Quarterly

Complete

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

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C2.V.2 Measure standard

General Hospital (Acute Care Hosptial)

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

General Hospital (Acute Care Hosptial)

C2.V.3 Standard type

Maximum time or distance

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

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

Allergy/Immunology and Respiratory Rehabilitation

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Allergy/Immunology and Respiratory Rehabilitation	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

Allergy/Immunology and Respiratory Rehabilitation

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Allergy/Immunology and Respiratory Rehabilitation	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

15 / 46

C2.V.2 Measure standard

Other Specialist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

16 / 46

C2.V.2 Measure standard

Other Specialist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

17 / 46

C2.V.2 Measure standard

Otolaryngology

C2.V.3 Standard type

Maximum time or distance

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

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

18 / 46

C2.V.2 Measure standard

Otolaryngology

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

19 / 46

C2.V.2 Measure standard

Pain Medicine

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

20 / 46

C2.V.2 Measure standard

Pain Medicine

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pain Medicine	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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

C2.V.2 Measure standard

Physical Medicine and Rehabilitation

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physical Medicine and Rehabilitation	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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

C2.V.2 Measure standard

Physical Medicine and Rehabilitation

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physical Medicine and Rehabilitation	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

23 / 46

C2.V.2 Measure standard

Psychiatry

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

24 / 46

C2.V.2 Measure standard

Psychiatry

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

25 / 46

C2.V.2 Measure standard

Neurology

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

26 / 46

C2.V.2 Measure standard

Neurology

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

27 / 46

C2.V.2 Measure standard

Cardiologist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

28 / 46

C2.V.2 Measure standard

Cardiologist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

29 / 46

C2.V.2 Measure standard

Clinical Medical Laboratory

C2.V.3 Standard type

Maximum time or distance

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

Clinical Medical Laboratory		Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

30 / 46

C2.V.2 Measure standard

Clinical Medical Laboratory

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Clinical Medical Laboratory	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

31 / 46

C2.V.2 Measure standard

Endocrinologist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

Endocrinologist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

Nephrologist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

Nephrologist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

35 / 46

C2.V.2 Measure standard

Ophthalmologist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

36 / 46

C2.V.2 Measure standard

Ophthalmologist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

37 / 46

C2.V.2 Measure standard

Podiatrist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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

C2.V.2 Measure standard

Podiatrist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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

C2.V.2 Measure standard

Radiologist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

40 / 46

C2.V.2 Measure standard

Radiologist

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

41 / 46

C2.V.2 Measure standard

Skilled Nursing Facility

C2.V.3 Standard type

Maximum time or distance

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Skilled Nursing Facility	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

42 / 46

C2.V.2 Measure standard

Skilled Nursing Facility

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Skilled Nursing Facility	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

43 / 46

C2.V.2 Measure standard

Urgent Care Center

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care Center	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

Urgent Care Center

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care Center	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

45 / 46

C2.V.2 Measure standard

Early Intervention

C2.V.3 Standard type

Maximum time or distance

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

Quarterly

Complete

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

46 / 46

C2.V.2 Measure standard

Early Intervention

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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://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.	BSS Entity: Maximus BSS Phone Number: Toll Free at 1-800-643-2273 BSS IVR: Automated phone system that allows callers to access information via prerecorded messages without having to speak to an agent, as well as to utilize menu options to have their call routed to specific departments. BSS Website: https://www.virginiamanagedcare.com BSS Cell Phone App: Virginia Medallion on Google Play or the App Store BSS Auxiliary Aids and Services: TTY: (teletypewriter) 1-800-817-6608, BSS Language/Translation interpreter line along with Spanish Bilingual employees staffed, BSS Marketing Materials website and printed marketing materials are created in large print for individuals with visual impairments.
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).	BSS ERB reports to the Contract Administrator via email, and or via good cause cases sent via CTS, all critical incidents, grievances, and appeals requests reported by Members and or Providers when assistance and decision making is required by DMAS. The BSS ERB CSR's educate and counsel callers of the Medicaid/Managed Care policies,

		procedures, and appeals process when needed, also identifying issues that require escalation and reporting to DMAS.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	BSS ERB included however not limited to, submits weekly, monthly and annual reports to the Contract Administrator regarding MCO helpline call summary, enrollment data, complaint logs, activity reports, webtrends, daily call stats, material inventory, SLA reports, staffing reports, IVR/Call Center phone activity, good cause report, change reports, EB invoices, health status assessments, and customer satisfaction surveys. The Contract Administrator also conducts call monitoring, meetings with BSS ERB leadership to discuss current initiatives and performance, as well as other monitoring efforts to ensure the ERB is within compliance of their contract.

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** 222,385 **Anthem** 495,404 **Molina** 107,284 **Optima** 314,991 **United Healthcare** 178,070 **Virginia Premier** 318,509
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** 12% **Anthem** 26% **Molina** 6% **Optima** 16%

		United Healthcare 9%
		Virginia Premier 16%
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** 12% **Anthem** 26% **Molina** 6% **Optima** 16% **United Healthcare** 9% **Virginia Premier** 16%

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** 85% **Anthem** 84% **Molina** 89% **Optima** 89% **United Healthcare** 88% **Virginia Premier** 90%
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** Program-specific statewide **Anthem** Program-specific statewide **Molina** Program-specific statewide **Optima** Program-specific statewide

United Healthcare

Program-specific statewide

Virginia Premier

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** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **Anthem** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **Molina** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **Optima** 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** 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** Yes **Anthem** Yes **Molina** Yes **Optima** Yes **United Healthcare** Yes **Virginia Premier** Yes
N/A	Enter the start date.	**Aetna** 07/01/2021 **Anthem**

		07/01/2021 **Molina** 07/01/2021 **Optima** 07/01/2021 **United Healthcare** 07/01/2021 **Virginia Premier** 07/01/2021
N/A	Enter the end date.	**Aetna** 06/30/2022 **Anthem** 06/30/2022 **Molina** 06/30/2022 **Optima** 06/30/2022 **United Healthcare** 06/30/2022 **Virginia Premier**

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** Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor’s payment cycle and in the form and manner specified by the Department." **Anthem** Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor’s payment cycle and in the form and manner specified by the Department." **Molina** Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor’s payment cycle and in the form and manner specified by the Department." **Optima** Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit

complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor's payment cycle and in the form and manner specified by the Department."

United Healthcare

Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor's payment cycle and in the form and manner specified by the Department."

Virginia Premier

Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor's payment cycle and in the form and manner specified by the Department."

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

Aetna

99%

Anthem

100%

Molina

	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.	62% **Optima** 93% **United Healthcare** 99% **Virginia Premier** 94%
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 care plan for the reporting period.	**Aetna** 98% **Anthem** 99% **Molina** 99% **Optima** 99% **United Healthcare** 100% **Virginia Premier** 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** 550 **Anthem** 2,735 **Molina** 8,380 **Optima** 283 **United Healthcare** 604 **Virginia Premier** 2,990
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** 85 **Anthem** 328 **Molina** 690 **Optima** 36

		United Healthcare 86 **Virginia Premier** 120
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** 0 **Anthem** 9 **Molina** 24 **Optima** 7 **United Healthcare** 2 **Virginia Premier** 89
D1IV.4	**Number of critical incidents filed during the reporting 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	**Aetna** 0 **Anthem** 0

	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.	**Molina** 0 **Optima** 0 **United Healthcare** N/A **Virginia Premier** 0
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	**Aetna** 426 **Anthem**

period.
See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.

2,338

Molina

8,169

Optima

290

United Healthcare

285

Virginia Premier

2,351

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

124

Anthem

337

Molina

99

Optima

15

United Healthcare

309

Virginia Premier

716

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** 551 **Anthem** 2,735 **Molina** 561 **Optima** 69 **United Healthcare** 593 **Virginia Premier** 222
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Aetna** 0 **Anthem** 1,241 **Molina** 7 **Optima**

0

United Healthcare

0

Virginia Premier

7

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** 0 **Anthem** 1,467 **Molina** 6,713 **Optima** 0 **United Healthcare** 11 **Virginia Premier** 1,093
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	**Aetna** 0 **Anthem**

	timely manner (as defined by the state).	0 **Molina** 0 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Aetna** 0 **Anthem** 242 **Molina** 0 **Optima** 0 **United Healthcare** 0 **Virginia Premier**

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** 10 **Anthem** 30 **Molina** 0 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 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** 0 **Anthem** 0 **Molina** 0 **Optima**

0

United Healthcare

0

Virginia Premier

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** 18 **Anthem** 848 **Molina** 1,041 **Optima** 1 **United Healthcare** 39 **Virginia Premier** 28
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Aetna** 503 **Anthem** 922 **Molina** 2,982 **Optima** 2

		United Healthcare 74 **Virginia Premier** 1,119
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** 3 **Anthem** 79 **Molina** 2 **Optima** 1 **United Healthcare** 1 **Virginia Premier** 31
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the	**Aetna** 13 **Anthem** 105

	managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Molina** 4 **Optima** 38 **United Healthcare** 31 **Virginia Premier** 248
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** 270 **Anthem** 628 **Molina** 243 **Optima** 224 **United Healthcare** 437 **Virginia Premier** 1,585

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** N/A **Anthem** 1 **Molina** 0 **Optima** 0 **United Healthcare** 2 **Virginia Premier** 3
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Aetna** N/A **Anthem** 4 **Molina** 11 **Optima** 4 **United Healthcare**

1

Virginia Premier

72

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** 0 **Anthem** 1 **Molina** N/A **Optima** 0 **United Healthcare** 0 **Virginia Premier** 1
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** 0 **Anthem** 0 **Molina**

0

Optima

0

United Healthcare

0

Virginia Premier

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** 0 **Anthem** 483 **Molina** 278 **Optima** 49 **United Healthcare** 19 **Virginia Premier** 1

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** 0 **Anthem** 24 **Molina** 3 **Optima** 0 **United Healthcare** 34 **Virginia Premier** 9
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** 0 **Anthem** 7 **Molina** 1 **Optima** 0

		United Healthcare 0 **Virginia Premier** 2
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** 0 **Anthem** 6 **Molina** 1 **Optima** 0 **United Healthcare** 13 **Virginia Premier** 2
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the	**Aetna** 0 **Anthem** 5

	reporting year prior to reaching a decision.	**Molina** 1 **Optima** 0 **United Healthcare** 21 **Virginia Premier** 3
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** 0 **Anthem** 0 **Molina** 0 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 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** 0 **Anthem** 0 **Molina** 0 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 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** 2,078 **Anthem** 2,266 **Molina** 1,785 **Optima** 8 **United Healthcare** 579 **Virginia Premier** 1,049
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** 532 **Anthem** 166 **Molina** 199 **Optima** 0

United Healthcare

150

Virginia Premier

10

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

0

Anthem

0

Molina

2

Optima

0

United Healthcare

79

Virginia Premier

6

D1IV.13

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

For managed care plans that cover LTSS, enter the number of critical incidents filed within

Aetna

0

Anthem

0

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 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

Molina

0

Optima

0

United Healthcare

N/A

Virginia Premier

2

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** 2,075 **Anthem** 2,264 **Molina** 1,784 **Optima** 8 **United Healthcare** 421 **Virginia Premier** 1,037

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** 0 **Anthem** 0 **Molina** 5 **Optima** 0 **United Healthcare** 9 **Virginia Premier** 58

D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna** 0 **Anthem** 0 **Molina** 6 **Optima** 0 **United Healthcare** 254 **Virginia Premier** 448
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** 0 **Anthem** 0 **Molina** 1 **Optima** 0 **United Healthcare**

0

Virginia Premier

3

D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna** 0 **Anthem** N/A **Molina** 7 **Optima** 0 **United Healthcare** 19 **Virginia Premier** 53
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	**Aetna** N/A **Anthem** 42 **Molina**

	cover this type of service, enter "N/A".	277 **Optima** 0 **United Healthcare** 10 **Virginia Premier** 84
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** N/A **Anthem** 0 **Molina** 0 **Optima** 0 **United Healthcare** 1 **Virginia Premier** 0
D1IV.15g	**Resolved grievances related to long-term services and**	**Aetna**

	supports (LTSS)	N/A
	Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 0 **Molina** 0 **Optima** 0 **United Healthcare** 2 **Virginia Premier** 6
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** 21 **Anthem** 0 **Molina** 20 **Optima** 0 **United Healthcare** 3

		Virginia Premier 4
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** 621 **Anthem** 361 **Molina** 230 **Optima** 429 **United Healthcare** 277 **Virginia Premier** 28
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** 1,783 **Anthem** 2,229 **Molina** 615

Optima

1

United Healthcare

4

Virginia Premier

390

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** 701 **Anthem** 47 **Molina** 99 **Optima** 1 **United Healthcare** 1 **Virginia Premier** 383
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the	**Aetna** 1 **Anthem** 3 **Molina** 9 **Optima** 0

	timeliness of an assessment or complaints about the plan or provider care or case management process.	**United Healthcare** 19 **Virginia Premier** 4
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** 0 **Anthem** 70 **Molina** 467 **Optima** 0 **United Healthcare** 23 **Virginia Premier** 118
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the	**Aetna** 0 **Anthem** 414

	effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Molina** 19 **Optima** 2 **United Healthcare** 144 **Virginia Premier** 152
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** 1 **Anthem** 47 **Molina** 145 **Optima** 0 **United Healthcare** 110 **Virginia Premier** 63

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** 1,589 **Anthem** 915 **Molina** 407 **Optima** 1 **United Healthcare** 102 **Virginia Premier** 280
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted	**Aetna** 0 **Anthem** 23 **Molina** 6 **Optima** 0 **United Healthcare**

	to another entity, such as a state Ombudsman or Office of the Inspector General.	0 **Virginia Premier** 1
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** 0 **Anthem** 0 **Molina** 0 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 7
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	**Aetna** 0 **Anthem** 0 **Molina**

	service authorization or appeal request (including requests to expedite or extend appeals).	29 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 3
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Aetna** 0 **Anthem** 1 **Molina** 0 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 4
D1IV.16k	**Resolved grievances filed for other reasons**	**Aetna**

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.	0 **Anthem** 31 **Molina** 618 **Optima** 3 **United Healthcare** 180 **Virginia Premier** 44

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: 7

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits—Total*

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1516

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

45.46

Anthem

54.70

Molina

36.30

Optima

48.35

United Healthcare

53.96

Virginia Premier

47.62

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Postpartum 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

75.43

Anthem

65.69

Molina

61.31

Optima

63.50

United Healthcare

70.32

Virginia Premier

68.86

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio - Total*

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

1800

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

72.69

Anthem

71

Molina

72.45

Optima

65.61

United Healthcare

67.58

Virginia Premier

71.70

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness- 7 day Follow-up Total*

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna

40.12

Anthem

45.43

Molina

36.07

Optima

44.36

United Healthcare

44.38

Virginia Premier

42.47

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

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

Not Required (NQ)

Anthem

No Benefit (NB)

Molina

.32

Optima

No Benefit (NB)

United Healthcare

No Benefit (NB)

Virginia Premier

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

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

81

Anthem

78

Molina

76

Optima

83

United Healthcare

78

Virginia Premier

81

Complete

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

7 / 7

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

Plan	Value
Aetna	53
Anthem	45
Molina	49.48
Optima	49
United Healthcare	47
Virginia Premier	44

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:

0 - No sanctions entered

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** 52 **Anthem** 39 **Molina** 5 **Optima** 20 **United Healthcare** 14.92 **Virginia Premier** 5
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Aetna** 29 **Anthem** 369 **Molina** 17 **Optima** 81

		United Healthcare 93 **Virginia Premier** 66
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** 0.1:1 **Anthem** 0.7:1 **Molina** 0.2:1 **Optima** 0.3:1 **United Healthcare** 0.5:1 **Virginia Premier** 0.2:1
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Aetna** 12 **Anthem** 77

		Molina 17 **Optima** 88 **United Healthcare** 34 **Virginia Premier** 48
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** 0.1:1 **Anthem** 0.2:1 **Molina** 0.2:1 **Optima** 0.3:1 **United Healthcare** 0.2:1 **Virginia Premier** 0.1:1

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** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Anthem** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Molina** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Optima** 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** 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	**Aetna** 2 **Anthem**

	made during the reporting year.	1 **Molina** 6 **Optima** 25 **United Healthcare** 51 **Virginia Premier** 5
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** 0.01:1 **Anthem** 0.01:1 **Molina** 0.5:1 **Optima** 0.08:1 **United Healthcare** 0.3:1 **Virginia Premier**

0.02:1

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 as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Aetna** N/A **Anthem** N/A **Molina** N/A **Optima** N/A **United Healthcare** N/A **Virginia Premier** N/A
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Aetna** Daily **Anthem** Daily **Molina** Daily **Optima**

Daily

United Healthcare

Daily

Virginia Premier

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
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/Choice Counseling