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

Due Date	Last edited	Edited By	Status
12/27/2022	12/22/2022	Marina Hench	Submitted

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

Section A: Program Information

Point of Contact

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A.1	**State name**	Virginia

Number	Indicator	Response
	Auto-populated from your account profile.	
A.2a	**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.	Marina Hench
A.2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	marina.hench@dmas.virginia.gov
A.3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Marina Hench
A.3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	marina.hench@dmas.virginia.gov
A.4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/22/2022

Reporting Period

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A.5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2021
A.5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2022
A.6	**Program name** Auto-populated from report dashboard.	Medallion 4.0

Add plans (A.7)

Find in the Excel Workbook
A_Program_Info

	Indicator	Response
	Plan name	Aetna Anthem Molina Optima United Healthcare Virginia Premier

Add BSS entities (A.8)

Find in the Excel Workbook
A_Program_Info

	Indicator	Response
	BSS entity name	Maximus

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
B_State

Number	Indicator	Response
B.I.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,036,963
B.I.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or	1,851,630

Number	Indicator	Response
	more than one managed care plan.	

Topic III. Encounter Data Report

Find in the Excel Workbook
B_State

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

Topic X: Program Integrity

Find in the Excel Workbook
B_State

Number	Indicator	Response
B.X.1	**Payment risks between the state and plans**	Fraud and Detection System - Analytics FADS, or the Fraud and Detection System, has various

Number	Indicator	Response
	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.	components and modules. This summary provides a high-level overview of the capabilities of the analytics focused components: 1. Algorithms Algorithms are analytics custom designed for a specific purpose and deployed by the Optum FADS team quarterly in collaboration with the DMAS PID FADS Analytics team. So far, the following eleven algorithms have been developed and deployed. FADS Algorithm Description Excessive Mental Health Services By Servicing NPI (FA207A) Identifies providers rendering excessive mental health services, excluding mental health centers. The report displays a report with servicing providers that exceed the threshold of services provided per member. LTC Members with No Patient Pay Obligation Amount (FA469B) Detects LTC members with a patient pay obligation amount of zero. Patient pay obligation is the amount a member in a LTC Facility is responsible for paying toward their Long Term Services and Support (LTSS) bill that is based on their income. Excessive Physician Hours per Day Summary (FA446A) Detects servicing providers who bill an excessive number of hours per day. The hours billed may be distributed across multiple claims by the same physician and are billable by a variety of provider types. Excessive Use of Miscellaneous Codes Servicing Provider Summary (FA065A) Identifies summary information for servicing providers billing 5 or more unlisted procedure codes in a quarter. DRG Inpatient and Readmission /Transfers Summary (FA479A) Detects inpatient facilities that are readmitting/transferring patients within 30 days or less from being discharged. These situations are considered a single admittance rather than two. The first claim should be adjusted to include the payment for both claims. The readmit/transfer claim should be voided. Misuse of Evaluation and Management – New Office Visits and Established office Visits (FA438A) Identifies servicing providers who bill

Number	Indicator	Response
		multiple new office visit evaluation and management (E&M) procedure codes or incorrectly use new office visits evaluation and management procedure codes in place of established office visit E&M procedure codes for the same member within a three year period. This algorithm also reports on any other evaluation and management services that are billed on the same date of service for the same member as a new or established office visit. FADS Algorithm Description Postmortem Services – Member (FA064A) Identifies paid claim lines with a date of service (DOS) that is after a member's date of death (DOD) and excludes certain reinstatement codes to prevent false positives. This algorithm focuses on all services that appear to have been rendered (based on the date of service) after the DOD and subsequently paid. The member's DOD comes from the member file. Time Limited services (FA484A) This algorithm identifies the servicing provider and corresponding claims where a provider has ordered time-limited services that exceeds identified time limits. The provider Summary will quickly identify which providers exceed the limit and how often they are exceeding the identified time limit. COVID-19 Lab Testing (FA482A) This algorithm identifies the billing provider on claims where a provider has ordered additional lab testing for a member in conjunction with a COVID-19 test. The summary report includes claim counts for COVID-19 testing and claim counts for additional lab tests performed on the same DOS for the same member. Payment Suspension (FA487A) The Payment Suspension Claims Summary Report will look at servicing providers at any of the three provider suspension levels: Good Cause Exception, Suspended & Post Suspension and display summary of any claims found. The drill down will take the user to the Payment Suspension Detail Report by clicking on the following hyperlinks on the summary report:

Number	Indicator	Response
		Total $ Paid GC, Total $ Paid S & Total $ Paid PS. Audit Plan Summary Report (FA489A/B) The Percent of Paid Claims For Oversight By MCO ID/FFS Summary Report counts claims based on calendar year (contract year) and fiscal year. The report is broken out by MCO ID or FFS. The following information is included in the report: distinct number of providers, distinct number of members, total dollars paid, and total number of claims. This report runs twice a year. It will run in October for fiscal year (July 1st through June 30th). It will also run in March for calendar year (January 1st through December 31st). 2. Configured Analytics Reports These preconfigured reports are available in FADS and provide insight to DMAS claims data in a passive and ongoing manner, which helps to illuminate potential improper payments or gaps in policy: FADS Report Description IDs In Multiple Algorithms This report compiles all of the providers by NPI that have appeared on multiple of the algorithms listed above. It details how many distinct algorithms the provider was found on, and how many times between them. Provider Activity Spike Detection This semi-configurable report allows the user to select a recent time period to view providers with a significant increase/decrease (spike) in billing activity. Long Term Care Facility Review This report compiles a list of facilities and providers that bill Medicaid member's part of a Long Term Care (LTC) facility, where ostensibly the majority of their care should be covered by the LTC facility itself. High Cost Members Report This list compiles the Medicaid members with the highest expenditures. Additional information is included in the report like the member's aid category, how many distinct diagnoses they have, how many providers they see, etc. Top N Reports A number of reports that compile the most commonly occurring data elements among DMAS claims data: ● Top N Diagnosis

Number	Indicator	Response
		Codes ● Procedure Codes ● Top N GDRG ● Top N NDC Codes
B.X.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
B.X.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 11.11.A Formal Initiation of Recovery
B.X.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	Generally, MCOs will be permitted to retain recoveries of overpayments identified and established through their own monitoring and investigative efforts. However, any overpayments for claims that were paid more than three years prior to the date that the Contractor formally notified the Department of the overpayment will be retained by the Department. In addition, one year from the date the Contractor is notified that they are permitted to recover an overpayment, the outstanding remainder of that overpayment will revert to the Department for collection and retention.
B.X.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	Overview The External Provider and Policy Review Unit (EPAP) was a new Program Integrity Unit in FY18. Each Managed Care Organization (MCO) is required to establish their own internal program integrity unit to guard against fraud, waste, and/or abuse of Medicaid program benefits and resources. The EPAP unit

Number	Indicator	Response
	requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	provides oversight to the MCO program integrity units and primarily focuses on ensuring compliance with the Medallion and CCC+ contracts. The EPAP unit will perform audits of contractor review documentation to ensure contract requirements are being met. EPAP follows policies and procedures within the Program Integrity section of the CCC Plus and Medallion contracts that outline the requirements for the contractor to uphold and how EPAP will conduct the review process. We Track timeliness and compliance by review and reconciliation of the quarterly report. Annual Review Process EPAP does not follow an audit plan but will provide direct DMAS oversight of the MCO and contractor Program Integrity Plans. This unit is like “the APA of the MCO Program Integrity Units;” DMAS will select reviews to ensure they were completed in accordance with policies and procedures, contract requirements, and the Code of Virginia. Contractors are required to submit electronically to DMAS each quarter all activities conducted on behalf of Program Integrity by the Contractor and include findings related to these activities. This report will serve as the annual report of overpayment recoveries required under 42 C.F.R. §§ 438.604(a)(7), 438.606, and 438.608(d)(3). The report must include, but is not limited to, the following: 1. Allegations received and results of preliminary review 2. Investigations conducted and outcome 3. Payment Suspension notices received and suspended payments summary 4. Claims Edits/Automated Review summary 5. Coordination of Benefits/Third-Party Liability savings and recoveries 6. Service Authorization/Medical Necessity savings 7. Provider Education Savings 8. Provider Screening reviews and denials 9. Providers Terminated 10. Unsolicited Refunds (Provider-identified Overpayments) 11. Archived Referrals (Historical Cases) 12. Other Activities Upon submission, DMAS will review the Quarterly

Number	Indicator	Response
		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 four analysts, and one supervisor. Although there are no required certifications or licenses, the EPAP staff have experience in Medicaid auditing and contract compliance.
B.X.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	"All initial member MCO enrollments and assignments are done in the state MES. All member enrollment and MCO changes are done within MES and communicated to the MCOs via a weekly enrollment roster (EDI 834). Enrollment Broker changes are also done directly in MES. The state MES is always the system of record for member enrollment. PMPM capitation payments are generated by the state MES based on the member enrollment data. Any changes to member data automatically trigger PMPM capitation adjustments which retract/adjust previous payments made to the MCO. In addition, MES does a reconciliation of member enrollment vs capitation payments each quarter to ensure

Number	Indicator	Response
		that all historical payments have been made accurately."
B.X.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 **Changes in provider circumstances: Metrics** Yes **Changes in provider circumstances: Describe metric** DMAS requests that the MCO identify providers whose terminations were associated with PI-related findings for the purposes of the quarterly report. As part of the overall MCO oversight conducted by the Program Integrity Division, the MCOs are required to document in their quarterly reports provider terminations. The provider terminations are documented on the designated tab of the quarterly report. The quarterly report is submitted to the Program Integrity Division for review of the MCOs program integrity efforts. The quarterly report is how PI tracks timely reporting of provider termination “for cause”. As pursuant to 42 CFR 438.608(a)(4), the quarterly report is used for the timely reporting of provider termination “for cause”.
B.X.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	No

Number	Indicator	Response
	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.	
B.X.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
B.X.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	N/A

Section C: Program-Level Indicators

Topic I: Program Characteristics

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.I.1	**Program contract** Enter the title and date of the contract between the state and plans participating in the managed care program.	Medallion 4.0 Managed Care Services Agreement
		07/01/2021
C1.I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.dmas.virginia.gov/media/3583/medallion-4-contract-sfy22-v1.pdf
C1.I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1.I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and	Behavioral health Transportation

Number	Indicator	Response
	managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	
C1.I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1.I.5	**Program enrollment** Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	1,561,094
C1.I.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.	Adult dental, BRAVO, prenatal coverage, preventive, 12 month postpartum, doulas, 12 month contraceptive

Topic III: Encounter Data Report

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Policy making and decision support Other, specify Pharmacy Rebates
C1.III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data certifications Use of correct file formats Overall data accuracy (as determined through data validation)
C1.III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which	Section 14 (Encounters) of the Medallion SFY 2022 contract.

Number	Indicator	Response
	managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	
C1.III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Sections 13.5.D (Data Quality Penalties) and section 14.2.A (Data Quality Requirements) in the Medallion SFY 2022 contract.
C1.III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	MCO rates are based on encounter data, so the MCOs are incentivized to submit complete and accurate encounter data.
C1.III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	• Documentation of EDI translator rules (compliance check) • IT turnaround time for MCOs to comply with SMA changes • Restrictions on number of records in EDI files • Issues with submission of adjustments & voids for failed originals • Timeliness of code set updates for encounter edits • Onboarding of new MCO systems and subcontractors requires extensive testing and staff resources.

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	A critical incident is any incident that threatens or impacts the well-being of the Member. Critical incidents shall include, but are not limited to, the following incidents: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death of a Member.
C1.IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	As expeditiously as the Member's health condition requires and not to exceed thirty (30) calendar days from the initial date of receipt of the internal appeal request.
C1.IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a	Within seventy-two (72) hours from the initial receipt of the appeal.

Number	Indicator	Response
	timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	
C1.IV.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

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	Meeting network adequacy time and distanct standards in rural areas or areas where there is only one zipcode in the region. Specifically in Bath Co., Highland Co., Fauquire Co., Campbell Co., and Bedford Co.
C1.V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in	Managed Care Organizations (MCO) submit quarterly provider network files based on requirements outlined in the Medallion 4.0 Network Requirements Submission Manual, which outlines the methodology that is used to

Number	Indicator	Response
	network adequacy?	determine adequacy in specific regions/ FIPS codes as it relates to time and distance standards. The quarterly provider files are analyzed internally, each MCOs strengths and weakness of their individual networks are documented and each plan receives a summarized finding of areas where the MCO does not meet time and distance standards based on contractual standards; along with a summary of the MCOs Network Adequacy Scorecard and Network Adequacy Map. Each MCO is given five business days to submit a Network Adequacy Exemption Request form to the Department. The form allows the MCO to detail the rational for an exception of not meeting adequacy standards for the out compliance region, a detail list of providers closest to the out of compliance region and the MCOs plan of action to meet time and distant standards in the out of compliance region. The Department analyzes the each MCOs Network Adequacy Exemption Request form and provides feedback to each MCO.

Topic V. Availability, Accessibility and Network Adequacy

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.

Find in the Excel Workbook
C2_Program_State

Access measure total count: 48

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

1 / 48

C2.V.2 Measure standard

Primary Care Provider (PCP)

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Primary Care Provider

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Pediatrician (Pediatrics)

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Pediatrician (Pediatrics)

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

OB/GYN (Obstetrics & Gynecology)

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

OB/GYN (Obstetrics & Gynecology)

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Outpatient Mental Health (Behavioral Health & Social Service Providers)

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Outpatient Mental Health (Behavioral Health & Social Service Providers)

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Pharmacy

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Pharmacy

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

General Hospital (Acute Care Hospital)

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

General Hospital (Acute Care Hosptial)

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

13 / 48

C2.V.2 Measure standard

General Hospital (Acute Care Hosptial)

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

14 / 48

C2.V.2 Measure standard

Allergy/Immunology and Respiratory Rehabilitation

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

15 / 48

C2.V.2 Measure standard

Allergy/Immunology and Respiratory Rehabilitation

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

16 / 48

C2.V.2 Measure standard

Other Specialist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

17 / 48

C2.V.2 Measure standard

Other Specialist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

18 / 48

C2.V.2 Measure standard

Otolaryngology

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

19 / 48

C2.V.2 Measure standard

Otolaryngology

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

20 / 48

C2.V.2 Measure standard

Pain Medicine

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Pain Medicine

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Physical Medicine and Rehabilitation

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Physical Medicine and Rehabilitation

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Psychiatry

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

25 / 48

C2.V.2 Measure standard

Psychiatry

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

26 / 48

C2.V.2 Measure standard

Neurology

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Neurology

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Cardiologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Cardiologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Clinical Medical Laboratory

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Clinical Medical Laboratory

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Endocrinologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Endocrinologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Nephrologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

35 / 48

C2.V.2 Measure standard

Nephrologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

36 / 48

C2.V.2 Measure standard

Nephrologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Ophthalmologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Ophthalmologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

39 / 48

C2.V.2 Measure standard

Podiatrist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

40 / 48

C2.V.2 Measure standard

Podiatrist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

41 / 48

C2.V.2 Measure standard

Radiologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

42 / 48

C2.V.2 Measure standard

Radiologist

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Skilled Nursing Facility

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Skilled Nursing Facility

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Urgent Care Center

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Urgent Care Center

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

47 / 48

C2.V.2 Measure standard

Early Intervention

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

48 / 48

C2.V.2 Measure standard

Early Intervention

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.virginiamanagedcare.com/
C1.IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	BSS Auxiliary Aids and Services: TTY: (teletypewriter) 1-800-817-6608, BSS Language/Translation interpreter line along with Spanish Bilingual employees staffed, BSS Marketing Materials website and printed marketing materials are created in large print for individuals with visual impairments.
C1.IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	BSS ERB reports to the Contract Administrator via email, and or via good cause cases sent via CTS, all critical incidents, grievances, and appeals requests reported by Members and or Providers when assistance and decision making is required by DMAS. The BSS ERB CSR's educate and counsel callers of the Medicaid/Managed Care policies, procedures, and appeals process when needed, also identifying issues that require escalation and reporting to DMAS.
C1.IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality,	BSS ERB included however not limited to, submits weekly, monthly and annual reports to the Contract Administrator regarding MCO helpline call summary, enrollment data, complaint logs, activity reports, webtrends,

Number	Indicator	Response
	effectiveness, and efficiency of the BSS entities' performance?	daily call stats, material inventory, SLA reports, staffing reports, IVR/Call Center phone activity, good cause report, change reports, EB invoices, health status assessments, and customer satisfaction surveys. The Contract Administrator also conducts call monitoring, meetings with BSS ERB leadership to discuss current initiatives and performance, as well as other monitoring efforts to ensure the ERB is within compliance of their contract.

Topic X: Program Integrity

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Aetna** 255,234 **Anthem** 556,838 **Molina** 130,105 **Optima** 349,817 **United Healthcare** 203,064 **Virginia Premier** 356,572
D1.I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Aetna** 13% **Anthem** 27% **Molina** 6% **Optima** 17% **United Healthcare** 10% **Virginia Premier**

Number	Indicator	Response
		18%
D1.I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Aetna** 14% **Anthem** 30% **Molina** 7% **Optima** 19% **United Healthcare** 11% **Virginia Premier** 19%

Topic II. Financial Performance

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO,	**Aetna** 84% **Anthem** 81%

Number	Indicator	Response
	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.	**Molina** 90% **Optima** 89% **United Healthcare** 80% **Virginia Premier** 86%
D1.II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Aetna** Program-specific statewide **Anthem** Program-specific statewide **Molina** Program-specific statewide **Optima** Program-specific statewide **United Healthcare** Program-specific statewide **Virginia Premier** Program-specific statewide
D1.II.2	**Population specific MLR description** Does the state require plans to submit separate MLR	**Aetna** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members.

Number	Indicator	Response
	calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Anthem** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **Molina** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **Optima** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **United Healthcare** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members. **Virginia Premier** Separate calculations for Base Medicaid members and Group VIII Medicaid Expansion members.
D1.II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Aetna** Yes 07/01/2020 06/30/2021 **Anthem** Yes 07/01/2020 06/30/2021 **Molina** Yes 07/01/2020 06/30/2021

Number	Indicator	Response
		Optima Yes 07/01/2020 06/30/2021 **United Healthcare** Yes 07/01/2020 06/30/2021 **Virginia Premier** Yes 07/01/2020 06/30/2021

Topic III. Encounter Data

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Aetna** Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor’s payment cycle and in the form and manner specified by the Department." **Anthem** Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor’s payment cycle and in the form and manner specified by the Department." **Molina**

Number	Indicator	Response
		Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor's payment cycle and in the form and manner specified by the Department." **Optima** Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor's payment cycle and in the form and manner specified by the Department." **United Healthcare** Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor's payment cycle and in the form and manner specified by the Department." **Virginia Premier** Section 14.2.A.5 in the Medallion SFY 2022 contract: "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor's payment cycle and in the form and manner specified by the Department."
D1.III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission?	**Aetna** 99% **Anthem** 96% **Molina** 99%

Number	Indicator	Response
	If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**Optima** 99% **United Healthcare** 72% **Virginia Premier** 98%
D1.III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**Aetna** 100% **Anthem** 99% **Molina** 98% **Optima** 99% **United Healthcare** 100% **Virginia Premier** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Aetna** 31 **Anthem** 108 **Molina** 22 **Optima** 25 **United Healthcare** 53 **Virginia Premier** 181
D1.IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Aetna** 38 **Anthem** 95 **Molina** 18 **Optima** 10 **United Healthcare** 28 **Virginia Premier**

Number	Indicator	Response
		159
D1.IV.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** N/A **Anthem** 92 **Molina** N/A **Optima** N/A **United Healthcare** N/A **Virginia Premier** 19
D1.IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”.	**Aetna** N/A **Anthem** N/A **Molina** N/A **Optima** N/A **United Healthcare** N/A

Number	Indicator	Response
	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.	**Virginia Premier** 0
D1.IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which	**Aetna** 532 **Anthem** 396

Number	Indicator	Response
	timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Molina** 503 **Optima** 545 **United Healthcare** 526 **Virginia Premier** 599
D1.IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Aetna** 246 **Anthem** 223 **Molina** 250 **Optima** 190 **United Healthcare** 219 **Virginia Premier** 220

Number	Indicator	Response
D1.IV.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** 427 **Anthem** N/A **Molina** 233 **Optima** 203 **United Healthcare** 1,267 **Virginia Premier** 84
D1.IV.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** 4 **Anthem** 3 **Molina** 4 **Optima** 0 **United Healthcare** 0 **Virginia Premier**

Number	Indicator	Response
		1
D1.IV.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** 2 **Anthem** 2,167 **Molina** 4,009 **Optima** 64 **United Healthcare** 3,113 **Virginia Premier** 743
D1.IV.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** 2 **Anthem** 0 **Molina** 0 **Optima** 0 **United Healthcare** 2

Number	Indicator	Response
		Virginia Premier 0
D1.IV.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** 2 **Anthem** N/A **Molina** 1 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 0
D1.IV.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** 1 **Anthem** 14 **Molina** 3 **Optima** 0

Number	Indicator	Response
		United Healthcare 0 **Virginia Premier** N/A
D1.IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Aetna** 0 **Anthem** N/A **Molina** 3 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response

Number	Indicator	Response
D1.IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Aetna** 13 **Anthem** 1,426 **Molina** 36 **Optima** 3 **United Healthcare** 712 **Virginia Premier** 12
D1.IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Aetna** 424 **Anthem** 191 **Molina** 16 **Optima** 67 **United Healthcare** 1,340 **Virginia Premier**

Number	Indicator	Response
		790
D1.IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Aetna** 2 **Anthem** 67 **Molina** 69 **Optima** N/A **United Healthcare** 111 **Virginia Premier** 5
D1.IV.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** 10 **Anthem** 204 **Molina** 83 **Optima** 6 **United Healthcare** 320

Number	Indicator	Response
		Virginia Premier 157
D1.IV.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** 209 **Anthem** 633 **Molina** 174 **Optima** 174 **United Healthcare** 419 **Virginia Premier** 1,664
D1.IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Aetna** N/A **Anthem** 25 **Molina** N/A **Optima** N/A

Number	Indicator	Response
		United Healthcare N/A **Virginia Premier** 1
D1.IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Aetna** N/A **Anthem** 17 **Molina** N/A **Optima** N/A **United Healthcare** N/A **Virginia Premier** 6
D1.IV.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** 2 **Anthem** 18 **Molina** N/A **Optima**

Number	Indicator	Response
		N/A **United Healthcare** N/A **Virginia Premier** N/A
D1.IV.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** 1 **Anthem** 0 **Molina** 0 **Optima** 0 **United Healthcare** 17 **Virginia Premier** 4
D1.IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not	**Aetna** 446 **Anthem** 1,611 **Molina** 22

Number	Indicator	Response
	cover services other than those in items D1.IV.7a-i, enter "N/A".	**Optima** 46 **United Healthcare** 190 **Virginia Premier** 64

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**Aetna** 7 **Anthem** 265 **Molina** 4 **Optima** 10 **United Healthcare** 14 **Virginia Premier**

Number	Indicator	Response
		9
D1.IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Aetna** 6 **Anthem** 8 **Molina** 0 **Optima** N/A **United Healthcare** 0 **Virginia Premier** 4
D1.IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Aetna** 0 **Anthem** 215 **Molina** 1 **Optima** N/A **United Healthcare** 3

Number	Indicator	Response
		Virginia Premier 0
D1.IV.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) prior to reaching a decision.	**Aetna** 0 **Anthem** 28 **Molina** 3 **Optima** N/A **United Healthcare** 11 **Virginia Premier** 4
D1.IV.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	**Aetna** 0 **Anthem** N/A **Molina** 1 **Optima** N/A

Number	Indicator	Response
	CFR §438.402(c)(i)(B).	**United Healthcare** 0 **Virginia Premier** N/A
D1.IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Aetna** 0 **Anthem** N/A **Molina** 0 **Optima** N/A **United Healthcare** 0 **Virginia Premier** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.10	**Grievances resolved**	**Aetna** 776

Number	Indicator	Response
	Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Anthem** 641 **Molina** 697 **Optima** 757 **United Healthcare** 765 **Virginia Premier** 895
D1.IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Aetna** 144 **Anthem** 0 **Molina** 56 **Optima** 0 **United Healthcare** 37 **Virginia Premier** 62

Number	Indicator	Response
D1.IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Aetna** N/A **Anthem** 3 **Molina** N/A **Optima** N/A **United Healthcare** N/A **Virginia Premier** 0
D1.IV.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 period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the	**Aetna** N/A **Anthem** N/A **Molina** N/A **Optima** N/A **United Healthcare** N/A **Virginia Premier**

Number	Indicator	Response
	critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	0
D1.IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period.	**Aetna** 766 **Anthem** 637 **Molina**

Number	Indicator	Response
	See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	696 **Optima** 757 **United Healthcare** 763 **Virginia Premier** 894

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna** 7 **Anthem** 0 **Molina** 1 **Optima** 0 **United Healthcare** 41 **Virginia Premier**

Number	Indicator	Response
		12
D1.IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna** 1,844 **Anthem** 890 **Molina** 3 **Optima** 4 **United Healthcare** 381 **Virginia Premier** 26
D1.IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna** 12 **Anthem** N/A **Molina** 1 **Optima** 0 **United Healthcare** 0

Number	Indicator	Response
		Virginia Premier 1
D1.IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna** 1,819 **Anthem** N/A **Molina** 2 **Optima** 0 **United Healthcare** 15 **Virginia Premier** 52
D1.IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna** 7 **Anthem** 23 **Molina** 4 **Optima** 0

Number	Indicator	Response
		United Healthcare 7 **Virginia Premier** 29
D1.IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna** N/A **Anthem** N/A **Molina** N/A **Optima** N/A **United Healthcare** N/A **Virginia Premier** 0
D1.IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including	**Aetna** N/A **Anthem** 4 **Molina** N/A **Optima**

Number	Indicator	Response
	personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	N/A **United Healthcare** N/A **Virginia Premier** 0
D1.IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna** 6 **Anthem** N/A **Molina** N/A **Optima** N/A **United Healthcare** N/A **Virginia Premier** 6
D1.IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not	**Aetna** 364 **Anthem** 409 **Molina** 220

Number	Indicator	Response
	cover this type of service, enter "N/A".	**Optima** 238 **United Healthcare** 494 **Virginia Premier** 50
D1.IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**Aetna** 1,474 **Anthem** 660 **Molina** 49 **Optima** 13 **United Healthcare** 7 **Virginia Premier** 430

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Aetna** 423 **Anthem** 47 **Molina** 19 **Optima** 0 **United Healthcare** 3 **Virginia Premier** 292
D1.IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Aetna** 2 **Anthem** 66 **Molina** 44 **Optima** 0 **United Healthcare** 37 **Virginia Premier**

Number	Indicator	Response
		3
D1.IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Aetna** 5 **Anthem** 606 **Molina** 1 **Optima** 3 **United Healthcare** 10 **Virginia Premier** 72
D1.IV.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** 12 **Anthem** 238 **Molina** 60 **Optima** 16 **United Healthcare** 23

Number	Indicator	Response
		Virginia Premier 87
D1.IV.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** 0 **Anthem** 15 **Molina** 10 **Optima** 0 **United Healthcare** 185 **Virginia Premier** 36
D1.IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**Aetna** 1,428 **Anthem** 906 **Molina** 37 **Optima** 1

Number	Indicator	Response
		United Healthcare 198 **Virginia Premier** 38
D1.IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Aetna** 0 **Anthem** 11 **Molina** 3 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 14
D1.IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases	**Aetna** 0 **Anthem** 0 **Molina** 3 **Optima**

Number	Indicator	Response
	involving potential or actual patient harm.	0 **United Healthcare** 0 **Virginia Premier** 8
D1.IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Aetna** 1 **Anthem** 28 **Molina** 9 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 0
D1.IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal.	**Aetna** 0 **Anthem** 0 **Molina** 0

Number	Indicator	Response
	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.	**Optima** 0 **United Healthcare** 0 **Virginia Premier** 3
D1.IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**Aetna** 5 **Anthem** 69 **Molina** 9 **Optima** 3 **United Healthcare** 492 **Virginia Premier** 15

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.

Find in the Excel Workbook
D2_Plan_Measures

Quality & performance measure total count: 7

Complete

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

01/01/2020 - 12/31/2020

D2.VII.8 Measure Description

N/A

Measure results

Aetna

43

Anthem

52

Molina

33

Optima

44

United Healthcare

47

Virginia Premier

44

Complete

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

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

10/08/2019 - 10/07/2020

D2.VII.8 Measure Description

N/A

Measure results

Aetna

61

Anthem

70

Molina

56

Optima

65

United Healthcare

69

Virginia Premier

67

Complete

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

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

01/20/2020 - 12/31/2020

D2.VII.8 Measure Description

N/A

Measure results

Aetna

70

Anthem

73

Molina

65

Optima

69

United Healthcare

73

Virginia Premier

71

Complete

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

4 / 7

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

01/20/2020 - 12/01/2020

D2.VII.8 Measure Description

N/A

Measure results

Aetna

41

Anthem

48

Molina

40

Optima

47

United Healthcare

39

Virginia Premier

49

Complete

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

5 / 7

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

01/01/2020 - 12/31/2020

D2.VII.8 Measure Description

N/A

Measure results

Aetna

N/A

Anthem

24

Molina

20

Optima

N/A

United Healthcare

N/A

Virginia Premier

N/A

Complete

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

6 / 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

Cross-program rate: CCC Plus

D2.VII.6 Measure Set

HEDIS

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

01/01/2020 - 12/31/2020

D2.VII.8 Measure Description

N/A

Measure results

Aetna

74

Anthem

79

Molina

75

Optima

81

United Healthcare

79

Virginia Premier

81

Complete

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

7 / 7

D2.VII.2 Measure Domain

Utilization

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

01/01/2020 - 12/31/2020

D2.VII.8 Measure Description

N/A

Measure results

Aetna

50

Anthem

39

Molina

50

Optima

44

United Healthcare

39

Virginia Premier

40

Topic VIII. Sanctions

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

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

Find in the Excel Workbook
D3_Plan_Sanctions

Sanction total count: 34

Complete

D3.VIII.1 Intervention type: Fine 1 / 34

D3.VIII.2 Intervention topic
Member Appeals Resolution

D3.VIII.3 Plan name
Virginia Premier

D3.VIII.4 Reason for intervention

Untimely Member Appeal Resolution

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
$ 5,000

D3.VIII.7 Date assessed
10/08/2021

D3.VIII.8 Remediation date non-compliance was corrected
11/07/2021

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

2 / 34

D3.VIII.2 Intervention topic

Member Appeals Resolution

D3.VIII.3 Plan name

Virginia Premier

D3.VIII.4 Reason for intervention

Untimely Member Appeal Resolution

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 5,000

D3.VIII.7 Date assessed

10/08/2021

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

11/07/2021

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance Points

3 / 34

D3.VIII.2 Intervention topic

Call Center Statistics/Performance

D3.VIII.3 Plan name

Molina

D3.VIII.4 Reason for intervention

Provider Call Answer Rate: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed
10/08/2021

D3.VIII.8 Remediation date non-compliance was corrected
11/07/2021

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance Points

4 / 34

D3.VIII.2 Intervention topic
PA/SA Review

D3.VIII.3 Plan name
United Healthcare

D3.VIII.4 Reason for intervention

Untimely Prior Auth / Service Auth Request Resolution: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance
11

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
10/08/2021

D3.VIII.8 Remediation date non-compliance was corrected
11/07/2021

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Fine

5 / 34

D3.VIII.2 Intervention topic
Call Center Statistics/Performance

D3.VIII.3 Plan name
Virginia Premier

D3.VIII.4 Reason for intervention

Provider Call Answer Rate

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 10,000

D3.VIII.7 Date assessed

10/08/2021

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

11/07/2021

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

6 / 34

D3.VIII.2 Intervention topic

Call Center Statistics/Performance

D3.VIII.3 Plan name

Virginia Premier

D3.VIII.4 Reason for intervention

Provider Call Answer Rate

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 10,000

D3.VIII.7 Date assessed

10/08/2021

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

11/07/2021

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

7 / 34

D3.VIII.2 Intervention topic

Claim Adjudication

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Untimely Claim Adjudication

Sanction details

D3.VIII.5 Instances of non-compliance

121

D3.VIII.6 Sanction amount

$ 5,000

D3.VIII.7 Date assessed

11/10/2021

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

12/10/2021

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

8 / 34

D3.VIII.2 Intervention topic

Member Appeals Resolution

D3.VIII.3 Plan name

Virginia Premier

D3.VIII.4 Reason for intervention

Untimely Member Appeal Resolution

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 10,000

D3.VIII.7 Date assessed

11/10/2021

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

12/10/2021

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance Points

9 / 34

D3.VIII.2 Intervention topic
PA/SA Review

D3.VIII.3 Plan name
United Healthcare

D3.VIII.4 Reason for intervention

Untimely Prior Auth / Service Auth Request Resolution: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance
4

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
11/10/2021

D3.VIII.8 Remediation date non-compliance was corrected
12/10/2021

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance Points

10 / 34

D3.VIII.2 Intervention topic
Call Center Statistics/Performance

D3.VIII.3 Plan name
Molina

D3.VIII.4 Reason for intervention

Provider Call Answer Rate: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
11/10/2021

D3.VIII.8 Remediation date non-compliance was corrected
12/10/2021

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Fine

11 / 34

D3.VIII.2 Intervention topic

Member Appeals Resolution

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Untimely Member Appeal Resolution

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 5,000

D3.VIII.7 Date assessed

12/08/2021

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

01/07/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance Points

12 / 34

D3.VIII.2 Intervention topic

Call Center Statistics/Performance

D3.VIII.3 Plan name

Aetna

D3.VIII.4 Reason for intervention

Provider Call Answer Rate: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

12/08/2021

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

01/07/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance Points

13 / 34

D3.VIII.2 Intervention topic
PA/SA Review

D3.VIII.3 Plan name
United Healthcare

D3.VIII.4 Reason for intervention

Untimely Prior Auth / Service Auth Request Resolution: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance
4

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
12/08/2021

D3.VIII.8 Remediation date non-compliance was corrected
01/07/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: MCO Improvement Plan

14 / 34

D3.VIII.2 Intervention topic
PA/SA Review

D3.VIII.3 Plan name
United Healthcare

D3.VIII.4 Reason for intervention

Untimely Prior Auth / Service Auth Request Resolution

Sanction details

D3.VIII.5 Instances of non-compliance
4

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed

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

01/06/2022 02/17/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: MCO Improvement Plan

D3.VIII.2 Intervention topic

Member Benefits/Services

D3.VIII.3 Plan name

Aetna

D3.VIII.4 Reason for intervention

Member Interpreter/Translation Services

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/19/2022

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

03/03/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

D3.VIII.2 Intervention topic

Call Center Statistics/Performance

D3.VIII.3 Plan name

Virginia Premier

D3.VIII.4 Reason for intervention

Provider Call Answer Rate

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 5,000

D3.VIII.7 Date assessed

02/04/2022

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

03/06/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance Points

17 / 34

D3.VIII.2 Intervention topic

Member Appeals Resolution

D3.VIII.3 Plan name

United Healthcare

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

$ 0

D3.VIII.7 Date assessed

03/04/2022

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

04/03/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance Points

18 / 34

D3.VIII.2 Intervention topic

Member Appeals Resolution

D3.VIII.3 Plan name

Anthem

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

03/04/2022

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

04/03/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

19 / 34

D3.VIII.2 Intervention topic

Member/Provider Communication

D3.VIII.3 Plan name

Molina

D3.VIII.4 Reason for intervention

Member Communication Materials

Sanction details

D3.VIII.5 Instances of non-compliance

N/A

D3.VIII.6 Sanction amount

$ 5,000

D3.VIII.7 Date assessed

03/04/2022

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

04/03/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic

Call Center Statistics/Performance

D3.VIII.3 Plan name

Molina

D3.VIII.4 Reason for intervention

Provider Call Answer Rate

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 5,000

D3.VIII.7 Date assessed

03/04/2022

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

06/04/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance Points

D3.VIII.2 Intervention topic

Claim Adjudication

D3.VIII.3 Plan name

Aetna

D3.VIII.4 Reason for intervention

Untimely Claim Adjudication: 5 Points

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/04/2022

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

04/03/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance Points

22 / 34

D3.VIII.2 Intervention topic

Member Appeals Resolution

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Untimely Member Appeal Resolution: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

04/11/2022

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

05/11/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: MCO Improvement Plan

23 / 34

D3.VIII.2 Intervention topic

Member Benefits/Services

D3.VIII.3 Plan name

Molina

D3.VIII.4 Reason for intervention

Member Interpreter/Translation Services

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed
05/06/2022

D3.VIII.8 Remediation date non-compliance was corrected
06/24/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: MCO Improvement Plan

24 / 34

D3.VIII.2 Intervention topic
Member Benefits/Services

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

Member Interpreter/Translation Services

Sanction details

D3.VIII.5 Instances of non-compliance
5

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
05/06/2022

D3.VIII.8 Remediation date non-compliance was corrected
06/20/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance Points

25 / 34

D3.VIII.2 Intervention topic
Member Appeals Resolution

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

Untimely Member Appeal Resolution: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance
3

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
05/06/2022

D3.VIII.8 Remediation date non-compliance was corrected
06/05/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance Points

26 / 34

D3.VIII.2 Intervention topic
PA/SA Review

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

Untimely Prior Auth / Service Auth Request Resolution: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance
9

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
05/06/2022

D3.VIII.8 Remediation date non-compliance was corrected
06/05/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Fine

27 / 34

D3.VIII.2 Intervention topic
PA/SA Review

D3.VIII.3 Plan name
Molina

D3.VIII.4 Reason for intervention

Untimely Prior Auth / Service Auth Request Resolution

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$ 5,000

D3.VIII.7 Date assessed

05/06/2022

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

06/05/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

28 / 34

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Molina

D3.VIII.4 Reason for intervention

Omitted Data

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 5,000

D3.VIII.7 Date assessed

06/03/2022

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

07/03/2022

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Compliance Points

29 / 34

Complete

D3.VIII.2 Intervention topic
Member Appeals Resolution

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

Untimely Member Appeal Resolution: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance
9

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
06/03/2022

D3.VIII.8 Remediation date non-compliance was corrected
07/03/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance Points

30 / 34

D3.VIII.2 Intervention topic
Member Appeals Resolution

D3.VIII.3 Plan name
Aetna

D3.VIII.4 Reason for intervention

Untimely Member Appeal Resolution: 1 Point

Sanction details

D3.VIII.5 Instances of non-compliance
4

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
06/03/2022

D3.VIII.8 Remediation date non-compliance was corrected
07/03/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance Points

31 / 34

D3.VIII.2 Intervention topic

Member Appeals Resolution

D3.VIII.3 Plan name

United Healthcare

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

06/03/2022

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

07/03/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

32 / 34

D3.VIII.2 Intervention topic

Call Center Statistics/Performance

D3.VIII.3 Plan name

Virginia Premier

D3.VIII.4 Reason for intervention

Provider Call Answer Rate

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 5,000

D3.VIII.7 Date assessed

06/03/2022

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

07/03/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: MCO Improvement Plan

33 / 34

D3.VIII.2 Intervention topic

Claim Adjudication

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

Untimely Claim Adjudication

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/03/2022

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

07/17/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

34 / 34

D3.VIII.2 Intervention topic

PDL Rebate Coding Errors

D3.VIII.3 Plan name

Molina

D3.VIII.4 Reason for intervention

Incorrect MCO PDL Rebates coding

Sanction details

D3.VIII.5 Instances of non-compliance

N/A

D3.VIII.6 Sanction amount

$ 29,408.32

D3.VIII.7 Date assessed

06/08/2022

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

07/08/2022

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Aetna** 40 **Anthem** 20 **Molina** 7 **Optima** 14 **United Healthcare** 292 **Virginia Premier** 6

Number	Indicator	Response
D1.X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Aetna** 26 **Anthem** 46 **Molina** 8 **Optima** 267 **United Healthcare** 123 **Virginia Premier** 1,408
D1.X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Aetna** 0.1:1 **Anthem** 0.08:1 **Molina** 0.06:1 **Optima** 0.76:1 **United Healthcare** 0.61:1 **Virginia Premier**

Number	Indicator	Response
		3.95:1
D1.X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**Aetna** 36 **Anthem** 2 **Molina** 9 **Optima** 95 **United Healthcare** 13 **Virginia Premier** 279
D1.X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Aetna** 0.14:1 **Anthem** 0:1 **Molina** 0.07:1 **Optima** 0.27:1 **United Healthcare** 0.06:1

Number	Indicator	Response
		Virginia Premier 0.78:1
D1.X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Aetna** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 10 **Anthem** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 2 **Molina** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 1 **Optima** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 1 **United Healthcare** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Number	Indicator	Response
		Count of program integrity referrals to the state 0 **Virginia Premier** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 2
D1.X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.	**Aetna** 0.04 **Anthem** 0 **Molina** 0.01 **Optima** 0 **United Healthcare** 0 **Virginia Premier** 0.01
D1.X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR	**Aetna** N/A **Anthem** N/A

Number	Indicator	Response
	438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**Molina** N/A **Optima** N/A **United Healthcare** N/A **Virginia Premier** N/A
D1.X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Aetna** Daily **Anthem** Daily **Molina** Daily **Optima** Daily **United Healthcare** Daily **Virginia Premier** Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Find in the Excel Workbook
E_BSS_Entities

Number	Indicator	Response
E.IX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus** Enrollment Broker
E.IX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus** Enrollment Broker/Choice Counseling