

Managed Care Program Annual Report (MCPAR) for Virginia: Cardinal Care Managed Care

Due date	Last edited	Edited by	Status
12/27/2025	12/19/2025	sunday Brownson	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected
Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If "No", please complete the following questions under each plan.	No

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.	Sunday Brownson
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	Sunday.Brownson@dmas.virginia.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	sunday Brownson
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	Sunday.brownson@dmas.virginia.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	12/19/2025

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	07/01/2024
A5b	Reporting period end date Auto-populated from report dashboard.	06/30/2025
A6	Program name Auto-populated from report dashboard.	Cardinal Care Managed Care

Add plans (A.7)

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

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


Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. 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 Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

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

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

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

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

Indicator	Response
ILOS name	Aetna
	Anthem
	Molina
	Sentara
	Unitedhealthcare

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	<p data-bbox="313 107 586 176">Statewide Medicaid enrollment</p> <p data-bbox="313 201 724 516">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.</p>	1,951,816
BI.2	<p data-bbox="313 569 724 638">Statewide Medicaid managed care enrollment</p> <p data-bbox="313 663 724 1041">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.</p>	1,738,535

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	<p data-bbox="313 107 618 136">Data validation entity</p> <p data-bbox="313 161 716 695">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.</p>	<p data-bbox="760 107 1114 136">State Medicaid agency staff</p> <p data-bbox="760 180 834 210">EQRO</p> <p data-bbox="760 254 1036 283">Proprietary system(s)</p> <p data-bbox="760 327 1114 357">Other, specify – All vendors</p>
BIII.2	<p data-bbox="313 751 675 865">HIPAA compliance of proprietary system(s) for encounter data validation</p> <p data-bbox="313 888 716 947">Were the system(s) utilized fully HIPAA compliant? Select one.</p>	Yes

Topic X: Program Integrity

Number	Indicator	Response
BX.1	<p data-bbox="313 107 695 180">Payment risks between the state and plans</p> <p data-bbox="313 201 727 865">Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.</p>	<p data-bbox="760 107 1395 2085">PI oversight collaboration between State and MCP: Program Integrity (PI) works closely with our managed care partners to ensure effective oversight. This oversight includes:</p> <ul data-bbox="760 226 1395 2085" style="list-style-type: none"> · Quarterly Reporting: Each quarter, PI issues a comprehensive report capturing 14 key data points: 1. Allegations 2. Investigations 3. Payment Suspensions 4. Automated Reviews 5. COB (Coordination of Benefits) Recovery 6. COB Savings 7. Member PI Issues 8. Service Authorizations 9. Provider Education 10. Provider Screenings 11. Provider Terminations 12. Unsolicited Refunds 13. Appeals 14. Other relevant activities · PI MCO Collaborative: Once per quarter, the DMAS Program Integrity Division (PID) convenes the PI MCO Collaborative. Participants include Managed Care Organizations (MCOs), the Medicaid Fraud Control Unit (MFCU), DMAS stakeholders, and subject matter experts (SMEs). The collaborative serves as a forum to: <ul data-bbox="760 905 1395 2085" style="list-style-type: none"> o Share updates on program integrity oversight efforts within Virginia Medicaid. o Discuss ongoing investigations and emerging industry trends. o Identify aberrant provider behaviors and activities. o Exchange best practices to strengthen PI efforts. Investigations discussed during the collaborative are documented in the MCOs' quarterly reports submitted to DMAS PID. PID monitors these investigations in accordance with the CCMC contract. When necessary, MCOs submit referrals to MFCU for further review. The collaborative also enables MCOs to learn from peers, DMAS, and MFCU about provider schemes and trends warranting closer scrutiny. PI contributes by sharing provider activity insights identified through algorithms in the Fraud abuse detection system (FADS) system. · Fraud Analytics : DMAS PI utilizes fraud and abuse detection technology to data mine large amounts of information across all MCP stored in data warehouses to identify patterns, associations, clusters, outliers, and other red flag phenomena that indicate the presence of possible fraud, waste, and abuse. PID uses Fraud and Abuse Detection System (FADS), developed for DMAS by Optum, is a web-based product suite that employs data mining of provider, member, and claims data to deliver actionable intelligence and provide

investigative leads. FADS aids in preventing erroneous payments, researching inappropriate payments, confidently pursuing suspicious activity, compiling/accessing accurate information, and increasing recoveries. FADS also enables PID to create algorithms, which are custom-designed analytics created for a specific purpose. 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. FADS also has an analytic library that consists of a group of pre-defined analytic reports that have been developed to enable users to research and analyze specific statistics regarding claims dollars paid. The analytic library results are also used for investigating and analyzing the yearly billing patterns of specific providers or MCOs that have been identified from a hot line complaint, algorithm, or peer grouping study. Considering all algorithms and analytic libraries contained in FADS, all Medicaid services are analyzed. · Public Assistance Reporting Information System (PARIS): DMAS participates in the CMS PARIS program to match recipients of public assistance to verify whether they are receiving duplicate Medicaid benefits in other states. Using this tool avoids duplicate payments and minimizes fraud and abuse. Together, these efforts enhance coordination, promote transparency, to combat fraud, waste, and abuse within Medicaid.

BX.2	<p>Contract standard for overpayments</p> <p>Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	State has established a hybrid system
BX.3	<p>Location of contract provision stating overpayment standard</p> <p>Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).</p>	19.3 Treatment of Recoveries
BX.4	<p>Description of overpayment contract standard</p>	19.3 Treatment of Recoveries Generally, the Contractor must be permitted to retain

Briefly describe the overpayment standard selected in indicator B.X.2.

recoveries of overpayments identified through their own monitoring and investigative efforts. However, any overpayments for claims that were paid more than three (3) years prior to the date that the Contractor formally notified the Department of the overpayment will be retained by the Department. In addition, if the Contractor has not recovered an overpayment within one (1) year of being authorized to recovery such overpayment, then the Department is entitled to recoup and retain such overpayment.

BX.5

State overpayment reporting monitoring

Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting?

The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.

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. Member PI Issues 8. Provider Education Savings 9. Provider Screening reviews and denials 10. Providers Terminated 11. Unsolicited Refunds (Provider-identified Overpayments) 12. Appeals 13. 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).

The Department posts an Enrollment Roster to its secure FTP EDI server using the X12 834 HIPAA compliant electronic data interchange (EDI) transaction set. These files will contain full member eligibility data (audit records) for member assignments to the MCOs. The 834 Enrollment Roster provides the MCOs with ongoing information about its active and disenrolled members. Twice a month throughout the term of the Department's contract with the MCOs, the Department posts an enrollment change file to its secure FTP EDI server using the 834 EDI transaction set. These files contain all changes to the MCO's member eligibility data since the last 834 was produced. These changes will include "add" transactions (member is newly enrolled for the MCO), "terminate" transactions (member is disenrolled or dropped from the MCO), and "audit" information (any information that changed for the current member).

BX.7a

Changes in provider circumstances: Monitoring plans

Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.

Yes

BX.7b

Changes in provider circumstances: Metrics

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.

As part of the overall MCO oversight conducted by the Program Integrity Division, the MCOs are required to document in their quarterly reports provider terminations. The provider terminations are documented on the designated tab of the quarterly report. The quarterly report is submitted to the Program Integrity Division for review of the MCOs program integrity efforts. As noted in the MCO contract, any MCO may terminate or suspend participating providers according to the terms described in its agreements with its network providers, including but not limited to "for cause" terminations, such as access, program integrity, or quality of care issues, as well as "not-for-cause" or "at-will" terminations under authority granted by the MCO contract. MCOs should report all providers who were terminated, suspended, or otherwise removed from the provider network. Though DMAS understands that for the MCO's purposes, many providers with terminations related to PI investigative activity are listed as "not-for-cause" or "at-will", DMAS requests that the MCO identify providers whose terminations were associated with PI-related findings for the purposes of the quarterly report.

BX.8a

Federal database checks: Excluded person or entities

During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.

No

BX.9a	Website posting of 5 percent or more ownership control Does the state post on its website the 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 42 CFR 438.602(g)(3) and 455.104.	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, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	https://dmas.virginia.gov/data-reporting/quality-population-health/studies-and-reporting/

Topic XIII. Prior Authorization

⚠ Beginning June 2026, Indicators B.XIII.1a-b-2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026?	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	<p>Program contract</p> <p>Enter the title of the contract between the state and plans participating in the managed care program.</p>	Cardinal Care Managed Care
N/A	<p>Enter the date of the contract between the state and plans participating in the managed care program.</p>	07/01/2024
C11.2	<p>Contract URL</p> <p>Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.</p>	https://www.dmas.virginia.gov/media/jtujhlt/sfy-2026-ccmc-contract-07-01-2025.pdf
C11.3	<p>Program type</p> <p>What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.</p>	Managed Care Organization (MCO)
C11.4a	<p>Special program benefits</p> <p>Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more.</p> <p>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.</p>	<p>Behavioral health</p> <p>Long-term services and supports (LTSS)</p> <p>Transportation</p>
C11.4b	<p>Variation in special benefits</p> <p>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.</p>	n/a
C11.5	<p>Program enrollment</p> <p>Enter the average number of individuals enrolled in this managed care program per</p>	1,738,535

month during the reporting year (i.e., average member months).

C11.6

Changes to enrollment or benefits

Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during the reporting year" as your response. "N/A" is not an acceptable response.

There were no major changes to the population or benefits during the reporting year."

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	<p data-bbox="313 107 634 136">Uses of encounter data</p> <p data-bbox="313 163 695 317">For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.</p> <p data-bbox="313 323 727 569">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)).</p>	<p data-bbox="760 107 911 136">Rate setting</p> <p data-bbox="760 180 1219 210">Quality/performance measurement</p> <p data-bbox="760 254 1089 283">Monitoring and reporting</p> <p data-bbox="760 327 997 357">Contract oversight</p> <p data-bbox="760 401 987 430">Program integrity</p> <p data-bbox="760 474 1219 504">Policy making and decision support</p> <p data-bbox="760 548 1203 577">Other, specify – Pharmacy rebates</p>
C1III.2	<p data-bbox="313 657 691 728">Criteria/measures to evaluate MCP performance</p> <p data-bbox="313 751 727 938">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.</p> <p data-bbox="313 945 727 1255">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).</p>	<p data-bbox="760 657 1349 968">Other, specify – Cardinal Care uses a Data Quality Scorecard (DQSC) to evaluate each MCO's performance in encounter data submission. The scorecard measures the completeness and reliability of payment cycle data, verifies certification, and assesses the timeliness, accuracy, and reasonableness of reported payments.</p>
C1III.3	<p data-bbox="313 1310 716 1381">Encounter data performance criteria contract language</p> <p data-bbox="313 1407 727 1688">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 references, not page numbers.</p>	<p data-bbox="760 1310 1349 1339">Section 11, Information Management Systems</p>
C1III.4	<p data-bbox="313 1743 699 1814">Financial penalties contract language</p> <p data-bbox="313 1839 727 2055">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</p>	<p data-bbox="760 1743 1057 1772">Section 17. OVERSIGHT</p>

standards. Use contract section references, not page numbers.

C1III.5 Incentives for encounter data quality MCO rates are based on the encounter data, this increasing commitment to data quality and completeness

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.

C1III.6 Barriers to collecting/validating encounter data The state did not experience any barriers to collecting or validating encounter data during the reporting year

Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	<p data-bbox="313 107 699 258">State’s definition of “critical incident”, as used for reporting purposes in its MLTSS program</p> <p data-bbox="313 279 727 562">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.</p>	<p data-bbox="760 107 1365 373">A critical incident is any incident that threatens or impacts the well-being of the Member. Critical incidents shall include, but are not limited to, the following incidents: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death of a Member.</p>
C1IV.2	<p data-bbox="313 615 686 730">State definition of “timely” resolution for standard appeals</p> <p data-bbox="313 751 727 1098">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.</p>	<p data-bbox="760 615 1365 772">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.</p>
C1IV.3	<p data-bbox="313 1150 686 1266">State definition of “timely” resolution for expedited appeals</p> <p data-bbox="313 1287 727 1633">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.</p>	<p data-bbox="760 1150 1365 1224">Within 72 hours from the initial receipt of the appeal.</p>

C1IV.4 State definition of “timely” resolution for grievances

Provide the state’s definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.

As expeditiously as the Member’s health condition requires, within state established timeframes not to exceed ninety (90) calendar days from the date the Contractor receives the grievance in a format and language that meets, at a minimum, the standards described in 42 CFR § 438.10.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	Gaps/challenges in network adequacy What are the state’s biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter “No challenges were encountered” as your response. “N/A” is not an acceptable response.	Major challenges include meeting network adequacy distance standards in areas that lack specific/critical provider types, in rural areas especially. Workforce adequacy is a challenge in Virginia, as it is in many other states.
C1V.2	State response to gaps in network adequacy How does the state work with MCPs to address gaps in network adequacy?	DMAS continues to work with MCOs to provide continuous education and technical assistance to ensure compliance with network adequacy standards. We are also exploring telehealth options to expand access.

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.



Complete

C2.V.3 Standard type: Maximum time or distance

1 / 31

C2.V.2 Measure standard

1 provider within 15 miles of every member

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Metro

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

2 / 31

C2.V.2 Measure standard

1 provider within 15 miles of every member

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

3 / 31

C2.V.2 Measure standard

1 provider for every member

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Hospital

C2.V.5 Region

Metro

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

4 / 31

C2.V.2 Measure standard

1 provider for every member

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Hospital

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

5 / 31

C2.V.2 Measure standard

No more than 5 business days after coverage criteria is met

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health

C2.V.5 Region

Metro

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

6 / 31

C2.V.2 Measure standard

No more than 5 business days after coverage criteria is met

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

7 / 31

C2.V.2 Measure standard

No more than 5 business days after coverage criteria is met

C2.V.1 General category

LTSS-related standard: provider travels to the enrollee

C2.V.4 Provider

LTSS

C2.V.5 Region

Metro

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



C2.V.3 Standard type: Appointment wait time

8 / 31

C2.V.2 Measure standard

No more than 5 business days after coverage criteria is met

C2.V.1 General category

LTSS-related standard: provider travels to the enrollee

C2.V.4 Provider

LTSS

C2.V.5 Region

Rural

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



C2.V.3 Standard type: Minimum number of network providers

9 / 31

C2.V.2 Measure standard

1 provider for every member

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care: Urgent
care

C2.V.5 Region

Metro

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



C2.V.3 Standard type: Minimum number of network providers

10 / 31

C2.V.2 Measure standard

1 provider for every member

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care: urgent care

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

11 / 31

C2.V.2 Measure standard

Emergency Appt-Made Immediately upon request. Follow-up services made within 24 hours of notification.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Emergency
Services/Crisis
Services

C2.V.5 Region

metro and rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

12 / 31

C2.V.2 Measure standard

Within 30 days of Member's request

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Metro

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

13 / 31

C2.V.2 Measure standard

Within 30 days of Member's request

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

14 / 31

C2.V.2 Measure standard

"Within 7 calendar days for 1st and 2nd trimester Within 3 business days for 3rd trimester and High Risk Pregnancy "

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Metro

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

15 / 31

C2.V.2 Measure standard

"Within 7 calendar days for 1st and 2nd trimester Within 3 business days for 3rd trimester and High Risk Pregnancy "

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Rural

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum distance to travel

16 / 31

C2.V.2 Measure standard

1 provider within 15 miles of every member

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 ProviderPrimary care:
pediatrician**C2.V.5 Region**

Metro

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum distance to travel

17 / 31

C2.V.2 Measure standard

1 provider within 30 miles of every member

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
pediatrician

C2.V.5 Region

Rural

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Provider to enrollee ratios

18 / 31

C2.V.2 Measure standard

At least one (1) full time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping, Custom method - Measured by the External Quality Reviewer as part of the Network Adequacy Validation Report

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Provider to enrollee ratios

19 / 31

C2.V.2 Measure standard

At least one (1) FTE pediatric PCP for every 1,500 Members under the age of eighteen (18).

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
pediatric

C2.V.5 Region

Statewide

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping, Custom method - Measured by the External Quality Reviewer as part of the Network Adequacy Validation Report

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Minimum number of network providers

20 / 31

C2.V.2 Measure standard

At least two (2) Providers for each type of service in each Cardinal Care locality

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

21 / 31

C2.V.2 Measure standard

At least two (2) Providers for each type of service in each Cardinal Care locality

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care: doula

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

22 / 31

C2.V.2 Measure standard

At least two (2) Providers for each type of service in each Cardinal Care locality

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care: home health

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

23 / 31

C2.V.2 Measure standard

At least two (2) Providers for each type of service in each Cardinal Care locality

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

LTSS

C2.V.5 Region

Statewide

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

24 / 31

C2.V.2 Measure standard

At least two (2) Providers for each type of service in each Cardinal Care locality

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

LTSS

C2.V.5 Region

Statewide

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

25 / 31

C2.V.2 Measure standard

At least two (2) Providers for each type of service in each Cardinal Care locality

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

LTSS

C2.V.5 Region

Statewide

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

26 / 31

C2.V.2 Measure standard

At least two (2) Providers for each type of service in each Cardinal Care locality

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health: "MHS
– Except for Mental
Health Case
Management, which
is provided by the
local Community
Services Board and
is exempt from the
two (2) Provider
requirement"

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

27 / 31

C2.V.2 Measure standard

At least one (1) Provider for each type of service in each Cardinal Care locality

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

C2.V.5 Region

C2.V.6 Population

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

28 / 31

C2.V.2 Measure standard

At least one (1) Provider for each type of service in each Cardinal Care locality

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

LTSS

C2.V.5 Region

Statewide

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

29 / 31

C2.V.2 Measure standard

At least one (1) Provider for each type of service in each Cardinal Care locality

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care: DME
Supplies

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum distance to travel

30 / 31

C2.V.2 Measure standard

1 provider within 15 miles of every member

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral health

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum distance to travel

31 / 31

C2.V.2 Measure standard

1 provider within 30 miles of every member

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health

C2.V.5 Region

Metro

C2.V.6 Population

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

Topic X: Program Integrity

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

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	<p>Does this program include MCOs?</p> <p>If “Yes”, please complete the following questions.</p>	Yes
C1XII.5	<p>Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?</p> <p>(i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)</p>	No
C1XII.6	<p>Did the State or MCOs complete the most recent parity analysis(es)?</p>	State
C1XII.7a	<p>Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?</p> <p>(e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)</p>	No
C1XII.8	<p>When was the last parity analysis(es) for this program completed?</p> <p>States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).</p>	01/10/2020
C1XII.9	<p>When was the last parity analysis(es) for this program</p>	01/10/2020

submitted to CMS?

States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).

C1XII.10a	In the last analysis(es) conducted, were any deficiencies identified?	No
<hr/>		
C1XII.12a	Has the state posted the current parity analysis(es) covering this program on its website?	Yes
	<p>The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.</p>	
<hr/>		
C1XII.12b	Provide the URL link(s). <p>Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.</p>	https://dmas.virginia.gov/data-reporting/programs-services/behavioral-health/

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D11.1	<p>Plan enrollment</p> <p>Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).</p>	<p>Aetna Better Health of Virginia 259,101</p> <p>Anthem Healthkeepers Plus 531,815</p> <p>Molina Healthcare 126,375</p> <p>Sentara Community Plan 594,532</p> <p>United Healthcare Community PLaN 226,996</p>
D11.2	<p>Plan share of Medicaid</p> <p>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)</p>	<p>Aetna Better Health of Virginia 13.3%</p> <p>Anthem Healthkeepers Plus 27.2%</p> <p>Molina Healthcare 6.5%</p> <p>Sentara Community Plan 30.5%</p> <p>United Healthcare Community PLaN 11.6%</p>
D11.3	<p>Plan share of any Medicaid managed care</p> <p>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)</p>	<p>Aetna Better Health of Virginia 14.9%</p> <p>Anthem Healthkeepers Plus 30.6%</p> <p>Molina Healthcare 7.3%</p> <p>Sentara Community Plan 34.2%</p>

**United Healthcare Community
PLan**

13.1%

D11.4: Parent

Organization: The name of the parent entity that controls the Medicaid Managed Care Plan.

If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.

Aetna Better Health of Virginia
cvs health,inc

Anthem Healthkeepers Plus
elevance health

Molina Healthcare
Molina Healthcare,inc

Sentara Community Plan
Sentara Health

**United Healthcare Community
PLan**
United Health group

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	<p>Medical Loss Ratio (MLR)</p> <p>What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.</p>	<p>Aetna Better Health of Virginia 94.3%</p> <p>Anthem Healthkeepers Plus 94.1%</p> <p>Molina Healthcare 91.1%</p> <p>Sentara Community Plan 97.3%</p> <p>United Healthcare Community PPlan 94%</p>
D1II.1b	<p>Level of aggregation</p> <p>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.</p>	<p>Aetna Better Health of Virginia Statewide all programs & populations</p> <p>Anthem Healthkeepers Plus Statewide all programs & populations</p> <p>Molina Healthcare Statewide all programs & populations</p> <p>Sentara Community Plan Statewide all programs & populations</p> <p>United Healthcare Community PPlan Statewide all programs & populations</p>
D1II.2	<p>Population specific MLR description</p> <p>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.</p>	<p>Aetna Better Health of Virginia n/a</p> <p>Anthem Healthkeepers Plus n/a</p> <p>Molina Healthcare n/a</p>

See glossary for the regulatory definition of MLR.

Sentara Community Plan

n/a

United Healthcare Community Plan

n/a

D1II.3

MLR reporting period discrepancies

Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?

Aetna Better Health of Virginia

No

Anthem Healthkeepers Plus

No

Molina Healthcare

No

Sentara Community Plan

No

United Healthcare Community Plan

No

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	<p data-bbox="310 100 708 174">Definition of timely encounter data submissions</p> <p data-bbox="310 195 708 453">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.</p>	<p data-bbox="813 128 1243 163">Aetna Better Health of Virginia</p> <p data-bbox="813 184 1377 499">Measure Unit: Each encounter submitted to EPS within forty-five calendar days of the end of the quarter with a ‘passed’ validation status and a payment date between the first day and last day of quarter with a ‘passed’ validation status and a payment date between the first day and last day of the quarter</p> <p data-bbox="813 533 1203 569">Anthem Healthkeepers Plus</p> <p data-bbox="813 590 1377 905">Measure Unit: Each encounter submitted to EPS within forty-five calendar days of the end of the quarter with a ‘passed’ validation status and a payment date between the first day and last day of quarter with a ‘passed’ validation status and a payment date between the first day and last day of the quarter</p> <p data-bbox="813 938 1073 974">Molina Healthcare</p> <p data-bbox="813 995 1377 1310">Measure Unit: Each encounter submitted to EPS within forty-five calendar days of the end of the quarter with a ‘passed’ validation status and a payment date between the first day and last day of quarter with a ‘passed’ validation status and a payment date between the first day and last day of the quarter</p> <p data-bbox="813 1344 1162 1379">Sentara Community Plan</p> <p data-bbox="813 1400 1377 1715">Measure Unit: Each encounter submitted to EPS within forty-five calendar days of the end of the quarter with a ‘passed’ validation status and a payment date between the first day and last day of quarter with a ‘passed’ validation status and a payment date between the first day and last day of the quarter</p> <p data-bbox="813 1749 1317 1785">United Healthcare Community PLaN</p> <p data-bbox="813 1806 1377 2032">Measure Unit: Each encounter submitted to EPS within forty-five calendar days of the end of the quarter with a ‘passed’ validation status and a payment date between the first day and last day of quarter with a ‘passed’ validation status</p>

and a payment date between the first day and last day of the quarter

D1III.2	Share of encounter data submissions that met state's timely submission requirements	Aetna Better Health of Virginia
		99%
		Anthem Healthkeepers Plus
		99.59%
		Molina Healthcare
		99.26%
		Sentara Community Plan
		88.87%
		United Healthcare Community Plan
		98.61%

D1III.3	Share of encounter data submissions that were HIPAA compliant	Aetna Better Health of Virginia
		100%
		Anthem Healthkeepers Plus
		100%
		Molina Healthcare
		100%
		Sentara Community Plan
		100%
		United Healthcare Community Plan
		100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	<p data-bbox="313 107 716 180">Appeals resolved (at the plan level)</p> <p data-bbox="313 201 716 642">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.</p>	<p data-bbox="813 138 1317 222">Aetna Better Health of Virginia 1,675</p> <p data-bbox="813 264 1317 348">Anthem Healthkeepers Plus 6,417</p> <p data-bbox="813 390 1317 474">Molina Healthcare 2,347</p> <p data-bbox="813 516 1317 600">Sentara Community Plan 6,806</p> <p data-bbox="813 642 1317 720">United Healthcare Community PLaN 883</p>
D1IV.1a	<p data-bbox="313 779 699 806">Appeals denied</p> <p data-bbox="313 831 699 989">Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.</p>	<p data-bbox="813 810 1317 894">Aetna Better Health of Virginia 1,084</p> <p data-bbox="813 936 1317 1020">Anthem Healthkeepers Plus 4,041</p> <p data-bbox="813 1062 1317 1146">Molina Healthcare 1,479</p> <p data-bbox="813 1188 1317 1272">Sentara Community Plan 3,314</p> <p data-bbox="813 1314 1317 1392">United Healthcare Community PLaN 458</p>
D1IV.1b	<p data-bbox="313 1451 699 1524">Appeals resolved in partial favor of enrollee</p> <p data-bbox="313 1545 699 1671">Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.</p>	<p data-bbox="813 1482 1317 1566">Aetna Better Health of Virginia 32</p> <p data-bbox="813 1608 1317 1692">Anthem Healthkeepers Plus 254</p> <p data-bbox="813 1734 1317 1818">Molina Healthcare 84</p> <p data-bbox="813 1860 1317 1944">Sentara Community Plan 222</p> <p data-bbox="813 1986 1317 2064">United Healthcare Community PLaN 7</p>

D1IV.1c Appeals resolved in favor of enrollee

Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.

Aetna Better Health of Virginia

559

Anthem Healthkeepers Plus

2,122

Molina Healthcare

784

Sentara Community Plan

3,270

United Healthcare Community Plan

418

D1IV.2 Active appeals

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

Aetna Better Health of Virginia

149

Anthem Healthkeepers Plus

816

Molina Healthcare

65

Sentara Community Plan

201

United Healthcare Community Plan

89

D1IV.3 Appeals filed on behalf of LTSS users

Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

Aetna Better Health of Virginia

98

Anthem Healthkeepers Plus

297

Molina Healthcare

181

Sentara Community Plan

831

United Healthcare Community Plan

125

D1IV.4**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal**

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

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare

0

Sentara Community Plan

5

United Healthcare Community Plan

4

D1IV.5a	Standard appeals for which timely resolution was provided	Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	Aetna Better Health of Virginia
			1,604
			Anthem Healthkeepers Plus
			5,798
			Molina Healthcare
			Sentara Community Plan
			2,130
			United Healthcare Community Plan
			6,097
			599

D1IV.5b	Expedited appeals for which timely resolution was provided	Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	Aetna Better Health of Virginia
			69
			Anthem Healthkeepers Plus
			602
			Molina Healthcare
			Sentara Community Plan
			217
			United Healthcare Community Plan
			425
			264

D1IV.6a	Resolved appeals related to denial of authorization or limited authorization of a service	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	Aetna Better Health of Virginia
			1,669
			Anthem Healthkeepers Plus
			6,371
			Molina Healthcare
			Sentara Community Plan
			2,002
			United Healthcare Community Plan
			4,555
			862

D1IV.6b Resolved appeals related to reduction, suspension, or termination of a previously authorized service

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.

Aetna Better Health of Virginia

4

Anthem Healthkeepers Plus

2,761

Molina Healthcare

121

Sentara Community Plan

1

United Healthcare Community PLAN

21

D1IV.6c Resolved appeals related to payment denial

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

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

3,091

Molina Healthcare

222

Sentara Community Plan

2,250

United Healthcare Community PLAN

0

D1IV.6d Resolved appeals related to service timeliness

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare

0

Sentara Community Plan

0

United Healthcare Community PLAN

0

D1IV.6e **Resolved appeals related to lack of timely plan response to an appeal or grievance**

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

Aetna Better Health of Virginia

2

Anthem Healthkeepers Plus

398

Molina Healthcare

2

Sentara Community Plan

0

United Healthcare Community Plan

0

D1IV.6f **Resolved appeals related to plan denial of an enrollee's right to request out-of-network care**

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

Aetna Better Health of Virginia

53

Anthem Healthkeepers Plus

213

Molina Healthcare

0

Sentara Community Plan

0

United Healthcare Community Plan

0

D1IV.6g **Resolved appeals related to denial of an enrollee's request to dispute financial liability**

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

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare

0

Sentara Community Plan

0

United Healthcare Community Plan

0

Appeals by Service

Number of appeals resolved during the reporting period related to various services.

Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	<p>Resolved appeals related to general inpatient services</p> <p>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”.</p>	<p>Aetna Better Health of Virginia 51</p> <p>Anthem Healthkeepers Plus 1,634</p> <p>Molina Healthcare 118</p> <p>Sentara Community Plan 606</p> <p>United Healthcare Community Plan 25</p>
D1IV.7b	<p>Resolved appeals related to general outpatient services</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). 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”.</p>	<p>Aetna Better Health of Virginia 1,519</p> <p>Anthem Healthkeepers Plus 1,773</p> <p>Molina Healthcare 68</p> <p>Sentara Community Plan 1,908</p> <p>United Healthcare Community Plan 169</p>
D1IV.7c	<p>Resolved appeals related to inpatient behavioral health services</p> <p>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”.</p>	<p>Aetna Better Health of Virginia 8</p> <p>Anthem Healthkeepers Plus 88</p> <p>Molina Healthcare 346</p> <p>Sentara Community Plan 25</p> <p>United Healthcare Community Plan 7</p>

D1IV.7d**Resolved appeals related to outpatient behavioral health services**

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

Aetna Better Health of Virginia

97

Anthem Healthkeepers Plus

296

Molina Healthcare

239

Sentara Community Plan

1,147

United Healthcare Community Plan

14

D1IV.7e**Resolved appeals related to covered outpatient prescription drugs**

Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".

Aetna Better Health of Virginia

741

Anthem Healthkeepers Plus

1,475

Molina Healthcare

23

Sentara Community Plan

2,554

United Healthcare Community Plan

536

D1IV.7f**Resolved appeals related to skilled nursing facility (SNF) services**

Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

6

Molina Healthcare

6

Sentara Community Plan

10

United Healthcare Community Plan

2

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".(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

Aetna Better Health of Virginia

82

Anthem Healthkeepers Plus

92

Molina Healthcare

235

Sentara Community Plan

393

United Healthcare Community PLan

15

D1IV.7h**Resolved appeals related to dental services**

Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".

Aetna Better Health of Virginia

1

Anthem Healthkeepers Plus

6

Molina Healthcare

0

Sentara Community Plan

3

United Healthcare Community PLan

0

D1IV.7i**Resolved appeals related to non-emergency medical transportation (NEMT)**

Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".

Aetna Better Health of Virginia

741

Anthem Healthkeepers Plus

1

Molina Healthcare

38

Sentara Community Plan

0

United Healthcare Community PLan

0

D1IV.7k: Resolved appeals related to durable medical equipment (DME) & supplies

Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of Virginia

285

Anthem Healthkeepers Plus

421

Molina Healthcare

70

Sentara Community Plan

414

United Healthcare Community Plan

97

D1IV.7l: Resolved appeals related to home health / hospice

Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of Virginia

82

Anthem Healthkeepers Plus

65

Molina Healthcare

63

Sentara Community Plan

15

United Healthcare Community Plan

16

D1IV.7m: Resolved appeals related to emergency services / emergency department

Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare

72

Sentara Community Plan

192

United Healthcare Community Plan

0

D1IV.7n: Resolved appeals related to therapies

Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of Virginia

47

Anthem Healthkeepers Plus

223

Molina Healthcare

14

Sentara Community Plan

45

United Healthcare Community PLan

0

D1IV.7o 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-n paid primarily by Medicaid, enter "N/A".

Aetna Better Health of Virginia

518

Anthem Healthkeepers Plus

1,997

Molina Healthcare

5

Sentara Community Plan

220

United Healthcare Community PLan

2

State Fair Hearings

Number	Indicator	Response
D1IV.8a	<p data-bbox="313 107 691 134">State Fair Hearing requests</p> <p data-bbox="313 161 721 317">Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.</p>	<p data-bbox="813 138 1243 165">Aetna Better Health of Virginia</p> <p data-bbox="813 193 841 220">11</p> <p data-bbox="813 262 1203 289">Anthem Healthkeepers Plus</p> <p data-bbox="813 317 862 344">126</p> <p data-bbox="813 386 1070 413">Molina Healthcare</p> <p data-bbox="813 441 846 468">33</p> <p data-bbox="813 510 1162 537">Sentara Community Plan</p> <p data-bbox="813 564 846 592">30</p> <p data-bbox="813 634 1317 661">United Healthcare Community PPlan</p> <p data-bbox="813 688 846 716">26</p>
D1IV.8b	<p data-bbox="313 779 711 890">State Fair Hearings resulting in a favorable decision for the enrollee</p> <p data-bbox="313 917 721 1066">Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.</p>	<p data-bbox="813 810 1243 837">Aetna Better Health of Virginia</p> <p data-bbox="813 865 829 892">0</p> <p data-bbox="813 934 1203 961">Anthem Healthkeepers Plus</p> <p data-bbox="813 989 846 1016">43</p> <p data-bbox="813 1058 1070 1085">Molina Healthcare</p> <p data-bbox="813 1113 829 1140">2</p> <p data-bbox="813 1182 1162 1209">Sentara Community Plan</p> <p data-bbox="813 1236 846 1264">10</p> <p data-bbox="813 1306 1317 1333">United Healthcare Community PPlan</p> <p data-bbox="813 1360 846 1388">13</p>
D1IV.8c	<p data-bbox="313 1451 721 1562">State Fair Hearings resulting in an adverse decision for the enrollee</p> <p data-bbox="313 1589 721 1709">Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.</p>	<p data-bbox="813 1482 1243 1509">Aetna Better Health of Virginia</p> <p data-bbox="813 1537 841 1564">11</p> <p data-bbox="813 1606 1203 1633">Anthem Healthkeepers Plus</p> <p data-bbox="813 1661 846 1688">37</p> <p data-bbox="813 1730 1070 1757">Molina Healthcare</p> <p data-bbox="813 1785 846 1812">18</p> <p data-bbox="813 1854 1162 1881">Sentara Community Plan</p> <p data-bbox="813 1908 846 1936">15</p> <p data-bbox="813 1978 1317 2005">United Healthcare Community PPlan</p> <p data-bbox="813 2032 829 2060">9</p>

D1IV.8d**State Fair Hearings retracted prior to reaching a decision**

Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

23

Molina Healthcare

5

Sentara Community Plan

0

United Healthcare Community PLAN

4

D1IV.9a**External Medical Reviews resulting in a favorable decision for the enrollee**

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

Aetna Better Health of Virginia

na

Anthem Healthkeepers Plus

na

Molina Healthcare

na

Sentara Community Plan

na

United Healthcare Community PLAN

n/a

D1IV.9b**External Medical Reviews resulting in an adverse decision for the enrollee**

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

Aetna Better Health of Virginia

na

Anthem Healthkeepers Plus

na

Molina Healthcare

na

Sentara Community Plan

na

United Healthcare Community PLAN

n/a

Grievances Overview

Number	Indicator	Response
D1IV.10	<p>Grievances resolved</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. A grievance is “resolved” when it has reached completion and been closed by the plan.</p>	<p>Aetna Better Health of Virginia 3,756</p> <p>Anthem Healthkeepers Plus 4,234</p> <p>Molina Healthcare 4,888</p> <p>Sentara Community Plan 756</p> <p>United Healthcare Community PLAN 1,680</p>
D1IV.11	<p>Active grievances</p> <p>Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.</p>	<p>Aetna Better Health of Virginia 730</p> <p>Anthem Healthkeepers Plus 597</p> <p>Molina Healthcare 204</p> <p>Sentara Community Plan 20</p> <p>United Healthcare Community PLAN 610</p>
D1IV.12	<p>Grievances filed on behalf of LTSS users</p> <p>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.</p>	<p>Aetna Better Health of Virginia 14</p> <p>Anthem Healthkeepers Plus 684</p> <p>Molina Healthcare 208</p> <p>Sentara Community Plan 45</p> <p>United Healthcare Community PLAN 353</p>

D1IV.13**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance**

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

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare

17

Sentara Community Plan

2

United Healthcare Community Plan

20

D1IV.14**Number of grievances for which timely resolution was provided**

Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements

Aetna Better Health of Virginia

3,756

Anthem Healthkeepers Plus

4,199

Molina Healthcare

related to the timely resolution
of grievances.

4,874

Sentara Community Plan

751

United Healthcare Community Plan

1,664

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	<p>Resolved grievances related to general inpatient services</p> <p>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”.</p>	<p>Aetna Better Health of Virginia 336</p> <p>Anthem Healthkeepers Plus 0</p> <p>Molina Healthcare 23</p> <p>Sentara Community Plan 49</p> <p>United Healthcare Community Plan 9</p>
D1IV.15b	<p>Resolved grievances related to general outpatient services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). 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”.</p>	<p>Aetna Better Health of Virginia 3,416</p> <p>Anthem Healthkeepers Plus 3</p> <p>Molina Healthcare 19</p> <p>Sentara Community Plan 360</p> <p>United Healthcare Community Plan 636</p>

<p>D1IV.15c</p>	<p>Resolved grievances related to inpatient behavioral health services</p> <p>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".</p>	<p>Aetna Better Health of Virginia</p> <p>0</p> <p>Anthem Healthkeepers Plus</p> <p>0</p> <p>Molina Healthcare</p> <p>49</p> <p>Sentara Community Plan</p> <p>3</p> <p>United Healthcare Community Plan</p> <p>2</p>
<p>D1IV.15d</p>	<p>Resolved grievances related to outpatient behavioral health services</p> <p>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".</p>	<p>Aetna Better Health of Virginia</p> <p>4</p> <p>Anthem Healthkeepers Plus</p> <p>0</p> <p>Molina Healthcare</p> <p>67</p> <p>Sentara Community Plan</p> <p>23</p> <p>United Healthcare Community Plan</p> <p>5</p>
<p>D1IV.15e</p>	<p>Resolved grievances related to coverage of outpatient prescription drugs</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>Aetna Better Health of Virginia</p> <p>29</p> <p>Anthem Healthkeepers Plus</p> <p>22</p> <p>Molina Healthcare</p> <p>911</p> <p>Sentara Community Plan</p> <p>40</p> <p>United Healthcare Community Plan</p> <p>28</p>

<p>D1IV.15f</p>	<p>Resolved grievances related to skilled nursing facility (SNF) services</p> <p>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".</p>	<p>Aetna Better Health of Virginia</p> <p>0</p> <p>Anthem Healthkeepers Plus</p> <p>0</p> <p>Molina Healthcare</p> <p>17</p> <p>Sentara Community Plan</p> <p>4</p> <p>United Healthcare Community PLAN</p> <p>1</p>
<p>D1IV.15g</p>	<p>Resolved grievances related to long-term services and supports (LTSS)</p> <p>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".</p>	<p>Aetna Better Health of Virginia</p> <p>9</p> <p>Anthem Healthkeepers Plus</p> <p>7</p> <p>Molina Healthcare</p> <p>205</p> <p>Sentara Community Plan</p> <p>5</p> <p>United Healthcare Community PLAN</p> <p>0</p>
<p>D1IV.15h</p>	<p>Resolved grievances related to dental services</p> <p>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".</p>	<p>Aetna Better Health of Virginia</p> <p>31</p> <p>Anthem Healthkeepers Plus</p> <p>0</p> <p>Molina Healthcare</p> <p>74</p> <p>Sentara Community Plan</p> <p>2</p> <p>United Healthcare Community PLAN</p> <p>6</p>

<p>D1IV.15i</p> <p>Resolved grievances related to non-emergency medical transportation (NEMT)</p> <p>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".</p>		<p>Aetna Better Health of Virginia</p> <p>1,246</p> <p>Anthem Healthkeepers Plus</p> <p>852</p> <p>Molina Healthcare</p> <p>762</p> <p>Sentara Community Plan</p> <p>13</p> <p>United Healthcare Community PLAN</p> <p>911</p>
<p>D1IV.15k</p> <p>Resolved grievances related to durable medical equipment (DME) & supplies</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".</p>		<p>Aetna Better Health of Virginia</p> <p>11</p> <p>Anthem Healthkeepers Plus</p> <p>102</p> <p>Molina Healthcare</p> <p>103</p> <p>Sentara Community Plan</p> <p>26</p> <p>United Healthcare Community PLAN</p> <p>4</p>
<p>D1IV.15l</p> <p>Resolved grievances related to home health / hospice</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".</p>		<p>Aetna Better Health of Virginia</p> <p>9</p> <p>Anthem Healthkeepers Plus</p> <p>0</p> <p>Molina Healthcare</p> <p>132</p> <p>Sentara Community Plan</p> <p>1</p> <p>United Healthcare Community PLAN</p> <p>1</p>

D1IV.15m	Resolved grievances related to emergency services / emergency department	Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	Aetna Better Health of Virginia
			4
			Anthem Healthkeepers Plus
			0
			Molina Healthcare
			Sentara Community Plan
			33
			United Healthcare Community Plan
			6

D1IV.15n	Resolved grievances related to therapies	Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".	Aetna Better Health of Virginia
			2
			Anthem Healthkeepers Plus
			29
			Molina Healthcare
			Sentara Community Plan
			9
			United Healthcare Community Plan
			0

D1IV.15o	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-n paid primarily by Medicaid, enter "N/A".	Aetna Better Health of Virginia
			2,424
			Anthem Healthkeepers Plus
			4,056
			Molina Healthcare
			Sentara Community Plan
			57
			United Healthcare Community Plan
			207
			United Healthcare Community Plan
			71

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	<p>Resolved grievances related to plan or provider customer service</p> <p>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.</p>	<p>Aetna Better Health of Virginia 1,376</p> <p>Anthem Healthkeepers Plus 200</p> <p>Molina Healthcare 22</p> <p>Sentara Community Plan 281</p> <p>United Healthcare Community Plan 130</p>
D1IV.16b	<p>Resolved grievances related to plan or provider care management/case management</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.</p>	<p>Aetna Better Health of Virginia 0</p> <p>Anthem Healthkeepers Plus 39</p> <p>Molina Healthcare 87</p> <p>Sentara Community Plan 17</p> <p>United Healthcare Community Plan 76</p>
D1IV.16c	<p>Resolved grievances related to network adequacy or access to care/services from plan or provider</p> <p>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.</p>	<p>Aetna Better Health of Virginia 0</p> <p>Anthem Healthkeepers Plus 603</p> <p>Molina Healthcare 1,706</p> <p>Sentara Community Plan 78</p>

D1IV.16d

Resolved grievances related to quality of care

Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

908

Molina Healthcare

102

Sentara Community Plan

183

**United Healthcare Community
PLan**

233

D1IV.16e

Resolved grievances related to plan communications

Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.

Aetna Better Health of Virginia

2

Anthem Healthkeepers Plus

79

Molina Healthcare

272

Sentara Community Plan

53

**United Healthcare Community
PLan**

677

D1IV.16f

Resolved grievances related to payment or billing issues

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.

Aetna Better Health of Virginia

2,147

Anthem Healthkeepers Plus

1,060

Molina Healthcare

909

Sentara Community Plan

**United Healthcare Community
PLan**

73

**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 perpetrated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

55

Molina Healthcare

30

Sentara Community Plan

4

**United Healthcare Community
PLan**

0

**D1IV.16h Resolved grievances related to
abuse, neglect or exploitation**

Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare

0

Sentara Community Plan

8

**United Healthcare Community
PLan**

0

**D1IV.16i Resolved grievances related to lack
of timely plan response to a prior
authorization/service authorization
or appeal (including requests to
expedite or extend appeals)**

Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

0

Molina Healthcare

15

(including requests to expedite or extend appeals).

Sentara Community Plan

0

United Healthcare Community Plan

0

D1IV.16j

Resolved grievances related to plan denial of expedited appeal

Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

4

Molina Healthcare

0

Sentara Community Plan

1

United Healthcare Community Plan

0

D1IV.16k

Resolved grievances filed for other reasons

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.

Aetna Better Health of Virginia

0

Anthem Healthkeepers Plus

114

Molina Healthcare

172

Sentara Community Plan

53

United Healthcare Community Plan

65

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.



Complete

D2.VII.1 Measure Name: Primary care access and preventive care

1 / 7

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

48.70

Anthem Healthkeepers Plus

55.60

Molina Healthcare

44.60

Sentara Community Plan

47.10

United Healthcare Community PPlan

55.60



Complete

D2.VII.1 Measure Name: Maternal and perinatal health

2 / 7

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

75.70

Anthem Healthkeepers Plus

70.30

Molina Healthcare

68.40

Sentara Community Plan

71.70

United Healthcare Community Plan

83.00



Complete

D2.VII.1 Measure Name: Care of acute and chronic conditions

3 / 7

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

75.00

Anthem Healthkeepers Plus

72.90

Molina Healthcare

73.60

Sentara Community Plan

75.10

United Healthcare Community PPlan

67.40



Complete

D2.VII.1 Measure Name: Behavioral health care

4 / 7

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

37.30

Anthem Healthkeepers Plus

40.30

Molina Healthcare

34.90

Sentara Community Plan

39.30

United Healthcare Community PLaN

35.60



Complete

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

5 / 7

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of Virginia

77.20

Anthem Healthkeepers Plus

81.09

Molina Healthcare

81.72

Sentara Community Plan

78.13

United Healthcare Community PLaN

74.02



Complete

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

6 / 7

D2.VII.2 Measure Domain

Long-term services and supports

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

2800

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

n/a

Measure results

Aetna Better Health of Virginia

39.60

Anthem Healthkeepers Plus

31.40

Molina Healthcare

40.10

Sentara Community Plan

35.50

United Healthcare Community PLaN



Complete

D2.VII.1 Measure Name: Ambulatory Care—Emergency Department Visits/1000 MY (total)

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health of Virginia**

744.9

Anthem Healthkeepers Plus

674.3

Molina Healthcare

698.4

Sentara Community Plan

680.2

United Healthcare Community PPlan

698.5

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. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

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.



Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 44

D3.VIII.2 Plan performance issue

Inappropriate Waiver Enrollment

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Waiver enrollment without valid screening

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$25,000

D3.VIII.7 Date assessed

07/01/2024

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

Yes, remediated 07/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Liquidated damages

2 / 44

D3.VIII.2 Plan performance issue

Inappropriate Waiver Enrollment

D3.VIII.3 Plan name

United Healthcare Community PPlan

D3.VIII.4 Reason for intervention

Waiver enrollment without valid screening

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$25,000

D3.VIII.7 Date assessed

12/01/2024

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

Yes, remediated 12/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 44

D3.VIII.2 Plan performance issue

Liquidated Damages
Inappropriate Waiver
Enrollment Anthem
Waiver enrollment
without valid screening

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Waiver enrollment without valid screening

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$25,000

D3.VIII.7 Date assessed

02/01/2025

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

Yes, remediated 03/03/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Liquidated damages

4 / 44

D3.VIII.2 Plan performance issue

Liquidated Damages
Inappropriate Waiver
Enrollment

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Waiver enrollment without valid screening

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$25,000

D3.VIII.7 Date assessed

02/01/2025

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

Yes, remediated 03/03/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Corrective action plan

5 / 44

D3.VIII.2 Plan performance issue

Timely access to care

D3.VIII.3 Plan name

Sentara Community Plan

D3.VIII.4 Reason for intervention

Access to Care

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

07/01/2024

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

Yes, remediated 07/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

6 / 44

D3.VIII.2 Plan performance issue

CCCP Waiver

D3.VIII.3 Plan name

United Healthcare Community PPlan

D3.VIII.4 Reason for intervention

Untimely waiver enrollment

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

07/01/2024

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

Yes, remediated 07/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Compliance Points

7 / 44

D3.VIII.2 Plan performance issue

CCCP Waiver

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Failure to meet CCMC requirements for contact attempts: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

07/01/2024

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

Yes, remediated 07/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Compliance Points

8 / 44

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Sentara Community Plan

D3.VIII.4 Reason for intervention

Late or Missing Data Submission: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

07/01/2024

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

Yes, remediated 07/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: MCO Improvement Plan

9 / 44

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Sentara Community Plan

D3.VIII.4 Reason for intervention

Late or Missing Data Submission: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

07/01/2024

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

Yes, remediated 07/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

10 / 44

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

Portal Entries

D3.VIII.4 Reason for intervention

Untimely waiver portal entry: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

08/01/2024

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

Yes, remediated 08/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 11 / 44

D3.VIII.2 Plan performance issue

CCCP Waiver

D3.VIII.3 Plan name

Aetna Better Health of Virginia

D3.VIII.4 Reason for intervention

Inappropriate waiver termination: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

08/01/2024

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

Yes, remediated 08/31/2024

D3.VIII.9 Corrective action plan

No



D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 12 / 44

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Member Benefits / Services Aetna Better Health of Virginia

D3.VIII.4 Reason for intervention
Inaccurate member communication: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance 1	D3.VIII.6 Sanction amount \$15,000
D3.VIII.7 Date assessed 08/01/2024	D3.VIII.8 Remediation date non-compliance was corrected Yes, remediated 08/31/2024
D3.VIII.9 Corrective action plan No	



D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 13 / 44

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
appeals Sentara Community Plan

D3.VIII.4 Reason for intervention
Untimely member appeal resolution: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance 1	D3.VIII.6 Sanction amount \$15,000
D3.VIII.7 Date assessed 08/01/2024	D3.VIII.8 Remediation date non-compliance was corrected Yes, remediated 08/31/2024
D3.VIII.9 Corrective action plan	

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 14 / 44

D3.VIII.2 Plan performance issue

Member Benefits / Services

D3.VIII.3 Plan name

Sentara Community Plan

D3.VIII.4 Reason for intervention

Delinquent LOCERI: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

656

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

09/01/2024

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

Yes, remediated 10/01/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 15 / 44

D3.VIII.2 Plan performance issue

Claims Payment

D3.VIII.3 Plan name

United Healthcare Community Plan

D3.VIII.4 Reason for intervention

Untimely Claims Adjudication: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

09/01/2024

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

Yes, remediated 10/01/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 16 / 44**D3.VIII.2 Plan performance issue**

Member Benefits / Services

D3.VIII.3 Plan name

Molina Healthcare

D3.VIII.4 Reason for intervention

Inappropriate denial of services: 1 point

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

10/01/2024

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

Yes, remediated 10/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: MCO Improvement Plan 17 / 44**D3.VIII.2 Plan performance issue**

Member Benefits / Services

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Failure to provide Care Coordination: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

10/01/2024

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

Yes, remediated 10/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 18 / 44

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

United Healthcare Community PLa

D3.VIII.4 Reason for intervention

Failure to respond: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

11/01/2024

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

Yes, remediated 12/01/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 19 / 44

D3.VIII.2 Plan performance issue

CCCP Waiver

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Failure to meet CCMC requirements for contact attempts: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

0

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/01/2024

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

Yes, remediated 12/01/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 20 / 44

D3.VIII.2 Plan performance issue

Member Benefits / Services

D3.VIII.3 Plan name

Aetna Better Health of Virginia

D3.VIII.4 Reason for intervention

Delinquent LOCERI: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

103

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

11/01/2024

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

Yes, remediated 12/01/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Corrective action plan 21 / 44

D3.VIII.2 Plan performance issue

Sentara Community Plan

D3.VIII.3 Plan name

Provider Relations

D3.VIII.4 Reason for intervention

Provider issues: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

46

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

11/01/2024

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

Yes, remediated 12/01/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Corrective action plan

22 / 44

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Sentara Community Plan

D3.VIII.4 Reason for intervention

Failure to report NCQA Accreditation status: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

11/01/2024

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

Yes, remediated 12/01/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 23 / 44

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Anthem Healthkeepers Plus
Appeals

D3.VIII.4 Reason for intervention

Untimely member appeal resolution: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
\$0

D3.VIII.7 Date assessed
11/01/2024

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 12/01/2024

D3.VIII.9 Corrective action plan
No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 24 / 44

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Sentara Community Plan
CCCP Waiver

D3.VIII.4 Reason for intervention

Untimely waiver portal entry: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
\$15,000

D3.VIII.7 Date assessed
11/01/2024

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 12/01/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 25 / 44

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Reporting (timeliness, completeness, accuracy) Molina Healthcare

D3.VIII.4 Reason for intervention

Late or Missing Data Submission: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance **D3.VIII.6 Sanction amount**
1 \$15,000

D3.VIII.7 Date assessed **D3.VIII.8 Remediation date non-compliance was corrected**
12/01/2024 Yes, remediated 12/31/2024

D3.VIII.9 Corrective action plan
No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 26 / 44

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Reporting (timeliness, completeness, accuracy) Aetna Better Health of Virginia

D3.VIII.4 Reason for intervention

Late or Missing Data Submission: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance **D3.VIII.6 Sanction amount**
1 \$15,000

D3.VIII.7 Date assessed

12/01/2024

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

Yes, remediated 12/31/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 27 / 44**D3.VIII.2 Plan performance issue**

CCCP Waiver

D3.VIII.3 Plan name

Molina Healthcare

D3.VIII.4 Reason for intervention

Delinquent LOCERI: 1 point

Sanction details**D3.VIII.5 Instances of non-compliance**

69

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

01/01/2025

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

Yes, remediated 01/31/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 28 / 44**D3.VIII.2 Plan performance issue**

CCCP Waiver

D3.VIII.3 Plan name

Molina Healthcare

D3.VIII.4 Reason for intervention

Incomplete LOCERI: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

01/01/2025

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

Yes, remediated 01/31/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 29 / 44

D3.VIII.2 Plan performance issue

CCCP Waiver

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Delinquent LOCERI: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

01/01/2025

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

Yes, remediated 01/31/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 30 / 44

D3.VIII.2 Plan performance issue

Appeals

D3.VIII.3 Plan name

United Healthcare Community PLaN

D3.VIII.4 Reason for intervention

Untimely member appeal resolution: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

01/01/2025

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

Yes, remediated 01/31/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 31 / 44

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Late or Missing Data Submission: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

01/01/2025

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

Yes, remediated 01/31/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 32 / 44

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Claims Payment Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Untimely Claims Adjudication: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance **D3.VIII.6 Sanction amount**
98.75 \$15,000

D3.VIII.7 Date assessed **D3.VIII.8 Remediation date non-compliance was corrected**
01/01/2025 Yes, remediated 01/31/2025

D3.VIII.9 Corrective action plan
No



D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 33 / 44

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
CCCP Waiver Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Inaccurate waiver portal entry: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance **D3.VIII.6 Sanction amount**
1 \$15,000

D3.VIII.7 Date assessed **D3.VIII.8 Remediation date non-compliance was corrected**
02/01/2025 Yes, remediated 03/03/2025

D3.VIII.9 Corrective action plan
No



Complete

D3.VIII.1 Intervention type: Corrective action plan

34 / 44

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
 Member Benefits / Services Molina Healthcare

D3.VIII.4 Reason for intervention

Failure to screen member face to face: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance
 1

D3.VIII.6 Sanction amount
 \$15,000

D3.VIII.7 Date assessed
 02/01/2025

D3.VIII.8 Remediation date non-compliance was corrected
 Yes, remediated 03/03/2025

D3.VIII.9 Corrective action plan
 No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

35 / 44

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
 Appeals United Healthcare Community PPlan

D3.VIII.4 Reason for intervention

Untimely member appeal resolution: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance
 2

D3.VIII.6 Sanction amount
 \$15,000

D3.VIII.7 Date assessed
 02/01/2025

D3.VIII.8 Remediation date non-compliance was corrected
 Yes, remediated 03/03/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 36 / 44

D3.VIII.2 Plan performance issue CCCP Waiver
D3.VIII.3 Plan name Sentara Community Plan

D3.VIII.4 Reason for intervention
Untimely waiver portal entry: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance 1	D3.VIII.6 Sanction amount \$15,000
D3.VIII.7 Date assessed 02/01/2025	D3.VIII.8 Remediation date non-compliance was corrected Yes, remediated 03/03/2025
D3.VIII.9 Corrective action plan No	



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 37 / 44

D3.VIII.2 Plan performance issue Claims Payment
D3.VIII.3 Plan name Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention
Untimely Claims Adjudication: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance 100	D3.VIII.6 Sanction amount \$15,000
D3.VIII.7 Date assessed	D3.VIII.8 Remediation date non-compliance was corrected

04/01/2025

Yes, remediated 05/01/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: MCO Improvement Plan

38 / 44

D3.VIII.2 Plan performance issue

Service Authorizations

D3.VIII.3 Plan name

Sentara Community Plan

D3.VIII.4 Reason for intervention

Inappropriate service authorization: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

04/01/2025

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

Yes, remediated 05/01/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

39 / 44

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Late or Missing Data Submission: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

\$15,000

4

D3.VIII.7 Date assessed

04/01/2025

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

Yes, remediated 05/01/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: MCO Improvement Plan

40 / 44

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Molina Healthcare

D3.VIII.4 Reason for intervention

Late or Missing Data Submission: 1

Sanction details

D3.VIII.5 Instances of non-compliance

149

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

04/01/2025

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

Yes, remediated 05/01/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

41 / 44

D3.VIII.2 Plan performance issue

Claims Payment

D3.VIII.3 Plan name

Molina Healthcare

D3.VIII.4 Reason for intervention

Untimely Claims Adjudication: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

27

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

04/01/2025

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

Yes, remediated 05/01/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 42 / 44

D3.VIII.2 Plan performance issue

Service Authorizations

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Untimely service authorizations: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

18

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

05/01/2025

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

Yes, remediated 05/31/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 43 / 44

D3.VIII.2 Plan performance issue

Service Authorizations

D3.VIII.3 Plan name

Anthem Healthkeepers Plus

D3.VIII.4 Reason for intervention

Untimely service authorizations: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

39

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

06/01/2025

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

Yes, remediated 07/01/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: MCO Improvement Plan

44 / 44

D3.VIII.2 Plan performance issue

Member Benefits / Services

D3.VIII.3 Plan name

United Healthcare Community PLa

D3.VIII.4 Reason for intervention

Delinquent LOCERI: 1 point

Sanction details

D3.VIII.5 Instances of non-compliance

672

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

06/01/2025

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

Yes, remediated 07/01/2025

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	<p data-bbox="313 107 711 176">Dedicated program integrity staff</p> <p data-bbox="313 201 711 390">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).</p>	<p data-bbox="813 138 1243 218">Aetna Better Health of Virginia 40</p> <p data-bbox="813 264 1203 344">Anthem Healthkeepers Plus 86</p> <p data-bbox="813 390 1070 470">Molina Healthcare 10</p> <p data-bbox="813 516 1162 596">Sentara Community Plan 20</p> <p data-bbox="813 642 1317 716">United Healthcare Community PLaN 12</p>
D1X.2	<p data-bbox="313 779 711 848">Count of opened program integrity investigations</p> <p data-bbox="313 873 711 999">How many program integrity investigations were opened by the plan during the reporting year?</p>	<p data-bbox="813 810 1243 890">Aetna Better Health of Virginia 127</p> <p data-bbox="813 936 1203 1016">Anthem Healthkeepers Plus 67</p> <p data-bbox="813 1062 1070 1142">Molina Healthcare 2</p> <p data-bbox="813 1188 1162 1268">Sentara Community Plan 130</p> <p data-bbox="813 1314 1317 1388">United Healthcare Community PLaN 132</p>
D1X.4	<p data-bbox="313 1451 711 1520">Count of resolved program integrity investigations</p> <p data-bbox="313 1545 711 1671">How many program integrity investigations were resolved by the plan during the reporting year?</p>	<p data-bbox="813 1482 1243 1562">Aetna Better Health of Virginia 96</p> <p data-bbox="813 1608 1203 1688">Anthem Healthkeepers Plus 596</p> <p data-bbox="813 1734 1070 1814">Molina Healthcare 79</p> <p data-bbox="813 1860 1162 1940">Sentara Community Plan 757</p> <p data-bbox="813 1986 1317 2060">United Healthcare Community PLaN 285</p>

D1X.6

Referral path for program integrity referrals to the state

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

Aetna Better Health of Virginia

Makes referrals to the SMA and MFCU concurrently

Anthem Healthkeepers Plus

Makes referrals to the SMA and MFCU concurrently

Molina Healthcare

Makes referrals to the SMA and MFCU concurrently

Sentara Community Plan

Makes referrals to the SMA and MFCU concurrently

United Healthcare Community Plan

Makes referrals to the SMA and MFCU concurrently

D1X.7

Count of program integrity referrals to the state

Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.

Aetna Better Health of Virginia

7

Anthem Healthkeepers Plus

16

Molina Healthcare

39

Sentara Community Plan

67

United Healthcare Community Plan

61

D1X.9a:

Plan overpayment reporting to the state: Start Date

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

Aetna Better Health of Virginia

07/01/2023

Anthem Healthkeepers Plus

07/01/2023

Molina Healthcare

07/01/2023

Sentara Community Plan

07/01/2023

United Healthcare Community Plan

07/01/2023

D1X.9b: Plan overpayment reporting to the state: End Date

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

Aetna Better Health of Virginia

06/30/2024

Anthem Healthkeepers Plus

06/30/2024

Molina Healthcare

06/30/2024

Sentara Community Plan

06/30/2024

United Healthcare Community Plan

06/30/2025

D1X.9c: Plan overpayment reporting to the state: Dollar amount

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

Aetna Better Health of Virginia

\$10,103,779.40

Anthem Healthkeepers Plus

\$6,352,458.12

Molina Healthcare

\$2,699,827.46

Sentara Community Plan

\$34,991,741.10

United Healthcare Community Plan

\$10,103,779.40

D1X.9d: Plan overpayment reporting to the state: Corresponding premium revenue

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

Aetna Better Health of Virginia

\$2,831,996,211.91

Anthem Healthkeepers Plus

\$5,624,958,821.69

Molina Healthcare

\$1,565,070,651.87

Sentara Community Plan

\$6,693,161,001.67

United Healthcare Community Plan

\$5,763,614.39

D1X.10

Changes in beneficiary circumstances

Select the frequency the plan reports changes in beneficiary circumstances to the state.

Aetna Better Health of Virginia

Daily

Anthem Healthkeepers Plus

Daily

Molina Healthcare

Daily

Sentara Community Plan

Daily

United Healthcare Community Plan

Daily

Topic XI: ILOS

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

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

Number	Indicator	Response
D4XI.1	ILOSs offered by plan Indicate whether this plan offered any ILOS to their enrollees.	<p>Aetna Better Health of Virginia Yes, at least 1 ILOS is offered by this plan</p> <p>Anthem Healthkeepers Plus Yes, at least 1 ILOS is offered by this plan</p> <p>Molina Healthcare Yes, at least 1 ILOS is offered by this plan</p> <p>Sentara Community Plan Yes, at least 1 ILOS is offered by this plan</p> <p>United Healthcare Community PLaN Yes, at least 1 ILOS is offered by this plan</p>
D4XI.2a	ILOSs utilization by plan Select all ILOSs offered by this plan during the contract rating period. For each ILOS offered by the plan, enter the deduplicated number of enrollees that utilized this ILOS during the contract rating period. If the plan offered this ILOS during the contract rating period but there was no utilization, enter "0".	<p>Aetna Better Health of Virginia Aetna:</p> <p>Anthem Healthkeepers Plus Anthem:</p> <p>Molina Healthcare Molina:</p> <p>Sentara Community Plan Sentara:</p> <p>United Healthcare Community PLaN Unitedhealthcare:</p>

Topic XIII. Prior Authorization

⚠ Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

⚠ Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

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	<p>BSS entity type</p> <p>What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).</p>	<p>Maximus (Enrollment Broker)</p> <p>Ombudsman Program</p> <p>Enrollment Broker</p> <p>Virginia Department for Aging and Rehabilitative Services</p> <p>State Government Entity</p> <p>State Long Term Care Ombudsman</p> <p>Ombudsman Program</p>
EIX.2	<p>BSS entity role</p> <p>What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).</p>	<p>Maximus (Enrollment Broker)</p> <p>Enrollment Broker/Choice Counseling</p> <p>LTSS Complaint Access Point</p> <p>LTSS Grievance/Appeals Education</p> <p>LTSS Grievance/Appeals Assistance</p> <p>Review/Oversight of LTSS Data</p> <p>Virginia Department for Aging and Rehabilitative Services</p> <p>Other, specify – Employment services, aging services, disability support.</p> <p>State Long Term Care Ombudsman</p> <p>LTSS Complaint Access Point</p>

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to "Review & submit."

Number	Indicator	Response
F1	Notes (optional)	Not answered