Revisiting Medicaid Managed Care Sanctions

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In 2022 NHeLP published a paper, Managed Care Sanctions: An Important Tool for Accountability that focused on how a select sample of states use their sanctioning powers to hold managed care organizations (MCOs) accountable to their contractual obligations.[1] The states we reviewed use only a fraction of the sanctioning tools available to them and in many cases the fines, liquidated damages, and monetary penalties levied on MCOs were so low they were unlikely to compel MCOs to alter or change their business practices. We also found wide variation in the ways states reported sanctioning activity and how readily available the information was to access.

This paper revisits the issue of sanctions to update our initial review. We assess if the sanctioning activity in our sample of states has led to any discernible MCO performance improvement. We searched each state's Medicaid website and reported on any posted sanctions information. Some of the states' sanctions information was easily accessible, while others required more effort to locate. We sent public records requests to a handful of states to access sanctions information when an online search produced no data. We learned that no two states approached posting sanctions information in the same way, with the possible exception of Arizona and California. Both of those states post the letters informing the MCOs of the sanctions being imposed upon them.

This time we added North Carolina to our sample. This review also incorporates a new tool for identifying states' sanctioning activity: the Managed Care Program Annual Report (MCPAR). These reports were not available when we conducted our initial review, but include standardized, plan-by-plan reporting of sanctions.

[1] Daniel Young, Nat'l Health Law Prog., *Managed Care Sanctions: An Important Tool for Accountability* (Dec. 2022), https://healthlaw.org/resource/managed-care-sanctions-an-important-tool-for-accountability/ [Our initial review included Arizona, California, Florida, Hawaii, Missouri, New Hampshire, Ohio, Oregon, and Tennessee].

MCPAR

The 2016 Medicaid and CHIP final rule created new reporting requirements for states on their managed care programs and operations. CMS later developed a MCPAR template along with several toolkits to facilitate state reporting.[2] Beginning in 2022, CMS required states to submit a MCPAR for each of their managed care programs. Each state must submit their MCPARs to CMS no later than 180 days after the end of the managed care contract year and publish the report on the state's managed care website within 30 days after submission to CMS.[3] This reporting schedule means report submissions are staggered throughout the year, but public availability of the information will be reasonably predictable. CMS started publicly posting MCPARs to its website beginning with the reports for the performance year 2023.[4] Going forward, as states submit their MCPARs, CMS plans to update their website on a quarterly basis.[5] We recommend that until CMS demonstrates that it will keep to this timeline, state Medicaid websites will be more reliable for finding the most recently posted MCPAR data.

The MCPARs standardize the information states report about their managed care plans, which makes the reports useful for identifying characteristics about each program, making comparisons between states, making comparisons between MCOs operating within the states, and tracking performance over time. The MCPARs also make data available and accessible from states that previously were not transparent with managed

[2] CMS, Medicaid and CHIP Managed Care Monitoring and Oversight Initiative, https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative (last visited July 7, 2025), [The first template was released in 2021, with Version 3 released in June 2024].
[3] The 30-day timeline for states to post the MCPAR to their website is a stipulation of the 2024 Medicaid and CHIP Managed Care Final Rule. 42 CFR § 438.66(e)(3)(i). Prior to this rule change, states had no specific timeline to post, which meant that many MCPARs were not posted or readily available at the time of our initial analysis.
[4] CMS, Public Access to State Submitted MCPARs, https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/public-access-state-submitted-mcpars/index.html (last visited May 1, 2025) [All of the 2023 MCPAR referenced in this review can be found online at this website. 2024 MCPARs are currently being added throughout the year].
[5] *Id.*

care data. States must currently collect information on the following areas for all MCOs, Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs):[6]

- Program Characteristics and Enrollment
- Financial Performance
- Encounter Data Reporting
- Grievance, Appeals, and State Fair Hearings
- Availability, Accessibility, and Network Adequacy
- Quality and Performance Measures
- Sanctions and Corrective Action Plans
- Beneficiary Support System
- Program Integrity
- In-Lieu of Services and Settings (a new requirement for 12/2025 submissions)
- Mental Health and Substance Use Disorder Parity (newly required as of 12/2024 submissions)

States with managed care programs that solely utilize Primary Care Case Management (PCCM) only have to collect information on program characteristics and enrollment and sanctions and corrective action plans. Beginning in June 2026, all states will also be required to collect and submit information on prior authorization and patient access application programming interface usage.

Each MCPAR is organized based on a standard template, with data elements from the categories listed above organized by and reported at state, program, or plan levels.[7]

State-level Indicators

- Medicaid and managed care enrollment statistics;
- Information on the state agency, division or contractor tasked with evaluating the validity of encounter data submitted by MCOs;
- Description of service-specific or other focused program integrity activities that the state conducted, and the state's standard and expedited timeframes for prior authorization decisions.

Program-level Indicators

[6] 42 CFR § 438.66(e).

[7] CMS, MCPAR Reporting Template, https://www.medicaid.gov/medicaid/downloads/mcpar-reporting-template-2024-v3.xlsx (last visited May 1, 2025).

- Links to the State's managed care contracts;
- The uses of encounter data, the references to the contact sections on measures used to assess MCO performance on reporting data, and references to the contact sections on the financial penalties for failing to meet performance standards.

- State definitions
    - Long-Term Services and Supports critical incidents[8]
    - State-set time limits for the timely resolution of appeals and grievances[9]
    - Description of any gaps or challenges the MCOs have in maintaining adequate provider networks and meeting access standards. Additionally, if they have challenges, the state must describe how they work with the MCOs to address these challenges.

Plan-level Indicators

The section on plan-level indicators covers plan characteristics like:

- **MCO enrollment.** This includes the plan's share of total Medicaid & managed care enrollment;
- **Financial performance** indicated by the plan's Medical Loss Ratio (MLR);
- **Appeals, hearing, and grievance data.** This data is broken down into appeals resolved, appeals denied, and appeals resolved in favor of enrollee, timely resolution, appeals resolved by type of service, hearing requests because of an Adverse Benefit Decision, decisions in favor or adverse of enrollee, external medical reviews in favor or adverse of enrollee. The grievance information is broken down into the numbers of grievances resolved, number of active grievances, number of grievances resolved in a timely manner, and numbers of grievances resolved by individual service lines, and the numbers of grievances

[8] Per 42 CFR § 441.302(a)(6)(i)(A) provides assurance that the State operates and maintains an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. This is the minimum definition but states can add criteria.

[9] Per 42 CFR § 438.408(b)(2) timely resolution of standard appeals must be no longer than 30 days from receipt of the appeal. Per 42 CFR § 438.408(b)(3) timely resolution of expedited appeals must be no longer than 72 hours from receipt of the appeal. Per 42 CFR § 438.408(b)(1) timely resolution of grievances must be no longer than 90 days from receipt of the grievance. States have flexibility to set shorter timelines.

resolved for specific reasons like customer service, care management, quality of care, payment or billing errors, and several other factors.

- **Program integrity.** Program integrity data is also reported at the plan level and covers counts of program integrity staff, the number of open and closed investigations, the number and ratios of integrity referrals to the state, and the amount of overpayment to the state.
- **Prior authorization.** States will be required to report prior authorization data at the plan level beginning in June 2026, but some states are already reporting this. This information must cover aggregate totals for standard and expedited prior authorization requests received, percentages of prior authorization requests that were approved, denied, and approved after appeal, and the average and median time to decisions on prior authorizations.
- **Quality performance.** States must also report on their quality and performance measures at the plan level across 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 each measure used, states must include if the measure is program specific, cross-program, the reporting period, a description of the measure, and the measure results for each plan.
- **Sanction-related actions.** States must report any sanction-related actions taken during the contract year, regardless of whether the issue was identified during the same contract year or earlier. These actions include, but are not limited to, financial penalties, corrective action plans, suspension of enrollment, written warnings, and other formal or informal intervention with a contracted plan to improve performance. States must report the following sanctions content in the MCPAR: the intervention type, the plan being sanctioned, the reason for the intervention, how many instances of noncompliance resulted in the sanction, the financial amount of the penalty if monetary, the date assessed, the remediation date noncompliance was corrected, and if the plan was subject to a prior corrective action plan in the previous two years. How the state determines what constitutes an instance of noncompliance is a bit ambiguous. This seems to give states significant wiggle room with how they apply sanctions. An example might be a MCO being sanctioned for one instance of reporting inaccurate provider information on the MCO's website, even though the reporting contained 35 errors in the provider directory. If a subsequent check reveals another 20 errors, the state may interpret that as two instances of reporting inaccurate provider information. The state may then impose one fine for two instances of inaccurate provider information and count that as one sanction. The federal

regulations do not define an instance, but they do put a maximum limit on civil monetary penalties per determination or per beneficiary, depending on the nature of the plan's infraction or failure to act.[10]

Liquidated Damages or Sanctions

Liquidated damages are a common tool that states use to hold MCOs accountable. Their use differs from sanctions and many managed care contracts define and detail them separately. Liquidated damages are negotiated in the contract in anticipation of potential violations such as a breach of contract, a service delay, or failing to meet performance standards. The liquidated damages are pre-determined reasonable estimates of what specific violations would cost the state due to the plan not meeting its contractual obligations. The plan then compensates the state for its financial losses. States may not characterize these damages as penalties against the plan, but rather as restitution (see Florida below).

Sanctions are intended to be viewed as penalties handed down by the state or the state's regulatory agency for violations of contract terms or non-compliance by the plan. Sanctions are intended to enforce compliance and deter future wrongdoing. They are not prearranged and are not limited to compensation for financial losses, but include a punitive component. Sanctions can be monetary (i.e. fines) or non-monetary (i.e. enrollment freezes, withholding payments, temporary management of a plan). Sanctions are often imposed after the violation is identified.

The use of liquidated damages and sanctions are not mutually exclusive and they can be combined to bolster compliance. CMS views liquidated damages as sanctions and states should report liquidated damages with other examples of compliance activity in the Sanctions section of the MCPAR. CMS plans to provide clarifying language to states on what to report in the sanctions section of the MCPAR, with the expectation that sanctions, informal and formal, monetary or not, will be fully reported.[11]

[10] Per 42 CFR § 438.704, the civil monetary penalty limits are: $25,000 for each determination under § 438.700(b)(1), (5), (6), and (c); $100,000 for each determination under § 438.700(b)(3) or (4); $15,000 for each beneficiary the State determines was not enrolled because of a discriminatory practice under § 438.700(b)(3), up to $100,000. For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater; "each determination" is defined as "each individual case that supports the state's finding of an MCO's... act or failure to act under § 438.700(b) through (d), https://www.federalregister.gov/d/2016-09581/p-1565

[11] E-mail from Daniel Young, to CMS Managed Care Technical Assistance (June 27, 2025) (on file with author).

Liquidated Damages or Sanctions

The states we reviewed for this analysis address liquidated damages and sanctions in their managed care contract as follows:

✦ Arizona's ACC contract does not mention liquidated damages, only sanctions.

✦ The contracts of California and Tennessee define sanctions and liquidated damages separately, but also refer to liquidated damages as sanctions.[12]

✦ Florida, Hawaii, Missouri, North Carolina, and Tennessee define sanctions and liquidated damages separately and include a chart in the contract or an attachment/ appendix detailing the liquidated damages.

✦ Ohio's contract does not use the term liquidated damages, instead using the term pre-determined financial sanctions, but like other states, the contract includes a chart of the aspects of noncompliance that trigger the pre-determined financial sanctions and their amounts.[13]

✦ Oregon's contract mentions liquidated damages, but only includes a description of sanctions, the conditions which may result in sanctions, the sanctions process, and the amounts of civil monetary penalties which may be imposed.

State Sanction-related Activities

Arizona

The Arizona Health Care Cost Containment System (AHCCCS) maintains a webpage

[12] Cal. Dep't of Health Care Servs., Managed Care Boilerplate Cont., (2024) Exhibit E.1.1.19.H. https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx; Tenn. Div. of TennCare, Statewide TennCare Managed Care Services Cont. with Amendment 20, (2024) E.29.1.2.1. https://www.tn.gov/tenncare/information-statistics/tenncare-contracts.html.

[13] Ohio Dep't of Medicaid, Ohio Medicaid Provider Agreement for Managed Care Organization. (Feb. 2025) Appendix N. Compliance Actions. https://medicaid.ohio.gov/resources-for-providers/managed-care/mc-policy/managed-care-agreements/managed-care-agreements.

detailing administrative actions imposed over time on the seven MCOs participating in their Complete Care (ACC) service line.[14] The types of actions are Notice of Concern, Notice to Cure, Corrective Action Plan (CAP), and Sanctions.[15] Despite reserving space for notifications of the different types of actions on the Administrative Actions webpage, since our initial analysis, all the notifications posted to this webpage are sanctions letters issued to the seven MCOs. These letters, dated between September 2023 and October 2024, address calendar year 2022 encounter data validation reporting errors. This is similar to what we observed in our 2022 analysis, when AHCCCS sanctioned Arizona Complete Health Care, Banner University Family Care, HealthChoice, Molina, and Mercy Care for pended encounters.[16] Mercy Care is the only plan AHCCCS sanctioned for pended encounters in this analysis, with 342 sanctioned encounters, earning a $2,725 penalty.

However, the sanctions detailed in the letter to Health Choice withheld a portion of its capitation payments. In October 2023, AHCCCS sanctioned this MCO for failing to

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[14] Ariz. Health Care Cost Containm't System, *AHCCCS Complete Care Contractors,* https://www.azahcccs.gov/Resources/OversightOfHealthPlans/AdministrativeActions/ACC.html (last visited May 1, 2025).

[15] Ariz. Health Care Cost Containm't System, AHCCCS Cont. #YH19-0001 (Apr. 2024) Section D.68 Compliance Actions, https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/contracts.html#CACC
[Arizona's contract describes sanctions as "including, but not limited to, temporary management of the contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract"].

[16] Ariz. Health Care Cost Containm't System, *AHCCCS Information Services Division (ISD) Encounter Manual*, (Oct. 2024) https://azahcccs.gov/PlansProviders/Downloads/Encounters/Manual/EncounterManualMaster.pdf
[Pended encounters 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. Encounters that have not been corrected or voided after 120 days are referred to as aged-pended encounters].

accurately enter air ambulance transportation rates into its claims system and failing to assess and follow-up claim accuracy, resulting in overpayment to the provider. This violation resulted in $150,000 withheld from their capitation payment. Then in September 2024, AHCCCS sanctioned Health Choice for scoring under 55% on seven quality management improvement standards and failing six must-pass utilization management standards. These issues also resulted in $150,000 withheld from a capitation payment. State Medicaid agencies may withhold capitation payments as a sanction, but our analysis has found few instances of this approach. The state withholds a portion of the MCO's expected, fixed per member, per period payment until the MCO's performance can be evaluated. If the MCO meets the performance target, then the payments are released. The withheld payment represents an incentive for the MCO to change behavior or improve performance.

As mentioned above, the MCPAR reports also offer a way to track sanctions and fines imposed on the MCOs. Arizona's 2023 MCPAR details how AHCCCS fined the state's five MCOs - Arizona Complete Health, Banner, Health Choice, Molina, and Mercy Care - seven times.[17] These sanctions covered a mix of errors on data validation audits and pended encounters for a total of $21,894. AHCCCS subjected each of the MCOs to a previous CAP.

The 2024 Arizona MCPARs detail six sanctions. AHCCCS imposed civil monetary penalties on HealthChoice, Mercy Care, and Banner University Family Care for aged-pended encounters.[18] The penalties totaled $6,225. Care1st received a $25,000 civil monetary penalty for noncompliance with their administrative cost percentage. Banner University Family Care received a second civil monetary penalty for failing a data validation audit which cost them $144,927. The increased amount of this CMP versus the fine documented against Banner in the 2023 MCPAR for a data validation audit ($1,229) could be for a repeat offense, but the MCPAR explanation does not specifically provide the context for the increase. Tiered sanctions with increasing monetary penalties for repeat violations could be a good idea for states to implement into

[17] Ariz. Health Care Cost Containm't System, AHCCCS Reports for Centers for Medicare and Medicaid Services (CMS), https://www.azahcccs.gov/Resources/Reports/federal.html#2023 (last visited May 1, 2025).

[18] Ariz. Health Care Cost Containm't System, AHCCCS Reports for Centers for Medicare and Medicaid Services (CMS), https://www.azahcccs.gov/Resources/Reports/federal.html#2024 (last visited May 1, 2025); Ariz. Health Care Cost Containm't System, *supra* note 16.

contracts to increase compliance. This is especially true, if states are reluctant to utilize other sanctions that impact plan payment, membership, or administration.

Arizona recently posted its 2025 MCPAR, which covers nine total counts of sanctions on all seven MCOs.[19] Only two of the sanctions are fines. AHCCCS fined Health Choice $150,000 and imposed a CAP on them for failing a NCQA re-accreditation survey, and failing to renew their accreditation status. The second fine was on Mercy Care, $2,725, which was mentioned above for pended encounters. The other sanctions AHCCCS imposed resulted from a secret shopper survey which found inaccurate Autism Spectrum Disorder provider data on the websites of all seven MCOS. This use of secret shopper surveys is the first of its kind we have encountered in our analysis up until this point. AHCCCS issued a compliance letter and imposed a CAP on each of the MCOs to address their provider networks.

The lower number of total pending encounters that drew monetary penalties in 2023 may suggest improvement on the part of Arizona MCOs, at least in the areas of encounter data reporting and monitoring where the MCOs received the most scrutiny in our initial review, or it could be an indication that AHCCCS simply shifted its attention to other areas of oversight. Our analysis has not uncovered documentation that the plans made organizational or system changes to achieve better data reporting result. AHCCCS withholding the capitation payment from Health Choice for failing to renew NCQA accreditation and subjecting them to a CAP could potentially lead to further administrative actions and sanctions if the MCO fails to make progress in this area.[20] The monetary penalties AHCCCS imposed, totaling less than $620,000 over three years, represent only a tiny sliver of what Arizona pays for managed care.[21] This reaffirms a point we made in our original analysis: the financial impact of the sanctions is minimal,

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[19] Ariz. Health Care Cost Containm't System, AHCCCS Reports for Centers for Medicare and Medicaid Services (CMS), https://www.azahcccs.gov/Resources/Reports/federal.html#2025 (last visited May 1, 2025).

[20] AHCCCS Compliance Action - Sanction: National Committee for Quality Assurance (NCQA) Accreditation Denial, (Sep. 20, 2024) https://www.azahcccs.gov/Resources/Downloads/AdminActions/ACC/Sanctions/BCBCAZ_HC-Sanction-Accreditation_September2024.pdf.

[21] KFF, 2023. Total Medicaid MCO Spending, https://www.kff.org/medicaid/state-indicator/total-medicaid-mco-spending/ (last visited Apr. 28, 2025) [Arizona spent $17 billion on managed care in FY 2023, 76.7% of their total Medicaid spending].

easily written off as a cost of doing business, and unlikely to have a major impact on how these MCOs do business.

California

California stands out from the other states we reviewed because for most contracted MCOs, the state has two oversight agencies that each can impose sanctions: the Department of Health Care Services (DHCS) (the state Medicaid agency) and Department of Managed Health Care (DMHC) (the state agency that licenses managed care plans).

Our initial review also highlighted California's sanctioning activity because the state imposed much higher monetary penalties on their MCOs than any other state in our review. The largest, a $55 million sanction imposed on LA Care Health Plan, pertained to an extended history of failing to adequately address and resolve members' grievances in a timely manner.

LA Care Sanctions

- In 2022, 95% of LA Care Health Plan's 2.7 million enrollees were Medi-Cal beneficiaries
- In May of 2022, DHCS and DMHC sanctioned LA Care Health Plan for an extended history of improperly handling enrollee grievances, failing to process requests for authorization and inadequately overseeing and supervising contracted entities regarding timely access, among other issues[22]
- $20 million monetary sanction imposed by DHCS
- $35 million penalty imposed by DMHC, for a total of $55 million
- In October 2024, the state agreed to a settlement with LA Care Health Plan
- LA Care is paying a $27 million financial penalty to the two agencies
- LA Care is paying the remaining $28 million in contributions over three years throughout LA County to a variety of community initiatives
- LA Care agreed to make meaningful improvements to the plan's core functions through their Quality Improvement and Health Equity Program in March 2025[23]

[22] Cal. Dep't of Health Care Servs., *State Fines L.A. Care Health Plan $55 Million in Enforcement Action to Protect Consumers*, (Mar. 2022) https://www.dhcs.ca.gov/formsandpubs/publications/oc/Documents/DMHCDHCS-JointPressRelease-LACare-Accusation-030422.pdf.

[23] LA Care Health Plan, *Quality Improvement and Health Equity Program*, (Mar. 2025) https://lacare.org/sites/default/files/la6784_qi_health_equity_program_202505.pdf.

DHCS Sanctions

Since our initial review in 2022, DHCS has sanctioned 22 of the 25 MCOs serving the Medi-Cal population. Administrative and/or financial sanctions letters posted online all impose monetary sanctions for "failure to meet required minimum performance levels (MPLs) for the measurement year (MY) on Medi-Cal Managed Care Accountability Set (MCAS) performance measures."[24] DHCS imposed monetary sanctions based on the following criteria:

- Number of eligible members impacted by the quality of care violation and scope of the harm (e.g. the number of individuals who did not receive a recommended preventative service);
- Degree to which the MCO is below each MPL;
- Whether MCO's performance on the MPL(s) at issue has improved or worsened over the previous measurement year; and
- Any other applicable factor under state law (Cal. Welf. & Inst. Code section 14197.7(g)).

Nine of the 22 MCOs saw their fines increase over the three MY covered by the letters. Fourteen MCOs saw the number of beneficiaries impacted increase over the three MY. Seven MCOs saw their fines decrease over the three MY and only two MCOs saw the number of beneficiaries impacted decrease over the three MY. Notably, six of the plans only had one year in which they received a sanctions letter from DHCS. The MCOs that received the highest fines for failure to meet MPL are Anthem Blue Cross, Health Net Community Solutions, and LA Care Health Plan, each of which was fined approximately $1.1 million over the three MYs. The total amount that DHCS imposed on the 22 MCOs for failure to meet MPL, across the three MY, was $7.3 million, which impacted 6.9 million beneficiaries served by those MCOs. California's MCOs were thus fined about $1.06 per beneficiary for failing to provide quality care. The effectiveness of whether these fines have influenced MCOs to improve their quality measurement performance is questionable. Over half (56%) of the MCOs fined more than once saw their fines increase (suggesting a repeat violation) and 87% of the MCOs saw the number of beneficiaries impacted increase during the three MYs.

[24] Cal. Dep't of Health Care Servs., Administrative and/or Financial Sanction Letters, https://www.dhcs.ca.gov/services/Pages/Admin-FinancialSanctions.aspx (last visited May 5, 2025).

Table 1. DHCS Fines for Failure to Meet Minimum Performance Levels, 2021-2023

MCO	Year(s) Fined	Total Beneficiaries Impacted	Total $ Fined
Aetna Better Health	2021 - 2023	62,735	$121,000
Alameda Alliance for Health	2021 - 2023	128,976	$142,000
Anthem Blue Cross	2022 & 2023	867,112	$1,142,000
Blue Shield of CA Promise HP	2022 & 2023	63,576	$57,000
California Health & Wellness	2022 & 2023	254,080	$326,000
CalOptima	2021	8,638	$25,000
CalViva HP	2022 & 2023	299,311	$139,000
CenCal Health	2023	3,441	$25,000
Central Cal Alliance for Health	2021 - 20023	119,960	$107,000
Contra Costa HP	2023	58,631	$57,000
Gold Coast	2022	54,053	$33,000
Health Net Comm. Solutions	2022 & 2023	1,057,311	$1,174,000
Health Plan of San Joaquin	2021 - 2023	448,163	$257,000
Inland Empire HP	2021 - 2023	717,832	$700,000
Kaiser	2022 & 2023	95,858	$110,000
Kern Health Systems	2021 - 2023	503,704	$287,000
LA Care HP	2021 - 2023	1,073,720	$1,192,000
Molina	2021 - 2023	410,432	$619,000
Partnership HP	2021 - 2023	565,958	$739,000
San Francisco HP	2023	31,883	$25,000
Santa Clara Family Health Plan	2021, 2023	89,017	$51,000
UnitedHealthcare Community Plan	2022	12,032	$31,000
TOTALS		**6,926,423**	**$7,359,000**

California's 2023 MCPAR report detailed 50 counts of sanctions activities DHCS imposed on 22 MCOs.[25] This includes many of the 2023 DCHS fines in Table 1 above, as well as sanctions for other violations. The majority of the MCOs, 16, received a sanction for failing to meet MPLs on performance improvement quality measures with an accompanying civil monetary penalty, also discussed above. In addition to the fines for failing to meet MPLs, DHCS imposed CAPs on these MCOs for failing to meet network adequacy time and distance standards and for untimely payments and unpaid claims for physician administered drugs. The six MCOs that did not receive a sanction for failing to meet MPLs were subjected to CAPs for a variety of reasons including violations related to case management care coordination, problems with access to care, poor quality management, and inadequate administrative capacity. The 2024 MCPAR is not yet publicly available (due to CMS by the end of June 2025) for comparison, but state advocates expect it to be fairly similar to the 2024 report.

DMHC Sanctions

The sanctions imposed on California MCOs by the DMHC are detailed online on their Enforcement Actions Dashboard.[26] The dashboard can be sorted on a variety of parameters, but of particular use is the ability to filter total results by years, number of enforcement actions, and highest fines. The individual MCOs can be compared on a yearly basis and sorted by number of enforcement actions, violations, enrollment, and amount fined. Unfortunately, the DMHC Enforcement Actions Dashboard does not allow users to stratify the dollar amount of fines by commercial, Medicaid, and Medicare product lines. Despite those limitations, the Enforcement Actions Dashboard is quite useful and can serve as a model transparency tool that other states should consider adopting.

In 2022, DMHC fined two MCOs over $1 million: Anthem Blue Cross ($1.5 million on 25 enforcement actions) and Molina ($1.02 million on 50 enforcement actions). Aetna Health was fined $606,000 on 7 enforcement actions, and four other plans - Blue Shield

[25] Cal. Dep't of Health Care Servs., Managed Care Program Annual Reports (MCPARs), https://www.dhcs.ca.gov/services/Pages/MCPAR.aspx (last visited May 5, 2025) [Community Health Group, and SCAN HP were not in the group of MCOs sanctioned by DHCS for failing to meet MPLs. CenCal Health and UnitedHealthcare Community Plan are not included in the 2023 MCPAR as MCOs sanctioned by DHCS].

[26] Cal. Dep't of Managed Health Care, Enforcement Actions, https://wpso.dmhc.ca.gov/dashboard/EnforcementActions.aspx (last visited May 5, 2025).

of California, Alameda Alliance for Health, HealthNet of California, and LA Care Health Plan - were fined between $240,000 down to $109,000.

In 2023, DMHC levied a $50 million fine on Kaiser Permanente for three enforcement actions: failing to provide timely care, maintain a sufficient number of mental health providers, and oversee its providers effectively. Only about 16% of Kaiser Permanente's total enrollment in California is in government plans. 76% of their enrollment is in commercial plans, so this analysis is unable to determine how much of that fine is connected to Medi-Cal business. The fine levied against Kaiser far exceeds any of the other fines DMHC levied in 2023. No other MCOs received fines over $1 million. DMHC fined Blue Shield of California, LA Care Health Plan, and HealthNet of California between $407,500and $616,400. Anthem Blue Cross was fined $359,000 on 30 enforcement actions, and Blue Shield's fines came on 25 enforcement actions.

In 2024, DMHC levied a $14 million fine on LA Care Health Plan. This fine is part of the settlement agreement between LA Care and the state resulting from the 2022 investigation into the MCO's grievance and authorization practices addressed in the call-out box above. DMHC also fined Anthem Blue Cross $9 million on 102 enforcement actions, most in the state in 2024. Blue Cross of California Partnership Plan $6 million on 65 enforcement actions. Blue Shield of California was fined $836,000 on 26 enforcement actions. Oscar Health Plan, another commercial plan, received the next highest fine at $240,000. These fines are larger in comparison to many of the sanctions and financial penalties other states imposed on their MCOs discussed in this analysis. However, the sheer size of California's Medicaid managed care enrollment, 13.5 million beneficiaries, as well as the fact that California is second in the country in managed care spending makes the impact of these fines less impressive.[27]

Florida

Florida's Agency for Health Care Administration (AHCA), which administers the Statewide Medicaid Managed Care (SMMC) program, catalogues all CAPs, liquidated damages, and sanctions imposed on the MCOs on their Compliance Action Dashboard.[28] The dashboard covers two different contract periods: 2014 – 2018, 2018 – 2023, and the fiscal years from 2018-2019 through the current 2024-2025. This update covers the

[27] KFF., *supra.* note 21.
[28] Fla. Agency for Health Care Admin., Compliance Action Dashboard, https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/ActionsTaken? (last visited May 7, 2025).

last three fiscal years. The dashboard shows 848 compliance actions closed and $41.6 million in total damages assessed.[29] All but one of these compliance actions are liquidated damages, the lone outlier being a $2,500 sanction imposed on Simply Healthcare. Florida's managed care contract defines liquidated damages not as a penalty against the plan but as, "reasonable estimates of the Agency's projected financial loss and damage resulting from the Managed Care Plan's nonperformance, including financial loss as a result of project delays."[30]

AHCA assessed liquidated damages on Sunshine Health a leading 113 times in the three fiscal years, followed by UnitedHealthcare (96 times), Humana Medical Plan (94 times), and Simply Healthcare (92 times). The Agency assessed liquidated damages on a second grouping of MCOs - Aetna Better Health, Florida Community Care, CMS Health Plan, and Molina Healthcare - ranging from 64 down to 53 times. The remaining 6 MCOs have all been assessed liquidated damages fewer than 42 times. Sunshine Health's liquidated damages total $15.4 million, the most of all the MCOs in this lookback period. The liquidated damages of United, Humana, and Simply Healthcare range from just above $4 million to $3.4 million. Two dental MCOs, DentalQuest ($2.9 million) and MCNA Dental ($2.7 million), rank above the 8 remaining MCOs, of which, 6 were assessed liquidated damages of more than $1 million.

Other information found in the Florida dashboard include the compliance actions stratified by categories.[31] Of the $41.6 million in assessed liquidated damages, $28.3 million (70.5%) of the total dollar amount was for failing to meet performance measure standards, even though AHCA only imposed damages in this category 15 times. Untimely or inaccurate reporting of provider services data, which was the most common reason AHCA imposed liquidated damages, accounted for another $4.8 million (12.5%) of the total monetary penalties. Failing to meet provider network adequacy standards, provider claims payment problems, and care coordination/ case management violations constituted another $3.2 million (8%). All the other categories of liquidated damages totaled $580,000 or less.

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[29] As of May 1, 2025.
[30] Fla. Agency for Health Care Admin., Attachment II – Scope of Service – Core Provisions (Feb. 2025) §XIII.A.2 https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/2025-2030-smmc-plans/model-health-plan-contract.
[31] Fla. Agency for Health Care Admin., Compliance Action Dashboard, https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/ActionsbyCategory? (last visited May 7, 2025).

Throughout the lookback period Florida's Medicaid agency issued only one sanction. In 2023, Simply Healthcare was sanctioned $2,500 for paying for one instance of gender dysphoria treatment. Florida's managed care contract includes a list of 121 program issues that if the MCO fails to comply with or meet a specific threshold, liquidated damages can be assessed. As was discussed above, it seems that because the contract considers liquidated damages as a type of compliance enforcement tool distinct from sanctions and CAPs, AHCA recoups larger fines from the MCOs than they would if they imposed sanctions like civil monetary penalties.[32] Florida did not report their assessment of liquidated damages in the MCPAR like other states in this analysis and CMS has indicated states should.[33]

Hawaii

Our prior analysis failed to turn up any publicly posted sanctions information. We requested information from the state but did not receive a response before we published our report. The MCPAR for 2022, posted on the state website, indicates that Hawaii did not report any sanctions activity.[34] The 2023 MCPAR only lists one count of sanctions activity, a compliance letter that stresses concern over an eight-month vacancy at the Administrator/CEO/Executive Director level and notes the staffing ratios of behavioral health service providers were above the 1:100 minimum threshold and could potentially impact timely access to mental health services for members. A CAP was not implemented as the MCPAR indicates the non-compliance was corrected within a month of receiving the letter.

Missouri

In our prior review of Missouri, we were also unable to find published information about MCO sanctions. We requested this information from the state but did not receive a response. But this time we have MCPAR reports detailing Missouri's sanctions.

[32] 42 CFR § 438.704, *supra* note 10; Young, *supra* note 11, [CMS plans to clarify whether liquidated damages are subject to the same monetary caps as civil monetary penalties under 42 CFR § 438.704]
[33] Young, *supra* note 11.
[34] State of Haw. Dep't of Human Servs. Med-QUEST Div., CMS Reports, https://medquest.hawaii.gov/en/resources/reports/cmsreports.html (last visited May 9, 2025).

Missouri's 2023 MCPAR lists 25 counts of sanctions that Missouri Medicaid, MO HealthNet Division, imposed on the state's three MCOs - Healthy Blue, Home State Health Plan, and UnitedHealthcare.[35] Every sanction is a CAP. MO HealthNet Division sanctioned Healthy Blue and Home State Health Plan for the same six CAP topics dealing with reporting: assurance of adequate capacity, availability of services, confidentiality, coordination and continuity of care, coverage & authorization, and provider selection. UnitedHealthcare was also given CAPs for five of the six mentioned above with the exception of availability of services. MO HealthNet sanctioned Home State Health Plan and UnitedHealthcare three additional CAPs covering the same topics dealing with reporting: grievance and appeal system, disenrollment, and enrollee rights. Lastly, UnitedHealthcare received two additional CAPs for emergency and post-stabilization services and health information systems. No additional details about these CAPs are given in the MCPAR other than the fact that, at the time the MCPAR was published, MO HealthNet listed all of the CAPs as "Remediation in progress" under the relevant section of the MCPAR where the state indicates the completion date for CAP remediation.

New Hampshire

In our 2022 report, we could not locate publicly posted information about New Hampshire's MCO sanctions. The state responded to our records request documenting 109 instances of sanctions, between June 2021 and the beginning of April 2022. Over this period NH Medicaid assessed liquidated damages against the three MCOs operating in the state, totaling $127,000. New Hampshire's 2023 and 2024 MCPARs, now posted, indicate similar levels of sanctions activities.[36]

There are noticeable differences between the liquidated damages we initially reviewed and those reported in the currently available MCPARs. For example, a significant portion of the 2021 and 2022 sanctions related to performance standard violations, although the majority of liquidated damages NH Medicaid assessed were for incomplete or incorrect data reporting. In contrast, the liquidated damages listed in the 2023 and 2024 MCPARs are entirely related to late, incorrect, or non-compliant data reporting.

[35] Mo. Dep't of Soc. Servs., Managed Care Program Annual Reports, https://mydss.mo.gov/media/pdf/managed-care-program-annual-report-mcpar (last visited May 9, 2025).
[36] N.H. Dep't of Health and Human Servs., Medicaid Managed Care Policies & Reports, https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-managed-care-policies-reports (last visited May 9, 2025).

This shift in focus away from performance standards violations to data reporting issues, could imply that the liquidated damages NH Medicaid assessed on the state's three MCOs had a positive impact on plan performance, or it could be an indication the state made a decision to target data reporting issues in the new performance year. The MCPAR does collect each MCO's results on the targeted performance measures, but without knowing what performance measures were assessed damages in 2021 and 2022, it is impossible to know if sanctions spurred performance improvement.[37] Comparing the performance measures in the 2023 and 2024 MCPARs is complicated because the number of reported measures increased dramatically from 12 measures the 2023 report to 111 in 2024.

Across the three reports, the total number of instances NH Medicaid assessed damages on the plans is remarkably consistent. In the 2023 MCPAR, the total liquidated damages against all three plans totaled 110 instances of late, incorrect, non-compliant data reporting for $428,000. In the 2024 MCPAR, the three plans were assessed liquidated damages 109 instances for $761,000. The total dollar amounts of the liquidated damages increase from year-to-year, but at the MCO-level, the dollar amounts of the liquidated damages assessed on the MCOs fluctuate significantly. In the 2023 MCPAR, NH DHHS assessed AmeriHealth Caritas $31,000 for 22 such instances. The 2024 MCPAR reports liquidated damages against AmeriHealth Caritas 17 instances for a total of $128,000. NH Medicaid assessed liquidated damages on New Hampshire Healthy Families in the 2023 MCPAR 17 instances for $139,000. The 2024 MCPAR indicates damages assessed to NH Healthy Families 15 instances for $11,000. NH Medicaid levied WellSense Health Plan with the highest totals of liquidated damages of the three MCOs in each MCPAR. In the 2023 report, the WellSense liquidated damages totaled 71 instances for $258,000. In the 2024 report the damages totaled 77 instances for $622,000.

Unfortunately, the MCPARs do not explain the wide variation in the dollar amounts of assessed damages despite only minor differences in the instances of sanctions. The large jump in damages from year-to-year could stem from higher fines for a repeat offense or from differences in the nature of the violations, but the available documentation does not explain this. Like other states, the monetary total of New Hampshire's liquidated damages is generally low and may represent minimal hardship to the MCO's bottom line. The low variation in the number of instances and the increase

[37] The liquidated damages data we received from New Hampshire detailed counts of performance standard violations and categorized them, but did not detail the specific measures or the scores on those measures.

in total dollar amount of damages assessed suggests that these sanctions have not incentivized New Hampshire MCOs to change their data reporting practices.

North Carolina

We expanded our scope to include North Carolina in this updated report. North Carolina has two MCPARs available online for their Medicaid Standard Plan. The 2023 MCPAR lists 30 counts and the 2024 MCPAR lists 24 counts of sanctions activity NC Medicaid imposed on the five MCOs operating in the state.[38] All of the sanctions are either a corrective action plan or a CAP with liquidated damages, which is counted as one sanction in the MCPAR, see Tables 2 and 3 below.

Table 2: 2023 Liquidated Damages and Corrective Action Plans Imposed on North Carolina Standard Plans

2023 Liq. damages & CAPs[39]	Network File	Call Center	Network Adequacy	Preferred Drug List	Welcome Packets	Privacy & Security Conditions
AmeriHealth Caritas	$1 million	$20,000 (2 counts)	$227,000	$400,000 (2 counts)	CAP only (2 counts)	
BCBS	$2,000	$20,000	$30,000	$400,000 (2 counts)	CAP only (2 counts)	$2,750
Carolina Complete	CAP only		CAP only		CAP only	$500
United Healthcare			$15,000	CAP only	CAP only (2 counts)	
WellCare	$14,800	$30,000	$90,000		CAP only (2 counts)	$1,000

[38] N.C. Medicaid Div. of Health Benefits, Managed Care Program Annual Report, https://medicaid.ncdhhs.gov/reports/managed-care-program-annual-report-mcpar#PerformanceYear2024MCPARs-4602 (last visited May 12, 2025).

[39] The five MCOs received sanctions for: network file discrepancy - failure to load provider information; call center noncompliance; failing to meet network adequacy standards; preferred drug list performance standards noncompliance; failure to mail member welcome packets within contractually obligated timeframes; and failure to comply with contractual confidentiality, privacy, and security protections.

Table 3: 2024 Liquidated Damages and Corrective Action Plans Imposed on North Carolina Standard Plans

2024 Liq. damages & CAPs	Call Center	Network Adequacy	Claims Processing NEMT & NEAT[40]	Welcome Packets	Privacy & Security Conditions
AmeriHealth Caritas	$15,000	$245,000	CAP only		$5,000 (2 counts)
BCBS	$50,000	CAP only	CAP only		$102,500 (2 counts)
Carolina Complete	$15,000	$5,000	CAP only	CAP only	$1,500
United Healthcare	$10,000	$151,120	CAP only	$7,500	$49,000
WellCare	$35,000 (2 counts)	$190,000		$500	

The two MCPARs show some differences in the types sanctions levied against the North Carolina standard plans from 2023 to 2024. None of the plans sanctioned for network file discrepancies or preferred drug list performance standards noncompliance in the 2023 MCPAR received a similar sanction in the 2024 report. This may suggest that the sanctions imposed and reported in the 2023 MCPAR led to changes that prevented similar violations from reoccurring, but the MCPAR does not provide enough information to confirm that. NC Medicaid did issue repeat and new liquidated damages and CAPs for call center noncompliance, network adequacy deficiencies, failure to mail welcome packets in a timely manner, and for failure to comply with contractual confidentiality, privacy, and security protections. NC Medicaid imposed higher liquidated damages in the 2024 report than in 2023 on AmeriHealth, UnitedHealthcare, and WellCare for network adequacy deficiencies, drawing into question the effectiveness of the sanctions reported in the earlier report on those MCOs for the same reasons.

[40] Failure to comply with automated claims processing for non-emergency medical transportation (NEMT) and non-emergency ambulance transportation (NEAT).

Ohio

We did not find sanction documentation online for Ohio's Medicaid program when researching our 2022 report. The Ohio Department of Medicaid (ODM) responded to our public records request with a one-page table listing six types of contract 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. That documentation did not include any information on the dollar amounts of financial sanctions, nor which MCOs incurred the contract violations.

Ohio now has two MCPARs available for comparison.[41] The 2023 MCPAR lists 21 counts of sanctions on seven MCOs. Fifteen of the counts of sanctions deal with provider panel network adequacy requirements: AmeriHealth Caritas, Anthem Blue Cross and Blue Shield, and UnitedHealthcare Community Plan of Ohio all have a CAP for provider panel requirements. ODM fined Buckeye Health Plan, CareSource Ohio, Molina Healthcare, Paramount Advantage, and UnitedHealthcare for deficiencies in their provider panels. Paramount Advantage had three counts of provider panel deficiencies, covering 28 instances which resulted in $28,000 in fines. However, the highest overall MCO fine was just $116,000, which ODM levied against AmeriHealth Caritas for one instance of missing or late care coordination policies.

Ohio's 2024 MCPAR details 55 counts of sanctions. Six of the plans again faced CAPS and or fines for provider panel network adequacy requirements. Each of the plans subjected to a CAP for failure to meet network adequacy requirements had more instances cited under the CAP than the number of instances for which they were subsequently fined for failure to meet network adequacy requirements, which seems to indicate the plans made some adjustments to their networks to avoid being fined for the original number of instances. For example, AmeriHealth Caritas's Network Adequacy CAP cites 42 instances of violations but their $9,000 fine only covers two counts and 9 instances. Similarly, Humana's Network Adequacy CAP cites 65 instances but ODM only fined the MCO for two counts and 15 instances totaling $15,000. ODM assessed the largest fine for failure to meet Network Adequacy requirements on UnitedHealthcare: 3 counts with 59 instances totaling $59,000.

[41] Ohio Dep't of Medicaid, Managed Care Program Annual Report., https://medicaid.ohio.gov/resources-for-providers/managed-care/mc-policy/mcpar (last visited May 12, 2025).

The largest overall fines reported in the 2024 MCPAR are for failure to meet HEDIS & CAHPS quality measurement minimum performance standards (MPS). ODM levied these against four MCOs: Anthem Blue Cross Blue Shield, 6 instances fined $1.9 million; Buckeye Health Plan, 3 instances fined $1.7 million; UnitedHealthcare, 2 instances fined $1.01 million; and CareSource, 2 instances fined $5.9 million. These fines are obviously much larger than the other fines ODM imposed for network adequacy requirements. The fines ODM levies for failing to meet quality measurement MPS are based on a percentage of the monthly average capitation payment for each quality measure that does not meet the MPS.[42] The fines also increase for consecutive instances of noncompliance. It is unclear from the information presented in the MCPAR how the low number of reported instances of failing to meet MPS add up to the fines ODM imposed. As was discussed above regarding New Hampshire's performance standards, the MCPAR does collect each of Ohio MCO's results on the targeted performance measures, but the MCPAR does not detail if those results are below MPS. The MCPAR also lacks documentation on whether the fines are for repeated instances of noncompliance.

Oregon

In 2022, we asked for Oregon's sanction information and Oregon Health Plan sent us three Notices of Noncompliance directed at the MCOs Cascade Health Alliance, Health Share of Oregon, and Trillium Health Plan, respectively. Each plan had to implement a CAP. None of the plans received monetary penalties during the period we examined.

Oregon's 2023 MCPAR only details one count of sanctions Oregon Health Plan imposed on Health Share of Oregon, a CAP related to five instances of non-reliable NEMT services covering 9 findings of disruption to access to services.[43] Oregon Health Plan imposed this CAP on Health Share of Oregon in 2019 and marked remediated in 2023.

Tennessee

In 2022, we did not find publicly posted information on sanctions against MCOs in Tennessee. The state did not respond to our public records request. The only information we found on sanctions concerned providers who were sanctioned for fraud.

[42] Ohio Dept. of Medicaid, *supra* note 13, at 328.
[43] St. Libr. of Or. Digital Collection, Managed Care Program Annual Report, https://digitalcollections.library.oregon.gov/nodes/view/297019 (last visited May 12, 2025).

Tennessee's 2023 MCPAR details 37 counts of liquidated damaged TennCare Medicaid imposed on the state's four MCOs - Blue Care, TennCare Select, UnitedHealthcare Community Plan, and Wellpoint.[44] The most common fines across all of the MCOs are for various aspects of NEMT service delivery: failure to comply with approval and scheduling requirements, pickup and delivery standards, urgent trip requirements, and post-accident reporting. Twelve counts of liquidated damages totaled 213 instances of failure to comply. The majority of those instances, 141, were for failing to comply with approval and scheduling requirements. Cumulatively, these violations for poor NEMT service delivery only amounted to $122,500, over half of which, $64,500, was levied against Wellpoint. TennCare Medicaid's largest single monetary penalty went to UnitedHealthcare for $51,657 for one instance of failing to provide 348 hours of personal assistance services.

Analysis

The states we wrote about in our 2022 analysis have MCPARs from 2023 posted to the CMS website. At the time of this review, three of those states and North Carolina have a 2024 MCPAR posted on their own state Medicaid websites and Arizona recently posted their 2025 MCPAR online for comparison as well. The data from these MCPARs are summarized in the three tables below.[45]

Table 4. Summary Counts of Compliance Activities – 2023 MCPARs

2023 MCPARs	MCOs Sanctioned	Total Count of Sanctions	Corrective Action Plans	Monetary Sanctions	Total $ Amount
Arizona	5	7	0	7	$21,894
California	22	50	33	17	$3,324,000
Florida	1	1	0	1	$2,500

[44] CMS, *supra* note 4, at Performance Year 2023 MCPARs.

[45] In these tables, the data reflect sanctions imposed on the Medicaid Managed Care lines of business. Hawaii's data for Compliance Letters is included under Corrective Action Plans and the totals for Monetary Sanctions include liquidated damages, civil monetary penalties, and fines. As discussed above, Florida's liquidated damages are also not included in this data.

Hawaii	1	1	1	0	$0
Missouri	3	25	25	0	$0
New Hampshire	3	3	0	3	$428,000
North Carolina	5	30	14	16	$2,235,000
Ohio	7	21	4	17	$183,700
Oregon	1	1	1	0	$0
Tennessee	4	37	0	37	$388,557

Table 5. Summary Counts of Compliance Activities – 2024 MCPARs

2024 MCPARs	MCOs Sanctioned	Total Count of Sanctions	Corrective Action Plans	Monetary Sanctions	Total $ Amount
Arizona	4	6	0	6	$144,927
New Hampshire	3	3	0	3	$761,000
North Carolina	5	24	6	18	$882,120
Ohio	7	55	20	35	$10,930,801

Table 6. Summary Counts of Compliance Activities – 2025 MCPARs

2025 MCPARs	MCOs Sanctioned	Total Count of Sanctions	Corrective Action Plans	Monetary Sanctions	Total $ Amount
Arizona	7	9	8	2	$152,275

The tables draw attention to the differences of how these states approach sanctioning their managed care providers. Only three states in this sample, California, North Carolina, and Ohio, utilized both CAPs and monetary sanctions in the same contract year. The rest of the states in this analysis report out either CAPs or some form of monetary sanctions. Another difference is the disparity in the level of sanctioning activity states with rather sizable Medicaid managed care populations report. The lack of sanctioning activity could be an indicator of service delivery quality. If the MCOs are doing everything they are obligated to do in their contracts, there would be very little need for imposing sanctions. We question if this reflects the reality of managed care services in those states. A comparison of the CMS quality scorecards between California (high sanction counts), Florida (low sanction count), and Tennessee (reliance on monetary sanctions) does not suggest much correlation between fewer sanctions and higher performance.[46]

The tables also highlight the fact that not all compliance activity is being reported through the use of the MCPARs, despite the CMS requirement. The time lag of the annual publication of the MCPAR, 180 days after the end of the contract period, may not reflect sanctioning information that is available on state websites and dashboards, which are often updated monthly. We also found that some states have not included liquidated damages in the umbrella of sanctions, despite CMS officials suggesting otherwise. Florida, for example, publishes an Enforcement Actions dashboard that focuses primarily on liquidated damages and none of that data is included in the MCPAR. Other states' publicly posted sanctions data may include multiple lines of business, not just Medicaid. California's Division of Managed Health Care (DMHC) has oversight on all MCOs operating in the state, both commercial plans and those which are government contracted. DMHC makes their sanctioning activity publicly available on their Health Plan Dashboard, but parsing the extent to which that information gets incorporated in the MCPAR is challenging.

The last column in the tables reaffirms what we concluded in our initial analysis: with the exception of a small handful of examples, the sanctions that impose any kind of monetary penalty are small in relation to the size of the payments and profits MCOs are bringing in.

[46] CMS, Medicaid and CHIP 2024 Scorecard, https://www.medicaid.gov/state-overviews/scorecard/main?pillar=5&focusStates=%5B%22CA%22,%22FL%22,%22TN%22%5D (last visited Jun. 3, 2025)

Conclusion

The implementation of publishing a yearly MCPAR for each Medicaid managed care program operating in a state is largely a positive development. This analysis primarily focused on the documentation of sanctions, but the reports contain useful information that was previously hard to collect. Future iterations of the MCPAR will also expand on the areas of managed care oversight states must report, and may also make it easier to analyze changes over time.

With regards to what data the MCPARs collect on sanctions, the data remains limited. Beyond a general reason for imposing each sanction, the report provides little context to help interpret the listed sanctions or track changes in outcomes. There is also little information detailing whether the contract violation drawing the sanction is a new issue or an ongoing one. Some states also have tiered sanctions in their contracts that escalate the financial penalty based on the severity of the contract violation and the potential harm caused to Medicaid beneficiaries.[47] If these types of details were included in the MCPAR, this could let readers evaluate whether the intensity of the penalty is appropriate, and the extent to which a MCO's response requires more scrutiny. Also, outside of the count of sanctions contained within the report and information included in CAP letters, there are no other summarizing data points, explanations, or footnotes describing what the state is reporting. Providing a way for states to expand on the context for why an instance of sanctions is being reported and a summation of the sanctions data would make the sanctions reporting easier to comprehend.

Much like what we concluded in our prior analysis, most of the sanctions activity observed in this analysis does not evaluate how effectively the enforcement actions changed MCO compliance. Documented monetary penalties are almost universally low and there are several other types enforcement actions, like withholding payments or enrollment freezes, that may actually compel MCOs to reassess their business practices. It remains to be seen if state Medicaid agencies have the capacity to identify those tools and the clout to hold MCOs accountable for high quality, timely care for Medicaid beneficiaries.

[47] Ohio Dept. of Medicaid, *supra* note 13, at 335.