Managed Care Sanctions: An Important Tool for Accountability

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Executive Summary

This report is part of the National Health Law Program's ongoing work on accountability in Medicaid managed care, focusing on sanctions, which are one of the tools available to states to hold managed care organizations (MCOs) accountable for failing to meet their obligations. We reviewed managed care contracts from a sample of nine states to determine what sanctions each state had available and investigated to determine what sanctions states have imposed on plans and whether this information is available to the public. We found that these states use only a fraction of their potential sanctioning powers, more often targeting violations that deal with MCO operations than on violations that directly impact beneficiaries. Only a few of those states post detailed sanctions against MCOs online. Lastly, we found that, except in a few cases, the fines imposed on MCOs are miniscule compared to their yearly revenues and profits. For example, in Arizona in 2019 and 2020, Banner University Family Care received fines totaling $1.25 million which amounted to only 0.049% of Banner's $2.54 billion in Medicaid revenues. In California, between 2017 and 2019, Anthem Blue Cross received fines totaling over $8 million and the MCO reported over $12 billion in Medicaid revenues. This was only 0.066% of the revenue Blue Cross received in those years. This suggests that it is unlikely the MCOs see paying these fines as a hindrance nor damaging enough to create lasting change in the ways MCOs operate.

More must be done to get MCOs to pay attention to the quality of care and services they are providing Medicaid beneficiaries, whether through more punitive sanctions or other methods of oversight. We recommend that all states begin by publishing their information about sanctions imposed on MCOs in a publicly accessible format. It will help inform policy makers, providers, beneficiaries, and the public about the extent to which states are holding MCOs accountable for the quality of their performance.

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Introduction

Capitated managed care is the primary delivery model for Medicaid services in the United States. In this system, state Medicaid agencies contract with managed care organizations (MCOs, referred to in some states as managed care plans, MCPs) which are paid a predetermined, set rate per enrolled person to provide the comprehensive, health care services to which beneficiaries are entitled Medicaid. The states view this as a way to increase budget predictability year-to-year and control health care costs because, generally speaking, they know going into a fiscal year what their health care expenditures are going to be regardless of the health care needs and use of services by the Medicaid population.[1]

As of 2020, 285 MCOs operated in forty-one states including Washington, D.C.[2] Over 57 million Medicaid enrollees, or 72% of the Medicaid population received services through this

[1] Kaiser Family Foundation. 2022. **Ten Things To Know About Managed Care**. Accessed June 2022.
[2] North Carolina transitioned from fee-for-service Medicaid to Medicaid managed care in 2021. They are included in the count of 41 states with managed care, but not included in the counts of MCOs, enrollees, and expenditures also referenced.

mode of service delivery. [3] On the low end, 4.7% and 11% of the Medicaid population in Arkansas and Colorado are covered by managed care, whereas over 99% of the Medicaid population in Hawaii, Nebraska, and Tennessee are covered on the high end. Nationwide, MCOs receive over $376 billion in state Medicaid premium payments to provide comprehensive services to Medicaid enrollees, approximately 52% of all Medicaid spending.[4] In 2021, the parent companies of the MCOs saw increased Medicaid enrollment lead to new revenues.[5] The MCOs can profit significantly if their expenses providing the contractually obligated Medicaid health care services are less than the amount they get paid by the state. With the high number of people under their care and the amount of money flowing from the states into the bank accounts of MCOs, it is of utmost importance that states know they are getting high-quality care for their Medicaid enrollees. In order to do this, state Medicaid agencies must be able to assess MCO performance and have ways to hold MCOs accountable when the performance metrics and other indicators reveal that the plans are failing to provide quality care or worse putting Medicaid enrollees at risk.

Managed care sanctions are regulated under **42 C.F.R. Subpart I** which sets out the basis for imposing sanctions, the types of sanctions a state may impose, and the amounts of civil monetary penalties available. There are three general categories of sanctions states have at their disposal to hold the MCOs accountable for their actions: taking control of the plan at the administrative level, imposing corrective action plans, and imposing monetary penalties. This report focuses on sanctions set forth in Medicaid managed care contracts, t, the extent to which states are imposing the sanctions at their disposal on managed care plans, and if that information is available to the public. Our expectation at the outset of this analysis was that we would find detailed information on monetary penalties imposed on the MCOs related to poor performance providing mandated Medicaid services to beneficiaries but that was not the case with most of the states we reviewed.

Methodology

We analyzed nine states: Arizona, California, Florida, Hawaii, Missouri, New Hampshire, Ohio, Oregon, and Tennessee. These states were selected for analysis due to the high penetration rate of managed care in each state and to

[3] Kaiser Family Foundation. 2022. **Total Medicaid Enrollment**. Accessed November 2022.
[4] Kaiser Family Foundation. 2022. **Total Medicaid MCO Spending**. Accessed November 2022.
[5] Center for Children & Families (CCF) of the Georgetown University Health Policy Institute McCourt School of Public Policy, Georgetown University. 2022. **Medicaid Managed Care Financial Results for 2021: A Big Year for the Big Five**. Accessed September 2022.

select from a wide geographic distribution of states across the nation. NHeLP maintains a collection of Medicaid managed care contracts and requests for proposals (RFPs). The model and baseline contracts, as well as the RFP, generally have the same content regarding member benefits, and MCO requirements and responsibilities. What distinguishes those versions compared to a final contract are details and numerical data specific between the state and an individual MCO. In this sample, we reviewed the final contract between most of the states and MCOs. For Missouri, New Hampshire, and Ohio we have the model and baseline contracts. Hawaii currently only has the RFP available (Going forward, we use the term 'contract' interchangeably throughout this report unless otherwise noted).

We examined these contracts to discern the extent to which states may impose sanctions on MCOs for failure to provide Medicaid services. Using a simple keyword search, we first identified the sections of the contracts that covered sanctions. Then we pulled the language that described the types of sanctions the states can impose on the MCOs as well as the reasons for why sanctions may be imposed on MCOs.

In the second part of the analysis we searched the Medicaid websites of the states in our sample for publicly available information on sanctions the states impose on MCOs. Those states which report partial sanctions information or do not make sanctions information available online, we sent public records requests to the state Medicaid agencies asking for "documentation of sanctions and monetary penalties assessed against managed care plans operating in [state] for the years 2016 to 2021."

Reasons to Impose Sanctions

The reasons the states may impose sanctions on managed care plans varied across the contracts in terms of the overall number of reasons specified and the level of detail about the sanctions in question. Across the nine contracts reviewed, there are forty-nine different reasons to impose a sanction on a MCO. In this sample of states, Ohio spells out twenty-two reasons for sanctions, followed by Florida with nineteen, Oregon with twelve, and California with eleven reasons. Hawaii, Missouri, and New Hampshire list nine. The remaining states in the sample – Arizona, New Hampshire, and Tennessee – all list six reasons for sanctions. The forty-nine different reasons for sanctions we narrowed down to fifteen groups of similar reasons.

Table 1 details the reasons among the fifteen condensed groups each state in our sample imposes sanctions.

TABLE 1: REASONS FOR IMPOSING SANCTIONS										
REASON	**AZ**	**CA**	**FL**	**HI**	**MO**	**NH**	**OH**	**OR**	**TN**	**COUNT**
NONCOMPLIANCE WITH ANY PROVISION OF CONTRACT	X	X	X				X			**4**
FAILURE TO PROVIDE MEDICALLY NECESSARY SERVICES, DISCRIMINATION, JEOPARDIZING HEALTH AND SAFETY OF ENROLLEES		X		X	X	X	X	X	X	**7**
FINANCIAL INFRACTIONS	X	X	X	X	X	X	X	X	X	**9**
HEALTH PLAN QUALITY		X	X			X	X	X		**4**
DATA REPORTING ERRORS	X	X	X	X		X	X	X		**6**
INADEQUATE NETWORK & ACCESS TO SERVICES, NONCOMPLIANCE W/ GRIEVANCE & APPEALS SYSTEM	X						X	X		**3**
NONCOMPLIANCE W/ PROVIDER CLAIMS DISPUTE, FAIR PAYMENT, CREDENTIALING	X		X				X			**3**
FAILURE TO MEET PROGRAM REQUIREMENTS			X				X	X		**3**
NONCOMPLIANCE W/ CORRECTIVE ACTION PLANS		X		X	X	X	X	X	X	**7**
INFORMATION SECURITY FAILURES			X							**1**
FRAUD			X	X	X					**3**
DISTRIBUTING FALSIFIED PLAN INFORMATION		X		X	X	X		X	X	**6**
ISSUES WITH SERVICE AUTHORIZATION & SUBCONTRACTING AGREEMENTS			X	X	X					**3**
NONCOMPLIANCE WITH PHYSICIAN INCENTIVE PLANS		X		X	X	X		X	X	**6**

NONCOMPLIANCE WITH FEDERAL OR STATE STATUTORY OR REGULATORY REQUIREMENTS		X								**1**
COUNT	**5**	**9**	**9**	**8**	**7**	**7**	**9**	**9**	**5**	

Financial infractions committed by the managed care organization are grounds for imposing sanctions in all nine of the reviewed contracts. Some types of infractions we included in this group included failing to report errors relating to capitated payments and failing to correct and resubmit accurate payment reports, submitting late or incomplete claims payments reports, noncompliance with records requests, and noncompliance with medical loss ratio requirements.

Violations that directly impact enrollees are mentioned in seven of the reviewed contracts, but not mentioned in the contracts of Arizona and Florida. Noncompliance with corrective action plans is also mentioned as a reason for sanctions in all of the reviewed contracts except for Arizona and Florida.

Types of Sanctions

We identified seventeen different types of sanctions across the nine contracts states may impose on MCOs, which we narrowed down to eight similar groups. These are:

- Temporary Management of a Contractor
- Corrective Action Plans
- Monetary Penalties
- Enrollment Penalties
- Payment Penalties
- Marketing Penalties
- Contract Termination or Refusal to Renew
- Referral for Investigation

In the contracts we reviewed, Corrective Action Plans (CAPs) are typically an intervention that precedes actual fines. CAPs consist of step-by-step structured activities, processes, or quality improvement initiatives implemented by the MCOs to improve operational and clinical quality

deficiencies.[6] Monetary Penalties (occasionally referred to as liquidated damages) are itemized fines for specific contract violations like failing to provide particular services, falling short of performance measure benchmarks, or being late on data reporting requirements. Monetary penalties carry a specific dollar amount for instances of infractions, or fines per member, per day, per month lasting until the MCO is back in compliance or corrects the issue for which they received the penalty. Enrollment penalties can include suspending member enrollment for a defined period of time, disenrolling plan members, allowing plan members the right to disenroll, and suspension of new member enrollment. Payment penalties include the state withholding payment, denying payment altogether, and suspension of payment for new enrollees. Marketing penalties are restrictions on the MCO's ability to market their services.

Table 2 displays the types of sanctions discussed in each state's contract.

TABLE 2: TYPE OF SANCTIONS IN REVIEWED CONTRACTS

TYPE OF SANCTIONS	AZ	CA	FL	HI	MO	NH	OH	OR	TN	COUNT
TEMP MGMT OF CONTRACTOR	X	X	X	X	X	X	X	X	X	9
CORRECTIVE ACTION PLANS	X	X	X	X		X	X		X	7
MONETARY PENALTIES	X	X	X	X	X	X	X	X	X	9
ENROLLMENT PENALTIES	X	X	X	X	X	X		X	X	8
PAYMENT PENALTIES	X	X		X	X	X		X	X	7
MARKETING PENALTIES		X								1
CONTRACT TERMINATION OR REFUSAL TO RENEW	X	X	X	X		X	X			6
REFERRAL FOR INVESTIGATION				X						1
COUNT	**6**	**7**	**5**	**7**	**4**	**6**	**4**	**4**	**5**	

[6] Centers for Medicare and Medicaid Services. 2013. Corrective Action Plan (CAP) Process. Accessed June 2022.

All of the contracts we reviewed contained temporary management of contractors and monetary penalties as a type of sanction the states can impose on the plans. Enrollment penalties, corrective action plans, and payment penalties are the next most frequently mentioned types of sanctions referenced in the managed care contracts. The use of marketing penalties and referrals for investigation by state or federal authorities are the least common, appearing in one contract each.

Monetary Penalties

Monetary penalties are a natural tool for states to use when attempting to hold MCOs accountable for failing to meet their obligations. This is because many MCOs operate as for-profit companies and withholding payment or forcing the MCOs to pay in response to poor performance is seen as a particularly effective way to motivate MCOs to make the changes that will lead to improved results. In each reviewed contract, sanctions include monetary penalties and the extent to which the monetary penalties are itemized and detailed varies widely across the contracts.

The contracts of seven states contain a list of the monetary penalties that may be imposed on the MCOs operating in those states. This includes four similar large sanctions that are found in the contracts of Hawaii, Missouri, New Hampshire, Oregon, and Tennessee. In these states, for each instance of discrimination against members on the basis of their health status or need for services, MCOs may be subjected to a fine up to $100,000. Additionally, the MCOs may be fined up to $15,000 (up to $100,000 total) for each individual member the state agency determines was discriminated against. The MCOs may be fined up to $100,000 if the plan is found to have misrepresented or falsified any information that is furnished to the Centers for Medicare and Medicaid Services (CMS) or to the state or their designees under this Contract. The fourth common sanction is if a MCO imposes premiums or charges on Members that are in excess of those permitted in the Medicaid program, a monetary penalty up to $25,000 or double the amount of the excess charges (whichever is greater) can be assessed. The contracts of **Arizona** and **California** mention the use of monetary penalties but do not detail those penalties, instead the both contracts simply state that the monetary penalties must be consistent with the federal and state regulations.[7]

[7] Arizona Health Care Cost Containment System - Contract Number: YH19-0001 - October 2021. §D. Program Requirements (pg. 244)

Other examples include **Florida**'s contract providing for a sanction of $200 per day for every day the MCO fails to implement a corrective action plan.[8] Additionally, the contract says the state may impose a fine of $5,000 per day for each day of noncompliance for encounter data reporting errors beginning on the 31st day of noncompliance. **Hawaii**'s contract has a detailed list of monetary penalties, which are broken down into eighteen categories.[9] They range from $100 to $50,000. **Missouri**'s contract mentions a variety of monetary sanctions throughout the contract but dollar amounts are not specified.[10]

New Hampshire's contract requires that the New Hampshire Department of Health and Human Service (DHHS) must impose intermediate sanctions if the MCO fails to substantially provide medically necessary services to a member that the MCO is contractually required to provide. Furthermore, an exhibit to the contract details fifty-four actions or inactions by the MCO which will draw "liquidated damages."[11] These are stratified into four levels depending whether the infractions seriously jeopardize the health, safety, and welfare of members, jeopardize the integrity of the managed care program, diminish the effective oversight and administration of managed care program, and/ or inhibit the efficient operation of the managed care program.

The **Ohio** Department of Medicaid (ODM) assesses financial sanctions based on a system imposing points for violations of program requirements.[12] The agency may assess five points for any instance of noncompliance with applicable rules, regulations, or contractual requirements that could: (1) impair a member's or potential enrollee's ability to obtain accurate information; (2) violate a care management process like failing to coordinate care for a member across providers and specialists or failing to follow up with the member and

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California Demonstration Three-Way Contract. 2018. §5.3.13.2.1. Intermediate sanctions and civil monetary penalties (pg. 198)

[8] Florida Attachment II - Scope of Service - Core Provisions - October 2020. §XIII. Sanctions (pg. 188-193)

[9] Hawaii QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals RFP, Dec 2020. §14.21.F Table 11 (pp 527-529)

[10] Missouri Managed Care Contract - August 2020. §2.29.10 Types of Intermediate Sanctions

[11] New Hampshire Medicaid Care Management Services Model Contract - July 2019-2024. Exhibit N Liquidated Damages Matrix (pp 1-7)

[12] Ohio Medicaid Managed Care Baseline - August 2021. §2 Types of Sanctions/Remedial Actions (pp 174-178)

provider; or (3) infringing on the rights of a member or potential enrollee. ODM may assess ten points for any instance of noncompliance with applicable rules, regulations or contractual requirements that could (1) affect the ability of the MCO to deliver, or a member to access, covered services; (2) place a member at risk for a negative health outcome; or (3) that jeopardizes the safety and welfare of a member. The points accumulate over a twelve-month rolling period and the amount of the monetary penalty goes up as the number of points accumulate. All of the financial sanctions are accompanied by a CAP. The fines range from $5,000 - $30,000. More than 100 accumulated points in a twelve-month period will result in termination of the contract between ODM and the MCO.

Ohio also has a list of twenty-five sanctions that have specific dollar amounts attached.[13] Many of these are for noncompliance with specific reporting requirements required by ODM, as well as for failing to meet quality measures and performance measures. The penalties for the sanctions range from $100 a day – for each instance of submitting data or documentation late – pup to $300,000 for failing to administer a CAHPS survey and not submitting the results to the National Committee for Quality Assurance.[14] The contract also stipulates that the total amount of financial sanctions assessed in any one month will not exceed 15% of one month's premium payments from ODM to the managed care plan.

Oregon's contract contains a chart of twelve types of civil monetary penalties ranging from $50 - $1,000 per claim, infraction, or occurrence which deal with instances of encounter data entry error, failing to provide timely reports or responses, failing to terminate ineligible providers, and others.[15]

Tennessee's contract contains a chart of sixty-seven specific responsibilities or requirements that may result in liquidated damages if the contractor fails to perform those responsibilities or requirements.[16] Similar to New Hampshire's contract, the monetary penalties in Tennessee's contract are divided into three tiers. Level A requirements are those which pose a significant

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[13] *Id.* at pp 178-192

[14] **National Committee for Quality Assurance** is an independent, nonprofit organization that specializes in health care quality rating and accreditation. Health plans seek accreditation and measure performance through the administration and submission of the **Healthcare Effectiveness Data and Information Set** (HEDIS) and **Consumer Assessment of Healthcare Providers and Systems** (CAHPS) survey.

[15] Oregon Health Plan Services Contract - Oct 2019-2024. Part 9 Program Integrity §7. Civil Money Penalties (pp 150-151)

[16] Tennessee Amerigroup TennCare Amendment 12 - 2022. §29.2.27 Liquidated Damages Chart (pp 401-414)

threat to patient care or to the continued viability of the TennCare program. Level B requirements are those which pose threats to the integrity of the TennCare program, but which do not necessarily imperil patient care. Level C requirements are those which represent threats to the smooth and efficient operation of the TennCare program but which do not imperil patient care or the integrity of the TennCare program. An example of a Level A requirement is providing coverage for prenatal care without a delay in care. Failure to do so results in a fine of $500 per day, per occurrence, for each calendar day that care is not provided. Failure to provide a written discharge plan or provision of a defective discharge plan for discharge from a psychiatric inpatient facility or mental health residential treatment facility is a Level B requirement that can result in liquidated damages of $1,000 per occurrence, per case. An example of a Level C violation is failing to comply in any way with encounter data submission requirements. This violation carries with it liquidated damages of $25,000 per occurrence.

Identifying Published Sanctions

We next determined if and where the nine states posted information online about sanctions imposed on MCOs operating in each state. If information about imposed sanctions was not found online, we sent those states a public records request for the documentation.

A few takeaways from this review: First, while contracts detail numerous reasons why a state may choose to impose sanctions on a MCOs, the states have only imposed sanctions for a handful of the possible reasons. Second, with the exception of a few instances, the size of the monetary penalties imposed on MCOs are unlikely to make a noticeable difference in a plan's yearly financial bottom line. Third, states do not always post sanctions information against MCOs online yet information about providers being terminated for Medicaid violations is easier to find. Finally, information about sanctions is made available to the public varies widely from state to state and the quality and depth of that information is wide ranging as well.

Arizona and California are the two states in this analysis that published the most detailed information about sanctions against MCOs. The documentation about imposed sanctions is relatively easy to find and it is well organized. These states are also the two which imposed the largest fines against MCOs, although we will discuss the extent to which these fines have an impact on the profitability of MCOs in each state. Neither state publishes – or this analysis did not find – summary information on the total number of sanctions imposed on MCOs or the total financial impact of the sanctions on the MCOs. Any totals presented here are based on the amounts of the sanctions reported in the available documentation, so it may not truly reflect the total penalties imposed on MCOs, but it's likely that all of the major penalties are reported and accounted for. There are also gaps in the years that these states report

sanctions which are not consistent across the different MCOs. We are unable to answer if this is simply due to the state not reporting sanctions in a specific year, the complete absence of sanctionable activity on the part of the MCOs, or activity not rising to the level of a sanctions.

Arizona

The Arizona Health Care Cost Containment System (AHCCCS) maintains a **webpage detailing administrative actions** imposed on managed care plans participating in their Complete Care (ACC) service line. The types of actions are Notice of Concern, Notice to Cure, Corrective Action Plan (CAP), and Sanctions. The state lists these by line of business and by contractor. The following charts summarize the reasons why AHCCCS imposed sanctions on their MCOs and the total amounts each plan was penalized the years they were sanctioned.

The vast majority of sanctions imposed on Arizona's MCOs deal with operational issues between the plan and Medicaid. AHCCCS most frequently sanctions MCOs for "pending encounters," which result from errors or delays when the plans report member encounter data. The state gives the plans 120 days to make corrections to the encounter data from the date AHCCCS receives the data. If no corrections are made to these denied or pended encounters, sanctions may be applied.[17] It is concerning that the plans continue to make the same mistakes year-after-year when it comes to reporting member encounter data. There are also published sanctions for failures that can lead to negative patient experiences or adverse health conditions for members. For example, Care1st Health Plan received a Notice of Concern for requiring prior authorization for crisis behavioral health services, which is a clear contract violation. Magellan received a sanction for failing to operate a Dual-Special Needs program in a geographic service area. These violations could be harmful because they delay access care or prevent beneficiaries from accessing the type of provider or specialist they require. In these instances, though, neither Care1st or Magellan received a large penalty for failing to meet the needs of their members (see tables below).

[17] **AHCCCS Division of Healthcare Management (DHCM) Encounter Manual**. October 2020. Accessed August 2022.

Year	2018	2019	2020	2021	2022
Plans Sanctioned by AHCCCS	Care1st Health Plan; Mercy Care	Arizona Complete HCP; Banner University Family Care; Care1st; Magellan/ Molina; Mercy Care; UnitedHealth Care	Arizona Complete HCP; Banner University Family Care; Health Choice Arizona; Mercy Care	Arizona Complete HCP; Banner University Family Care; Mercy Care	Magellan / Molina Complete Care; Mercy Care
Total $ of Penalties	$50,000	$1.1 million	$817,075	$342,129	$23,230

Arizona Complete Health Care Plan			
	2019	**2020**	**2021**
Reason	The plan chose to merge physical health and behavioral health providers into a single provider network database. Implementing the provider network database resulted in significant adverse impacts, led to an inability to effectively process and issue timely and accurate claims payments to providers; failed to meet CAP deadlines	Ongoing provider network database problems; inaccurate and late payments to providers	Failure to timely issue member ID cards; failure to provide accurate member data to providers resulting in inaccurate incentive payments
Total Monetary Penalty	$375,000	$54,285	$281,360

Banner University Family Care			
	2019	**2020**	**2021**
Reason	43,179 sanctioned pending encounters	39,543 sanctioned pending encounters; failed to provide accurate member assignment data	5,913 sanctioned pending encounters; inaccurate facility encounter/ claims data
Total Monetary Penalty	$507,735	$744,010	$53,889

Care1st Health Plan		
	2018	**2019**
Reason	Prior Authorization (PA) requirements for Behavioral Health services (See Appendix A)	NEMT providers were not properly licensed or credentialed
Action	Plan to remove all PA for crisis behavioral health services, review all other PA for other behavior health services	Ordered to develop an action plan to bring all drivers into compliance

Health Choice Arizona		
	March 2020	**December 2020**
Reason	277 sanctioned pending encounters	909 sanctioned pending encounters
Total Monetary Penalty	$1,530	$6,920

Magellan / Molina Complete Care		
	2019	**2022**
Reason	Failure to operate a Dual-Special Needs program in a geographic service area (See Appendix A)	Failure to provide accurate and complete financial reporting from December 2019 to present
Total Monetary Penalty	$75,000	$10,000

Mercy Care					
	2018	**2019**	**2020**	**2021**	**2022**
Reason	Failure to maintain compliance with Telephone Performance Standards	25,161 sanctioned pending encounters	1,409 sanctioned pending encounters	933 sanctioned pending encounters	1,708 sanctioned pending encounters
Total $ Penalty	$50,000	$158,270	$10,330	$6,880	$13,230

United Healthcare Community Plan	
	2019
Reason	Potentially utilizing non-emergency medical transportation providers that were not properly credentialed
Notice of Concern	The state ordered UHCP to develop and implement an Action Plan to bring all drivers into compliance on a specific timeline. Notices of Concern do not impose monetary penalties.

California

The oversight of managed care plans in California is a complicated interplay between the state Department of Health Care Services (DHCS), the single State Medicaid Agency, and the state's Department of Managed Health Care (DMHC). DMHC licenses most of the Medi-Cal MCOs, giving them oversight responsibility for the areas associated with licensure: the financial status of the plan, compliance with covered service requirements, relevant Affordable Care Act provisions, access to care requirements, utilization review provisions, and grievance requirements. DHCS is responsible for enforcing all federal and state Medicaid laws, and also has a contract relationship with the plans so it also enforces the contract requirements. This creates some overlap between the two departments, particularly related to covered services, access to care, utilization review, and grievance requirements. In general, DHCS has primary responsibility for enforcing those items, but coordinates with DMHC. The exception is issues related to grievances, since the state law and Medicaid Act each impose distinct requirements. In these cases, DMHC enforces state law requirements and DHCS enforces the Medicaid requirements.

California DHCS maintains a webpage to which the state posts letters **announcing administrative and financial sanctions** imposed on managed care plans. There are currently seventeen letters dating back to January 2017, describing sanctions assessed to twelve different plans. In addition, DMHC **publishes annual reports** which, among other topics, detail enforcement actions against the managed care plans separate from the sanctions detailed in the letters produced by the DHCS.

In 2017 DHCS implemented a change in how Medi-Cal MCOs submit provider network data to the state. MCOs that were not ready and did not properly submit their data by March 2017 were first subjected to a CAP, and then had monetary penalties imposed on them for continued noncompliance with the new system. Fines started at $5,000 per month, but increased to $10,000 for additional months of noncompliance. Several of the MCOs failed to meet this and subsequent deadlines in 2017, 2019, and 2020.

Another common infraction on the part of the MCOs that drew fines from the state was failing to respond to members' grievances in a timely manner (See charts below: Aetna, Anthem, Blue Shield, Health Net, L.A. Care). MCOs are responsible for setting up systems to properly identify, receive, resolve, and hear appeals from members regarding grievances with plan determinations. Failure to properly meet the needs of beneficiaries on any one of those points can result in delays in payment, delays in authorizations, and delays in members seeking and receiving appropriate care which can lead to health concerns going unaddressed.

California's managed care oversight agencies occasionally imposed large monetary penalties of millions of dollars, which was not found among the other states in this analysis. Anthem Blue Cross amassed just over $8 million in monetary penalties between 2017 and 2019. In 2017 Kaiser Permanente racked up over $4.6 million in penalties in 2017 and another $100,000 in 2019. Blue Cross of California Partnership Plan received a $1.2 million fine in 2020. The highest monetary penalties in California and in the other states included in this review, however, were imposed in 2022 on L.A. Care Health Plan, for $55 million. Due to a variety of factors but primarily centered around thousands of instances of failing to address grievances, appeals, and prior authorization requests in a timely manner, L.A. Care Health Plan received a large penalty of $20 million from DHCS and another of $35 million by DMHC.

Year	2017	2018	2019	2020	2021	2022
Number of DHCS Letters	6	2	5	3	0	1
Plans Sanctioned by DHCS	AIDS Healthcare Foundation; California Health & Wellness; Gold Coast Health Plan; Kaiser Permanente (x2); L.A. Care Health Plan	Health Plan of San Joaquin; Health Net Community Solutions	Contra Costa Health Plan; Inland Empire (x2); Molina; San Francisco Health Plan	California Health & Wellness; Molina; Santa Clara Family Health Plan	N/A	L.A. Care Health Plan
DHCS Total $ of Penalties	$2.3 million	$470,000	$101,000	$11,500	$0	$20 million
Plans Fined by DMHC	Anthem Blue Cross; Blue Shield of CA; Health Net; Molina -	Aetna Health; Anthem Blue Cross; Molina - 2018	Aetna Health; Anthem Blue Cross; Kaiser Permanente; L.A. Care	Aetna Health; Blue Cross of California Partnershi	Aetna Dental of CA; Blue Shield of CA; Health Net; Health	L.A. Care Health Plan

	2017 DMHC Annual Report does not include information on all 21 plans given fines and penalties for consumer grievance system violations	DMHC Annual Report does not include information on all of the fines and penalties	Health Plan; 12 plans fined collectively	p Plan; Community Health Group; Ventura County Health	Net Community Solutions; L.A. Care Health Plan; Premier Health Plan Services, Inc.	
DMHC $ of Penalties	$8.9 million	$2.9 million	$6.9 million	$3.72 million	$2.6 million	$35 million
Total $ of DHCS & DMHC Penalties	$11.2 million	$3.4 million	$7.05 million	$3.73 million	$2.6 million	$55 million

Aetna Health of California			
	2018	**2019**	**2020**
Reason	Numerous violations for two medication requests - same enrollee	Denying enrollee requests for gender reassignment services	1) Wrongfully denying payment for emergency medical services 2) Continued failure to cover speech therapy services
Total Monetary Penalty	$45,000	$50,000	1) $500,000 2) $120,000

Aetna Dental of California	
	2021
Reason	Multiple deficiencies: quality assurance program, grievance system, failure to timely make and convey utilization management decisions, failure to meet the statutory requirements for language assistance programs
Total Monetary Penalty	$85,000

AIDS Healthcare Foundation	
	2017
Reason	Failure to comply with 2017 CAP Failure to submit provider network data file
Total Monetary Penalty	$25,000

Anthem Blue Cross			
	2017	**2018**	**2019**
Reason	1) Failure to timely provide documents for Independent Medical Review (IMR) 2) consumer grievance system violations	Untrue or misleading advertising and conduct that constitutes fraud or dishonest dealing	1) Failure to properly identify and resolve enrollee grievances and appeals 2) Incorrectly charged enrollees a copayment for oral contraceptive prescriptions
Total Monetary Penalty	1) $50,000 2) $5 million	$70,000	1) $2.8 million penalty settlement agreement 2) $100,000

Blue Cross of California Partnership Plan	
	2020
Reason	Failure to timely authorize coverage twice for medically necessary services after IMR determination
Total Monetary Penalty	$1.2 million

Blue Shield of California		
	2017	**2021**
Reason	Consumer grievance system violations	Failure to timely implement an IMR decision adopted by the DMHC
Total Monetary Penalty	$342,000	$150,000

California Health & Wellness		
	2017	**2020**
Reason	Failure to comply with 2017 & 2020 CAPs Failure to submit provider network data file each year	
Total Monetary Penalty	$35,000	$8,500

Contra Costa Health Plan	
	2019
Reason	Failure to comply with 2019 CAP Failure to submit provider network data file

Total Monetary Penalty	$5,000

Gold Coast Health Plan	
	2017
Reason	Failure to comply with 2017 CAP Failure to submit provider network data file
Total Monetary Penalty	$25,000

Health Net		
	2017	**2021**
Reason	Unlawful denial of coverage for medical services (re: gender reassignment surgery)	Failure to pay claims for medically necessary and authorized services, failure to timely pay claims, and failure to adequately consider the enrollee's grievance
Total Monetary Penalty	$200,000	$35,000

Health Net Community Solutions		
	2018	**2021**
Reason	Failed to meet or exceed MPLs on HEDIS performance measures in 2014 - 2016 Failed to meet MPLs on 34 plan-wide measures in 2018	Imposing an impermissible referral requirement for OB/GYN care and for its repeated failure to initiate a grievance
Total Monetary Penalty	$335,000	$25,000

Health Plan of San Joaquin	
	2018
Reason	Failure to meet or exceed Minimum Performance Levels (MPL) on HEDIS performance measures in 2014-2016 Failed to meet MPLs on 14 plan-wide measures in 2018
Total Monetary Penalty	$135,000

Inland Empire		
	May 2019	**November 2019**
Reason	Failure to submit provider network data file	Failure to report required encounter data from Sept 2014 to April 2015
Total Monetary Penalty	$5,000	$80,000

Kaiser Permanente			
	January 2017	**May 2017**	**2019**
Reason	Failure to submit encounter data for external medical claims and failure to submit Physician Administered Drugs (PAD) data from March 2010 to March 2015	Failure to submit encounter data for external medical claims, correct paid claim information, all institutional, professional, and pharmacy encounter data, all PAD data	Failure to have a designated contact representative to respond to DMHC for urgent matters outside of normal business
Total Monetary Penalty	$2,535,500	$2,211,000	$100,000

L.A. Care Health Plan				
	2017	**2019**	**2021**	**2022**
Reason	Failure to comply with 2017 CAP Failure to submit provider network data file	Illegal recoupment of claims paid to providers	Multiple enrollee grievance enforcement actions	Failure to timely resolve grievances and appeals and send resolution letters to members (40,000+ instances) Failure to timely process prior authorization requests (92,000+ instances)
Total Monetary Penalty	$35,000	$75,000	$173,500	$55 million

Molina				
	2017	**2018**	**2019**	**2020**
Reason	Inappropriate personnel making utilization management modifications and denials	Numerous failures to pay for covered emergency services, and repeated failures to identify enrollee grievances	Failure to comply with 2017 CAP Failure to submit provider network data file	Submitted a provider network data file a day past due date
Total Monetary Penalty	$150,000	$100,000	$5,000	$1,000

Premier Health Plan Services	
	2021
Reason	Failure to maintain the minimum required tangible net equity (TNE) and for various claims payment and provider dispute resolution violations
Total Monetary Penalty	$130,000

San Francisco Health Plan	
	2019
Reason	Failed to submit provider network data file
Total Monetary Penalty	$5,000

Santa Clara Family Health Plan	
	2020
Reason	Submitted provider network data file three days late
Total Monetary Penalty	$2,000

Ventura County Health Plan	
	2020
Reason	Failed to calculate cost-sharing financial requirements in accordance with the Mental Health Parity Act regulations.
Total Monetary Penalty	$25,000

Florida

Florida does not publish information about sanctions against MCOs that we were able to identify. We requested documentation from Florida about sanctions against MCOs, but have not received a response at this time. The Office of Medicaid Program Integrity **maintains a searchable database of providers** – individuals and entities – that have been sanctioned and terminated while participating in Florida Medicaid. The database currently contains 1,437 entries from January 2016 through the present, 68% of which are actions taken against provider entities. Pharmacies, home and community-based services providers, assistive care services agencies, home health agencies, and behavioral analysis clinics are the provider entities that received the highest number of total sanctions.

The state imposed fines on 529 provider entities and 61 individuals, which ranged from $2.74 to $402,000.[18] While the largest fines were levied on provider entities, two individuals received fines over $100,000. Suspensions were also unevenly distributed as provider entities received 68% of the suspensions. Terminations were more evenly divided between the two groups. Individual providers constituted 53% of the 482 total provider entities and individuals who were removed from participating in the Medicaid program. Physicians received over half of the fines in the individual providers group but providing unauthorized behavioral analysis services was the most common reason individuals were terminated from participating in the Medicaid program. See Appendix B for a full list of the types of provider entities and individual providers that the state fined, suspended, and terminated from participation in the Medicaid program.

Sanction Type	2016	2017	2018	2019	2020	2021	2022	Total
Fines	102	97	104	112	84	59	32	590
Fines Rescinded	1			2	1			4
Suspension	74	62	58	44	55	23	25	341
Suspension Rescinded	1		10	1	3	4	1	20

[18] There is no indication of whether the amount of $2.74 was an actual fine amount or if this is a data reporting error.

Termination	76	61	87	65	30	134	29	482
Total	**254**	**220**	**259**	**224**	**173**	**220**	**87**	**1437**

Amount of Fine $	**$0 - $1000**	**$1000 - $2500**	**$2500 - $5000**	**$5000 - $10000**	**$10000 - $25000**	**$25000 - $50000**	**$50000 - $100000**	**$100000 +**
Number of providers fined	176	77	182	68	41	21	12	10

Hawaii

Hawaii does not publish information about sanctions against MCOs that we were able to identify. We requested documentation from Hawaii about sanctions against MCOs, but have not received a response at this time.

Missouri

Missouri does not publish information about sanctions against MCOs that we were able to identify. We requested documentation from Missouri about sanctions against MCOs, but have not received the requested documentation at this time. The Department of Social Services **publishes a list of providers** – individuals and entities – that have been terminated from participating in Missouri Medicaid programs. Missouri's data shows from 2016-2022 the state terminated 121 provider entities and individuals, with the most terminations occurring in 2019 and 2018.

Year	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Number of Providers Terminated	18	15	29	35	11	12	1

The most common individual providers and entities terminated from Missouri Medicaid are independent health clinics, personal care services agencies, and individual physicians. Independent health clinics, which includes rural health clinics, were mainly terminated for

carrying bad debt, which happened thirteen times. Four clinics were terminated for a fraud settlement, conviction, or failure to disclose fraud and four clinics were terminated for not meeting various Medicaid contract stipulations. Personal Care/ Homemaker Chore/ Adult Day Care providers were also mostly terminated for bad debt followed by fraud settlement, conviction, or failure to disclose fraud. Physicians were the third mostly likely providers to be terminated from Missouri Medicaid. The top reasons for termination were split between the fraud group and having their license to participate in Medicaid revoked, six times for each category. The remaining reasons physicians were terminated fell across several other categories including other state Medicaid termination; felony charge, plea, or conviction; OIG exclusion; and bad debt. All of the physicians terminated during this time period were individual providers. See Appendix B for full lists.

Most Common Provider Types Terminated	2016	2017	2018	2019	2020	2021	2022	Total
Independent Clinic / Rural Health Clinic	3	1	11	9		2		26
Personal Care/ Homemaker Chore/ Adult Day Care	2	2	4	8	5	2	1	24
Physician MD & DO	3	3	4	7	3	3		23

Most Common Reason for Termination	2016	2017	2018	2019	2020	2021	2022	Total
Bad Debt		1	17	13	2	4	1	38
Fraud/ Settlement/ Conviction/ Failed To Disclose	9	3	5	6	4	3		30
License Revoked		2	3	3	3	1		12
OIG Exclusion	4	4	1	1	1			11

New Hampshire

The New Hampshire Department of Health and Human Services (DHHS) does not publish sanction documentation online that we could find. The state responded to our public records request by returning an Excel file documenting 109 instances, dated between June 2021 and the beginning of April 2022, in which NH DHHS assessed liquidated damages against the three MCOs operating in the state. Those MCOs are AmeriHealth Caritas New Hampshire, New Hampshire Healthy Families, and Well Sense Health Plan.

New Hampshire imposed $127,000 in liquidated damages on the three managed care plans. Collectively, 51% of the sanctions across the plans were for incomplete or incorrect deliverables, such as data reports, 43% were for performance standard violations, and 5% of the sanctions were for late deliverables, but those sanctions were only applied to Well Sense and AmeriHealth Caritas. Well Sense was the most penalized receiving 55 sanctions for a total of $62,000. The majority of the sanctions, 52%, were for submitting incorrect data reports, but they also received 38% for performance standard violations. AmeriHealth Caritas New Hampshire received 36 sanctions for a total of $47,000. The majority of the sanctions, 55%, were for performance standard violations, but 42% were for submitting incorrect data reports. New Hampshire Healthy Families received 18 sanctions for a total of $18,000. Two-thirds of the sanctions were for submitting incorrect data reports.

The most detailed information in New Hampshire's sanctions documentation as to why liquidated damages were imposed comes out of the performance standard violations. Each instance of a violation lists the contract performance standard, the plan's performance below the standard, and the date the violation occurred. See Appendix A for a breakdown of the reasons why New Hampshire's managed care plans were assessed liquidated damages by service category and a look at which violations cost each plan the most money.

Managed Care Organization	Number of Sanctions	Total Monetary Penalty
Well Sense	55	$62,000
AmeriHealth Caritas New Hampshire	36	$47,000
New Hampshire Healthy Families	18	$18,000

Count of Monetary Penalties by Type of Violation				
Managed Care Organization	**Incomplete/Incorrect Deliverable**	**Late Deliverable**	**Performance Standard Violation**	**Total**
Well Sense	29	5	21	55
ACNH	15	1	20	36
NHHF	12		6	18
Total	**56**	**6**	**47**	**109**

Ohio

We did not find sanction documentation online for Ohio's Medicaid program. Ohio Department of Medicaid (ODM) responded to our public records request with a one-page table listing six types of violations, the type of sanctions applied to each type of violation, and the number of sanctions applied for each type of violation by year from 2016 to 2021.

The contract violation most frequently cited for sanctions in each year of the documentation period is failure to meet provider panel requirements in accordance with federal access standards. Financial sanctions were applied to these violations but Ohio's data does not include information on the dollar amounts levied on those violations. The highest number of these sanctions, 19, were applied in 2017 and 2021.

Failure to meet performance measure benchmarks was the second-most cited contract violation across the documented years. Corrective action plans and financial sanctions were applied to these violations but the data is combined so it is unclear how these penalties were applied individually. The highest number of sanctions for failing to meet performance measures, 13, were applied in 2017. In 2020 there were no sanctions or corrective action plans applied for failure to meet performance measures.

Other violations which resulted in financial sanctions were failing to pay late fees and failing to make prompt payments. Other violations being subject to corrective action plans were prior authorization failures and failure to follow file specifications.

The Sanctions Table is reproduced here:

Ohio Number of Sanctions Per Year							
Violations	**Type of Sanction**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Failure to Meet Provider Panel Requirements	Financial Sanctions	13	19	16	17	8	19
Performance Measures	Corrective Action Plans, Financial Sanctions	10	13	5	6	0	5
Late Fees	Financial Sanctions	3	2	4	4	2	3
Prompt Pay	Financial Sanctions	0	0	5	2	0	2
Prior Authorization	Corrective Action Plans	2	1	0	5	0	0
Failure to Follow File Specifications	Corrective Action Plans	3	3	4	0	0	6
Total Number of Sanctions Applied		**31**	**38**	**34**	**34**	**10**	**35**

Oregon

We did not find documentation of sanctions imposed for Oregon. Oregon Health Authority (OHA) responded to our public records request with Notices of Noncompliance to the individual managed care plans operating in the state. Three plans were issued Notices of Noncompliance: Cascade Health Alliance and Health Share of Oregon were notified in 2019 and Trillium Health Plan received a notice in 2020.

Cascade Health Alliance received a Notice of Noncompliance in May 2019, for repeated instances of not covering appropriate Hepatitis C treatments. Cascade was ordered to take immediate action to correct the noncompliance by developing and implementing a Corrective Action Plan. The CAP described actions and activities to correct noncompliance, data gathering, and interventions to improve outcomes and maintain compliance in the problem areas. OHA lifted the CAP on December 31, 2019 without imposing monetary penalties, on the basis of data submitted by Cascade showing they were in compliance with all required actions

Health Share of Oregon received a Notice of Noncompliance in October 2019 due to very poor performance not providing reliable Non-Emergent Medical Transportation and an excessive complaint rate for a host of scheduling and service delivery problems (see Appendix A). OHA ordered Health Share to develop and implement a CAP describing actions and activities to correct various problems and to submit weekly performance reports.

In September 2020, Trillium Community Health Plan (Tri-County) received a Notice of Noncompliance from OHA. The Notice cited numerous problems relating to deficiencies in network adequacy, health equity & language access, community engagement, and intensive care coordination services. The Notice came at a time when Trillium was beginning the process of requesting approval for a service area expansion. OHA subjected Trillium to a CAP to correct the plan's deficiencies in order to get approved for the service area expansion. Refer to Appendix A for complete details on the Notices of Noncompliance as well as the parameters of the CAPs agreed to by Cascade, Health Share, and Trillium.

While information about monetary sanctions imposed on MCOs was not published, Oregon Health Authority does publish **a list of sanctioned providers**, which currently has one entry for 2021 and one for 2020. The state also maintains a searchable database of **providers convicted of Medicaid fraud**, which currently has 134 entries dating back to 2016.

Tennessee

We did not find information about sanctions imposed by Tennessee. We requested documentation from Tennessee about sanctions against MCOs, but have not received a response at this time. The Division of TennCare **publishes a list of providers** – individuals and entities – that have been terminated from participating in TennCare Medicaid programs. From 2015-2021 the state only terminated 13 individual providers and 6 provider entities. TennCare terminated 9 providers in 2019-2021 for making false statements or misrepresentation of material facts. Five providers were terminated under the catch-all reason Violation of the Terms of the Contract.

Number of Providers Terminated Per Year								
Reason for Termination	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**Total**
Failure to respond to requests for records on TennCare patients	2						1	3

Failure to disclose required information	1							1
Felony conviction		1						1
Making false statements or misrepresentation of material facts.					1	6	2	9
Violation of the terms of the contract.		2		2			1	5
Total	**3**	**3**		**2**	**1**	**6**	**4**	**19**

Analysis

The purpose of sanctions is to penalize MCOs for failing to live up to the contractual requirements. There are two primary ways for sanctions to be effective. First, the amount of the fine or penalty must be enough of a financial burden for the managed care plan that continued noncompliance with the contract would result in the managed care plan paying fines that hurt the MCO's overall profitability. Or, the public's awareness of the managed care plan being sanctioned may convince potential enrollees choose a different plan or current enrollees decide not to re-enroll, also impacting the MCO's overall profitability.

Our analysis did not enable us to determine whether any sanctions led to decrease in enrollment. We can, however, get an idea of the financial impact of sanctions by looking at the total amount of money the plans bring in a given contract year and the amount of money the plans paid in fines during that same time period. Because we were only able to obtain data on financial sanctions against MCOs for Arizona, California, and New Hampshire, our analysis focuses on those states. Making this assessment is challenging because these states do not make information on how much they are paying the individual MCOs readily available. Instead, we used information published in their annual financial reports on capitation payments received and reported as revenue as our basis for comparison

In FY2021 these three states each spent over a billion dollars on premium payments to MCOs:[19] **Arizona** spent $14.5 billion which was 82.5% of Arizona's total Medicaid spending. **California**, which has the largest Medicaid enrollment in the country, spent $47.7 billion on

[19] Kaiser Family Foundation. 2022. Total Medicaid MCO Spending. Accessed August 2022.

managed care. This was 43.6% of the state's total spending. **New Hampshire**, whose Medicaid population is about 1.5% of the size of California's, spent $1.1 billion on managed care. This was 48.2% of New Hampshire's total Medicaid spending.

Looking at the financial statements published by the MCOs contracted in **Arizona** to provide the ACC services, a picture forms of the mostly negligible impact the sanctions may have on the health of each MCO's financial bottom line.[20] In 2019 and 2020 Banner University Family Care received the largest fines of MCOs participating in ACC. With fines totaling $1.25 million and Medicaid revenues exceeding $ 2.54 billion, the imposed fines equate to 0.049% of the Medicaid premium revenues Banner University Family Care received in 2019 and 2020.

Between 2019 and 2021, Arizona Complete Health Care Plan was assessed fines totaling $710,645. They reported capitation premiums revenues of $4.13 billion. The fine on Arizona Complete equates to 0.017% of the Medicaid premium revenues they were paid.

In 2019, Mercy Care was the only other ACC MCO to be fined over $100,000. All of the other reported fines against MCOs in Arizona as a part of this analysis were less than $100,000 in each instance.

Another noteworthy finding from Arizona is that from 2018 to 2021 UnitedHealthcare Community Plan reported the highest capitation premium revenues, exceeding $1.5 billion in 2019, over $1.7 billion in 2018 and 2020, and over $1.9 billion in 2021. UnitedHealthcare is the only MCO contracted with the ACC program not to be fined in the timeframe covered by this analysis. Although they did receive a Notice of Concern in 2019 regarding potentially uncredentialed nonemergency transportation providers, UnitedHealthcare resolved this by implementing a Corrective Action Plan.

In **California**, four MCOs received large monetary penalties exceeding $1 million during the period of this analysis: Anthem Blue Cross, Kaiser Permanente, Blue Cross of California Partnership Plan, and L.A. Care Health Plan.[21] Between 2017 and 2019, while Anthem Blue Cross was fined over $8 million, the MCO reported over $12 billion in Medicaid revenues. The fine equates to 0.066% of the revenue they received in those years.

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[20] Contracted Health Plan Audited Financial Statements. 2021 **AHCCCS Complete Care Contractors**. Accessed September 2022 See Appendix C for the full list of capitation premiums received by Arizona MCOs in 2018 – 2021.
[21] See Appendix C for a chart of capitation premiums received by these four MCOs in the 2017–2021

In 2017 and 2019 Kaiser Permanente totaled over $4.8 million in penalties which equates to 0.092% of the Medicaid revenues they received in those years. Blue Cross of California Partnership Plan received a fine of $1.2 million in 2020 for failing to authorize medically necessary services. This equates to 0.048% of Medicaid revenue received in 2020.

For continual failure to timely resolve member grievances and appeals, as well as failing to process prior authorization requests, as we previously noted, L.A. Care Health Plan was fined $35 million by DMHC and $20 million by the state's DHCS. Looking at the fine from the perspective of what L.A. Care was paid in 2021, the penalty equates to 0.65% of their 2021 Medicaid revenue. Looking farther back, LA. Care Health Plan also received fines in 2017, 2019, and 2021 which added up to $283,500. The $55 million in fines were for activities that stretched back to 2019. Taking those years into consideration, LA Care Health Plan received over $23.7 billion in Medicaid revenues during that time, which means their total fines equate to 0.23% of total Medicaid revenues.

New Hampshire imposed $127,000 in monetary penalties on their three MCOs from June 2021 to April 2022. We were unable to locate Medicaid capitation premium revenue data for New Hampshire's MCOs for the period we have sanction data. Assuming New Hampshire's total Medicaid spending in FY2021 was reasonably similar to FY2020, the total penalties imposed equate to approximately 0.013% of their Medicaid spending.

Clearly, fines that only account for a fraction of a percentage of what the MCOs are bringing in premiums from the state are not hurting the bottom line of those MCOs. The question then becomes whether these sanctions influence the MCOs to change the behavior that led to the plans being sanctioned in the first place? Second, are the sanctions hurting the reputations of the MCOs such that enrollees are seeking alternative health coverage? Or is that even an option? The case in California with L.A. Care Health Plan gives some possible answers to those questions.

As a non-profit MCO, in 2020 L.A. Care spent 97% of its revenue on providing medical services.[22] During the three years of activity which later drew their fines, L.A. Care's total operating income was $215 million. A fine of $55 million when viewed from this perspective, constitutes a quarter of the income the plan brought in over three years. In that regard, it seems that such a fine could influence L.A. Care to make significant changes so that they are

[22] California Health Care Foundation. 2022. **California Health Care Almanac - California Health Insurers: Staying the Course**. Appendix F (pp 54-58). Accessed July 2022.

not subject to future fines. Additionally, the fact that L.A. Care is the largest, publicly funded health plan in the country – serving over 2.4 million enrollees – **these fines made headlines**. Even if the huge fine damages the plan's reputation, the impact on enrollment is likely to be minimal because L.A. Care Health Plan is **one of only two Medicaid managed care plans** available to enrollees in Los Angeles County. This leaves Medicaid beneficiaries with little choice as to who covers their care.

Conclusions

States have a variety of sanctions available to use against managed care plans that fail to meet the obligations of their contracts. Based on the states reviewed, there is a significant lack of publicly available information about how states are utilizing their ability to impose sanctions. The most detailed information about the types of sanctions imposed, the dollar amounts of those fines, and the managed care plans which received those sanctions came from Arizona and California. The information received through public records requests from New Hampshire and Oregon contained plenty of detail but revealed, in the case of New Hampshire, insignificant monetary penalties, and from Oregon, no mention of monetary penalties actually being applied to the managed care plans, but only Corrective Action Plans. The data received from Ohio only gives information on the numbers of sanctions applied. It may be that Ohio tracks much more detailed information on which plans are being fined but this information was not conveyed to us. This analysis did not uncover any instances of a state taking administrative actions against plans in the form of assuming control of a plan's operations or implementing any measures that would impact member enrollment.

In this sample of states, it was easier to find detailed, publicly available information about provider entities and individual providers who were sanctioned or terminated from Medicaid programs than information about MCO sanctions. While this information is useful in certain contexts, it does not provide a way to understand how those states are doing in maintaining oversight and accountability of the MCOs operating which are providing health care to Medicaid enrollees. In 2023, most states will be **submitting annual reports to Medicaid** that detail the results of any sanctions, corrective action plans, or other performance improvement actions, which should tell a more complete story of state sanction activity. This will be useful to those who know how and where to access the information. The approach that Arizona and California take, posting the sanctions documentation online where it can be easily obtained by the public should be a standard practice across all states contracting with managed care providers. It is a necessary first step toward understanding the full landscape of MCO performance and the extent to which states are holding these companies accountable for their performance.

APPENDIX A

Detailed information on what sanctions are levied against managed care plans and published by each state both online and what was returned through Freedom of Information Act requests.

Arizona

- Arizona Complete Health Care Plan
  - $100,000 monetary penalty September 2021
    - $50,000 to Arizona Complete Health Care Plan
    - $50,000 to Arizona Regional Behavioral Health Authority
    - October 2018 - February 2021 Failed to issue or timely issue Member ID cards to 39,013 members
  - $177,032 owed to providers and $10,000 monetary penalty August 2021
    - Failure to provide accurate member assignment data
    - Inaccurate Targeted Investment financial incentive payments to providers
  - $4,328 monetary penalty October 2021
    - Inaccurate Facility encounter / claim data matches
    - 8.6% error rate exceeded the allowable 5% error rate
  - $4,285 monetary penalty August 2020
    - 775 sanctioned pended encounters
  - $50,000 monetary penalty March 2020
    - $25,000 failed to meet deadline for correcting provider network database migration deficiencies - failed to make timely and accurate payments to providers
    - $25,000 failed to notify AHCCCS of inaccurate payments to providers
  - Capped membership November 2019
    - Central and South geographic service areas
  - $250,000 monetary penalty October 2019
    - Ongoing failure to correct deficiencies and meet deadlines of January 2019 CAP
    - Withheld from future capitation payment
  - $125,000 monetary penalty January 2019
    - Failed to successfully implement the provider network database
    - Led to inability to effectively process and issue timely and accurate claims payment
  - $4,175 monetary penalty Cenpatico Integrated Care December 2018
    - 413 sanctioned pended encounters
- Banner University Family Care

    - $1,129 monetary penalty October 2021
        - Inaccurate Facility encounter / claim data matches
        - 6.6% error rate exceeded the allowable 5% error rate
    - $52,760 monetary penalty June 2021
        - 5,913 sanctioned pending encounters
    - $208,350 monetary penalty December 2020
        - 16,922 sanctioned pending encounters
    - $203,050 monetary penalty August 2020
        - 22,612 sanctioned pending encounters
    - $332,610 owed to providers and $10,000 monetary penalty April 2020
        - Failure to provide accurate member assignment data
        - Inaccurate Targeted Investment financial incentive payments to providers
    - $1,215 monetary penalty September 2019
        - 191 sanctioned pending encounters
    - $160,285 monetary penalty October 2019
        - 16,283 sanctioned pending encounters
    - $346,235 monetary penalty October 2019
        - 26,705 sanctioned pending encounters
- Care1st Health Plan
    - Notice of Concern - NEMT February 2019
        - Potentially utilizing providers that were not properly credentialed
        - Care1st ordered to develop and implement an Action Plan to bring all drivers into compliance as well as a timeline for completion
    - Notice of Concern - Prior Authorization Requirements for Behavioral Health Services November 2018
        - PA was required for several crisis intervention services after utilization of a pre identified number of service units
        - PA was also required for Behavioral Health services such as Family Support, Psychosocial Rehabilitation Services (Living Skills Training), and Skills Training and Development
        - According to the ACC Contract Paragraph 9 Scope of Services and AHCCCS Medical Policy Manual (AMPM) 310-B, PA cannot be required for crisis services
        - Plan ordered to remove all PA for crisis behavioral health services
        - Review all PA for other behavioral health services and decide which can be removed
        - No sanctions for pending encounters over $1,000
- Magellan / Molina Complete Care
    - $10,000 monetary penalty June 2022

        - Failure to provide accurate and complete financial reporting from December 2019 to present
        - Molina submitted to AHCCCS eleven consecutive financial statement reports which were inaccurate and/or incomplete and which failed to conform to the Financial Reporting Guide requirements
    - $75,000 monetary penalty January 2019
        - CMS denied Magellan's Part-D application because of the past performance of an affiliated Prescription Drug plan
        - MCC therefore could not fulfill all Medicare benefits to dual-eligible members sanction for Failure to operate a Dual-Special Needs Program in the Central geographic service area (Maricopa, Gila, and Pena counties)
        - Expected to establish and operate a D-SNP by January 2020
- Mercy Care
    - $13,230 monetary penalty March 2022
        - 1,708 sanctioned pending encounters
        - AHCCCS applied offsets due to accounting errors
    - $6,880 monetary penalty June 2021
        - 933 sanctioned pending encounters
    - $10,330 monetary penalty August 2020
        - 1,409 sanctioned pending encounters
    - $16,975 monetary penalty for Mercy Care Acute October 2019
        - 1,9214 sanctioned pending encounters
    - $4,260 monetary penalty for Mercy Maricopa Integrated Care Health Plan - October 2019
        - 465 sanctioned pending encounters
    - $81,810 monetary penalty August 2019
        - 13,502 sanctioned pending encounters
    - $55,225 monetary penalty for Mercy Maricopa Integrated Care Health Plan - August 2019
        - 9,280 sanctioned pending encounters
    - $50,000 monetary penalty Mercy Care Acute October 2018
        - Failure to maintain compliance with Telephone Performance Standards
        - Only met member calls performance standard on 46% of days June-September
        - Only met provider calls performance standard on 32% of days June-September
        - Required to submit an Action Plan by beginning of November 2018
        - Met and sustained telephone performance metrics Dec-April Sanction and subsequent reporting requirements were closed May 2019

- Health Choice Arizona
  - $6,920 monetary penalty December 2020
    - 909 sanctioned pending encounters
  - $1,530 monetary penalty Mach 2020
    - 277 sanctioned pending encounters
- United Healthcare Community Plan
  - Notice of Concern - NEMT February 2019
    - Potentially utilizing providers that were not properly credentialed
    - UHCCP ordered to develop and implement an Action Plan to bring all drivers into compliance as well as a timeline for completion

California

- AIDS Healthcare Foundation (2017)
  - Failure to comply with 2017 CAP
  - Failure to submit provider network data file
  - $25,000 monetary penalty
    - Noncompliance March ($5,000) through May ($10,000 2 mos.)
  - AHF submitted the provider network data file in June 2017
- California Health & Wellness (2020, 2017)
  - Failure to comply with 2020 & 2017 CAPs
  - Failure to submit provider network data file each year
  - 2020 $8,500 monetary penalty - $1,000 first day of failure to submit, $500 each subsequent day of failure to submit
    - Noncompliance 16 days
  - 2017 $35,000 monetary penalty
    - Noncompliance March ($5,000) through June ($10,000 3 mos.)
- Contra Costa Health Plan (2019)
  - Failure to comply with 2019 CAP
  - Failure to submit provider network data file
  - $5,000 monetary penalty May
- Gold Coast Health Plan (2017)
  - Failure to comply with 2017 CAP
  - Failure to submit provider network data file
  - $25,000 monetary penalty
    - Noncompliance March ($5,000) through May ($10,000 2 mos.)
- Health Plan of San Joaquin (2018)
  - Failure to comply with 2017 Quality of Care CAP
  - Failure to meet or exceed Minimum Performance Levels (MPL) on HEDIS performance measures in 2014 - 2016

    - Failed to meet MPLs on 14 plan-wide measures in 2018
    - DHCS imposed $5,000 monetary penalty of first violations of failing to meet MPLs and $10,000 for each subsequent failure
    - $135,000 total monetary penalty
    - Plan had to submit a revised CAP strategy to meet or exceed all 2019 MPLs
- Health Net Community Solutions (2018)
    - Failure to comply with 2017 Quality of Care CAP
    - Failure to meet or exceed MPLs on HEDIS performance measures in 2014 - 2016
    - Failed to meet MPLs on 34 plan-wide measures in 2018
    - DHCS imposed $5,000 monetary penalty of first violations of failing to meet MPLs and $10,000 for each subsequent failure
    - $335,000 total monetary penalty
    - Plan had to submit a revised CAP strategy to meet or exceed all 2019 MPLs
- Inland Empire (twice in 2019)
    - Failure to comply with 2019 CAP twice
    - Failure to submit provider network data file
    - $5,000 monetary penalty May
    - Failure to report required encounter data from Sept 2014 to April 2015
        - CAP imposed December 2017
        - MCO was given until April 2018 to submit required encounter data
        - Extended twice until March 2019
    - $80,000 total monetary penalty
        - $1,000 sanction and $500 per day for each day encounter data submission is inaccurate (not to exceed $10,000 per violation month)
        - $5,000 sanction and $500 per date for each day the report is late (not to exceed $10,000 per violation month)
- Kaiser Permanente (twice in 2017)
    - Sept 2016 CAP imposed for failure to submit outstanding encounter data
    - $99,000 penalty failure to submit encounter data for external medical claims from October 2016 through December 2016.
    - $379,500 penalty failure to submit encounter data for correct paid claim information January 2016 through December 2016
    - $940,500 penalty failure to submit all institutional, professional, and pharmacy encounter data November 2014 through March 2017
    - $792,000 penalty for failure to submit all Physician Administered Drugs data from April 2015 through March 2017
- L.A. Care Health Plan (2022, 2017)
    - $55 million March 2022
        - **$35 million** by California Department of Managed Health Care (DMHC)

- **$20 million** by California Department of Health Care Services (DHCS)
- Failure to timely resolve grievances and appeals and send resolution letters to members violates both federal and state law.
- 11,660 grievances and appeals without a resolution letter from LA CHP from 2018 - 2021
- Oct-Nov 2021 DCHS document request uncovered 41,446 instances LA CHP failed to issue a resolution letter Jan 2019 - Oct 2021
- February 2022 backlog of grievance & appeals remained over 1,600

- DCHS investigations found L.A. Care failed to timely process prior authorization requests
  - 8,517 Untimely inpatient authorizations from early April 2021 - mid June 2021
    - 3,773 cases delinquent for 8 to 30 days
    - 3,105 cases delinquent for more than 30 days
  - 92,854 instances in which prior authorization requests were not processed timely due to delay in decision and/or notification from January 2019 - October 2021
  - Failed to adequately fund or staff its Utilization Management Department, failed to properly train staff and temporary staff, failed to develop adequate systems for timely responding to prior authorizations, failed to take appropriate steps to mitigate member harm, and failed to accurately and fully disclose the full extent of its prior authorization processing backlog and past violations.
- Failure to ensure compliance on the part of subcontractor Los Angeles County Department of Health Services (LA DHS)
  - **LA Times article** in September 2020 about LA DHS members who were harmed or died as a result of not getting a timely appointment with a specialist, spurred an audit by DHCS
  - Failure to ensure Quality of Care improvements
  - Failed to take action when the Potential Quality of Care Issues case files demonstrated potential quality issues, failed to refer cases to the Medical Director, and failed to develop appropriate CAPs as to LA DHS's delays in providing specialty care
  - Failed to monitor, evaluate, follow-up, and confirm LA DHS's progress or completion of the CAP
    - LA DHS was out of compliance in the areas of cultural and linguistic services, information security, privacy, provider network, and utilization management

        - Failure to monitor CAP potentially caused serious member harm in all areas where LA DHS was out of compliance
    - Failed to ensure LA DHS provided timely access to care
        - LA DHS did not meet the performance goals for 10 out of the 15 measures for appointment availability
    - L.A. Care failed to monitor its grievance process to ensure that grievances brought by LA DHS members were timely resolved and the appropriate notifications timely sent
        - All sampled grievance files showed a failure to comply with 30-day deadline
        - Average age of grievance notifications was 242 days
  - Failure to comply with 2017 CAP
  - Failure to submit provider network data file
  - $35,000 monetary penalty
    - Noncompliance March ($5,000) through June ($10,000 x 3 mos.) 2017
- Molina (2020, 2019)
  - Failure to submit provider network data file
  - $5,000 monetary penalty June 2019
  - $1,000 monetary penalty July 2019 for submitting a day past due date
- San Francisco Health Plan (2019)
  - Failure to submit provider network data file
  - $5,000 monetary penalty June
- Santa Clara Family Health Plan (2020)
  - Failure to submit provider network data file
  - $2,000 monetary penalty November 2019
    - Submitted three days late: $1,000 day 1, $500 x 2 days

New Hampshire

Reason for Liquidated Damages by Category	ACNH	NHHF	Well Sense	Total
Incomplete/Incorrect Deliverable	**15**	**12**	**29**	**56**
Data	14	4	29	47
Pharmacy	1	8		9
Late Deliverable	**1**		**5**	**6**

Data	1		5	6
Performance Standard Violation	**20**	**6**	**21**	**47**
Care Management	10	3	8	21
Member Services	1		6	7
Mental Health		1	1	2
NEMT		1		1
Provider Services	7		4	11
SUD	1	1	2	4
Utilization Management	1			1
Total	**36**	**18**	**55**	**109**

Dollar Amount of Monetary Penalties by Violation Category

Managed Care Organization	Care Mgmt.	Data	Member Services	Mental Health	NEMT	Pharmacy	Provider Services	SUD	Utilization Mgmt.	Total
Well Sense	$8,000	$34,000	$6,000	$1,000			$11,000	$2,000		$62,000
ACNH	$10,000	$15,000	$1,000			$1,000	$18,000	$1,000	$1,000	$47,000
NHHF	$3,000	$4,000		$1,000	$1,000	$8,000		$1,000		$18,000
Total	**$21,000**	**$53,000**	**$7,000**	**$2,000**	**$1,000**	**$9,000**	**$29,000**	**$4,000**	**$1,000**	**$127,000**
Percent of Total	17%	42%	6%	2%	1%	7%	23%	3%	1%	

Oregon

- Cascade Health Alliance May 2019
    - Noncompliance with appropriate Hepatitis C treatment
        - Did not provide medically appropriate services required under contract
        - Procedures for prior authorization and denial of services did not comply with Federal, State, and contract provisions
        - Failed to timely dispense Hep-C medications
        - Did not provide notice to members and providers of adverse benefits determinations for Hep-C medications within required timelines
    - Ordered to take immediate action to correct noncompliance: immediate claims processing of those authorized for treatment (2 days), approve or deny all received requests for Hep-C treatment (3 days), submit evidence of completion and confirmation that Hep-C medication has been dispersed to pharmacies and members (5 days of first two)
    - Develop and implement a Corrective Action Plan describing actions and activities to correct noncompliance, data gathering, and interventions to improve outcomes and maintain compliance in the problem areas
    - Submit quarterly reports of all Hep-C requests and their resulting actions July 2019 - at least July 2020
    - No imposition of monetary penalties
    - OHA lifted CAP on December 31, 2019 - CHA submitted data shows they are in compliance with all required actions
- Health Share of Oregon October 2019
    - Regarding Non-Emergent Medical Transportation
    - Complaint rate 268% higher than the average coordinated care organizations (CCO) complaint rate
        - Failure to pick up before and after appointment
        - Ride cancellations
        - Wrong drop-off location
        - 45-min call center wait times
        - Transportation providers not properly credentialed or trained
        - Inappropriate vehicles and equipment dispatched for pickup
    - HSO met w/ OHA in June 2019 to discuss performance
    - HSO agreed to send weekly performance reports Aug 2019
    - Ordered to develop and implement a CAP describing actions and activities to correct noncompliance, data gathering, and interventions to improve outcomes and maintain compliance in NEMT

    - Submit weekly reports of all transportation services received by HSO members and their resulting actions Oct 2019 - at least six months
        - Driver On Time performance 90% of all rides +/- 15 mins. of pickup time
        - Provider No-shows less than 10% of all rides +/- 30 mins. of pickup time = no show
        - Call Center Abandonment less 10% or all calls a member hangs up before receiving service
        - Wait Time 90% of all calls answered in less than 5 minutes
- Trillium Community Health Plan (Tri-County) September 2020
    - regarding network adequacy, health equity & language access, community engagement, and intensive care coordination services
    - Service area expansion includes Tri-County region subject to a CAP
    - Initial request by Trillium in July 2019 to expand was denied in Nov 2019 due to deficiencies
    - Offered until end of June 2020 to remedy deficiencies in network adequacy
        - All providers in all service areas must be under a signed contract, none pending
        - Providers must have a valid numerical Provider capacity identifying the number of members they intend to serve
        - Providers listed must be sufficient to establish an adequate provider network
    - April 2020 Trillium announced intention to proceed w/ expansion
    - Trillium found to not be meeting contractual obligations of regarding network adequacy, health equity & language access, and community engagement OHA issued a sanction to prepare a CAP
        - Trillium Tri-County should have network adequacy to cover 55,000 members in their service area
        - 2020 Trillium identified how many more members each provider could serve above current capacity
        - Lack detailed analysis about member service needs and providers to determine if member-to-provider ratios would be sufficient
        - Trillium has not demonstrated adequate network provider capacity to serve behavioral health needs
    - CAP stipulates:
        - Trillium must prove that its current low number of home health agencies, hospitals, rural health centers, and mental health crisis centers are sufficient to provide needed services or show how they will expand to meet the needs of their expanding member population.

- Provide validation of provider capacity to serve member count by county. Supply contracts that detail each provider's "accepting new members" capacity, or written documentation from providers attesting their willingness to accept new Medicaid members
- Demonstrate increased counts of providers and facilities new Medicaid members for outpatient and community-based mental health treatment services for members with Severe and Persistent Mental Illness
- Across BH continuum identify strategies Trillium will implement to increase delivery system capacity and increase access to BH care
- Trillium must assess interpretation needs, volumes, and needed / available languages. Use information to proactively identify gaps in access
- Demonstrate meaningful access to interpreter services for individuals who speak a language other than English
- Demonstrate meaningful engagement of the community to identify health equity issues
- Demonstrate how health equity demographic info, disparities data, and community engagement are used to inform Trillium operations, policies and procedures, and initiatives.
- Develop a formal community engagement plan and demonstrate recruiting community advisory committee and RAC, establishing CHA and CHP. Policy and procedure must address how Trillium will engage the community in a meaningful manner, ensure community participation in CCO decision making

APPENDIX B

Detailed information on providers that were sanctioned and/ or terminated by managed care organizations and published by each state both online and what was returned through Freedom of Information Act requests.

Florida

Count of Sanctions Type by Individual Providers and Provider Entities						
	FINES	FINES RESCIND	SUSPEN	SUSPEN RESCIND	TERMIN	Grand Total
INDIVIDUAL PROVIDERS	**61**	**0**	**138**	**3**	**257**	**459**
Assistive Care Services	3		2		4	9
Behavior Analysis	1		9	1	130	141
Community Behav. Health Services	1					1
Dentist	6		3		3	12
Hearing Aid Specialist			1			1
Home & Community-Based Services	7		13		7	27
Home Health Agency			10		11	21
Licensed Midwife			1			1
Nurse Practitioner (ARNP)			5		5	10
Optician	1					1
Physician (MD, DO)	37		44	2	57	140
Physician Assistant			4		4	8
Podiatrist			3		8	11
Private Transportation			1		1	2

Professional Early Intervention Services			1			1
Registered Nurse/Registered Nurse First Assistant			2			2
Social Worker/Case Manager	1		13		13	27
Specialized Therapeutic Services	1		18		10	29
Therapist (PT, OT, ST, RT)	3		8		4	15
PROVIDER ENTITIES	**529**	**4**	**203**	**17**	**225**	**978**
Ambulatory Surgery Center			1		1	2
Assistive Care Services	33		40	2	67	142
Behavior Analysis	43		8	8	10	69
Billing Agent					1	1
Case Management Agency	14		7	3	14	38
Community Behav. Health Services	14		15	1	14	44
Dentist	4		3		3	10
Dialysis Center					4	4
Durable Med Equip/ Medical Supplies	34		12		9	55
General Hospital	52	2				54
Hearing Aid Specialist			9			9
Home & Community-Based Services	51	2	56		40	149
Home Health Agency	52		6		11	69
Hospice	4					4
Independent Laboratory	9		2		1	12

Nurse Practitioner (ARNP)					3	3
Pharmacy	123		18	1	16	158
Physician (MD, DO)	40		14		13	67
Physician Assistant			1		1	2
Podiatrist			1		3	4
Private ICF/DD Facility	1					1
Professional Early Intervention Services	1		1			2
Skilled Nursing Facility	44		1	1	10	56
Social Worker/Case Manager					1	1
Specialized Therapeutic Services			4			4
Therapist (PT, OT, ST, RT)	10		4	1	3	18
Grand Total	**590**	**4**	**341**	**20**	**482**	**1437**

Missouri

Count of Providers Terminated	2016	2017	2018	2019	2020	2021	2022	Total
Hospital	1							1
Nursing Home	1							1
Physician MD, DO	3	3	4	7	3	3		23
Personal Care; Homemaker Chore	2	2	5	8	5	2	1	25
Adult Day Care	1			1				2
Podiatrist	1		1		1			3

Dentist		1		1	1			3
Advanced Practice RN				3		1		4
Clinical Social Worker	1	2			1			4
Professional Licensed Counselor	2		5	2				9
Independent Clinic; Rural Health Clinic	3	1	11	9		2		26
Home Health Agency		1		1				2
Pharmacy				1				1
DME	2							2
Independent Lab	1	2	1	1		1		6
Portable X-Ray Supplier				1				1
Chiropractor		2						2
Hospice		1	1			1		3
Provider Eligibility Verification Only						1		1
CRNA			1			1		2
Grand Total	**18**	**15**	**29**	**35**	**11**	**12**	**1**	**121**

Most Common Reasons for Termination	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
Bad Debt		1	17	13	2	4	1	38
Board Discipline		1						1
CMS Contract Termination	3	3	3					9
License Revoked		2	3	3	3	1		12

OIG Exclusion	4	4	1	1	1			11
Other State Medicaid Termination				3	1	4		8
Suspension				1				1
Fraud/ Settlement/ Conviction/Failed To Disclose	9	3	5	6	4	3		30
Felony Charge/ Guilty Plea/ Conviction	1	1		5				7
Medicare Revocation/ Termination/ Exclusion	1			3				4
Total	**18**	**15**	**29**	**35**	**11**	**12**	**1**	**121**

Count of Reasons for Termination by Provider Type	Individual Providers	Provider Entities	Total
BAD DEBT	**8**	**30**	**38**
Physician MD	1		1
Personal Care; Homemaker Chore	1	14	15
Professional Licensed Counselor	6		6
Independent Clinic		13	13
Home Health Agency		1	1
Independent Lab		1	1
Hospice		1	1
BOARD DISCIPLINE	**1**		**1**
Dentist	1		1

CMS CONTRACT TERMINATION	**1**	**8**	**9**
Hospital		1	1
Podiatrist	1		1
Independent Clinic; Rural Health Clinic		4	4
Home Health Agency		1	1
Hospice		2	2
FELONY CHARGE/ GUILTY PLEA/ CONVICTION	**5**	**2**	**7**
Physician MD	3		3
Personal Care		1	1
Advanced Practice RN	2		2
Independent Clinic		1	1
FRAUD/ SETTLEMENT/ CONVICTION/FAILED TO DISCLOSE	**11**	**19**	**30**
Physician MD, DO	6		6
Personal Care; Homemaker Chore		8	8
Adult Day Care		2	2
Dentist	1		1
Clinical Social Worker	1		1
Professional Licensed Counselor	3		3
Independent Clinic; Rural Health Clinic		4	4
DME		2	2
Independent Lab		2	2
Provider Eligibility Verification Only		1	1

LICENSE REVOKED	**11**	**1**	**12**
Physician MD, DO	6		6
Personal Care		1	1
Dentist	1		1
Advanced Practice RN	2		2
Clinical Social Worker	1		1
CRNA	1		1
MEDICARE REVOCATION/ TERMINATION/ EXCLUSION	**1**	**3**	**4**
Nursing Home		1	1
Physician MD	1		1
Independent Clinic		2	2
OIG EXCLUSION	**7**	**4**	**11**
Physician MD	1		1
Podiatrist	2		2
Clinical Social Worker	2		2
Independent Clinic		2	2
Independent Lab		1	1
Portable X-Ray Supplier		1	1
Chiropractor	2		2
OTHER STATE MEDICAID TERMINATION	**5**	**3**	**8**
Physician MD	4		4
Pharmacy		1	1

Independent Lab		2	2
CRNA	1		1
SUSPENSION	**1**		**1**
Physician MD	1		1
Grand Total	**51**	**70**	**121**

APPENDIX C

Capitation premiums revenue received by MCOs in Arizona and revenue from Medicaid, Healthy Families, and other government / public sponsored programs by MCOs in California as reported in financial statements.

Arizona

Capitation Premiums Revenue					
MCO	**2018**	**2019**	**2020**	**2021**	**Total Revenue from Medicaid**
Arizona Complete Health Care Plan	$ 486,022,441	$ 1,241,974,667	$ 1,283,677,933	$ 1,607,269,963	$ 4,618,945,004
Banner University Family Care	$ 774,762,450	$ 1,139,237,190	$ 1,402,231,496	$ 1,633,807,901	$ 4,950,039,037
Care1st Health Plan	$ 568,185,000	$ 771,421,000	$ 805,047,000	$ 759,312,000	$ 2,903,965,000
Health Choice Arizona	$ 785,472,648	$ 849,123,577	$ 804,133,668	$ 1,244,911,509	$ 3,683,641,402
Magellan/ Molina Healthcare	$ 5,747,194	$ 83,546,327	$ 205,113,000	$ 241,343,000	$ 535,749,521
UnitedHealthcare	$ 1,738,657,307	$ 1,515,329,059	$ 1,701,196,275	$ 1,997,383,275	$ 6,952,565,916

California

Revenue from Medicaid, Healthy Families, and Other Government Sponsored Programs						
MCO	**2017**	**2018**	**2019**	**2020**	**2021**	**Total Revenue from Medicaid**
Anthem Blue Cross	$ 4,941,421,000	$ 3,590,732,000	$ 3,616,884,000	$ 1,119,315,000	$ 2,625,313,000	$ 15,893,485,000
Blue Cross Partnership Plan	Same as above	Same as above	Same as above	$ 2,466,253,000	$ 2,853,995,000	$ 5,320,248,000
Kaiser Permanente	$ 2,485,249,000	$ 2,679,233,000	$ 2,776,627,000	$ 3,050,468,000	$ 5,034,957,000	$ 16,026,534,000
L.A. Care Health Plan	$ 8,259,556,224	$ NA	$ 7,173,043,829	$ 7,574,222,284	$ 8,354,930,637	$ 31.361,762,974