Policy:	HH.2002
Title:	**Sanctions**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 11/20/2024*
Effective Date:	10/01/1998
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima Health shall impose Sanctions on a First Tier, Downstream, or Related Entity (FDR) to enforce effective correction of non-compliance with statutory, regulatory, contractual, or CalOptima Health policy requirements, Fraud, Waste, and Abuse, or the FDR's failure to satisfactorily implement corrective actions.

II. POLICY

A. CalOptima Health, through the Compliance Committee, may impose Sanctions against an FDR if it fails to comply with statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to CalOptima Health programs. The Compliance Committee shall approve and oversee all Sanctions.

B. CalOptima Health may impose Sanctions against an FDR immediately following the FDR's failure to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements related to CalOptima Health programs, with or without a Corrective Action Plan (CAP) requirement.

C. If required by CalOptima Health, an FDR must submit a CAP response to CalOptima Health, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan. CalOptima Health may also impose Sanctions if an FDR fails to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP in the time, or manner, required by CalOptima Health.

D. The extent of the Sanction shall be commensurate with the severity of the deficiency identified as it relates to the risk posed to the CalOptima Health Member(s), as well as other financial or accreditation exposure to CalOptima Health and designed to correct the underlying issue and prevent future recurrence.

E. Sanctions include, but are not limited to, financial penalties, suspension of membership enrollment, de-delegation, and/or termination of contract. CalOptima Health retains the right to take termination action in addition to, and notwithstanding, the imposition of other Sanctions under this Policy.

F. In the event an FDR fails to remediate its non-compliance in the time or manner required by CalOptima Health, CalOptima Health may impose additional and/or more severe Sanctions.

III. PROCEDURE

A. Basis for Sanctions

1. CalOptima Health may impose Sanctions or take any other action against an FDR based on the identification of deficient performance or non-compliance of an FDR. Non-compliance may be established through and may include, but is not limited to:

    a. Findings from performance reviews and/or delegation oversight activities, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight;

    b. Findings from regulatory reviews; including but not limited to the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the Centers for Medicare & Medicaid Services (CMS) audits;

    c. Findings from Provider and Member complaints and surveys;

    d. Engaging in Fraud, Waste, or Abuse as specified in CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection;

    e. Failing to report data, or other information, in the time or manner required by CalOptima Health including, but not limited to, Encounter data;

    f. Engaging in any prohibited Marketing Activities, as outlined in CalOptima Health Policy MA.2001: Marketing Materials Standards;

    g. Failing to have the required amounts and types of financial reserves, or to meet financial solvency requirements;

    h. Failing to comply with the CalOptima Health Compliance Program and investigations including, but not limited to, CalOptima Health's Code of Conduct and policies;

    i. Breaching any covenant, condition, or term of the contract or agreement including, but not limited to, failing to perform contracted duties and responsibilities in the time or manner required by CalOptima Health;

    j. Failing to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP response in the time or manner required by CalOptima Health; and

    k. Failing to comply with any other review of statutory, regulatory, contractual, CalOptima Health policy and other requirements related to a CalOptima Health policy.

B. Determining Sanction

1. CalOptima Health's Compliance Committee shall review findings of an FDR's deficient performance or non-compliance as provided by CalOptima Health's Delegation Oversight Committee (DOC) and in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

2. The CalOptima Health Compliance Committee has the authority to authorize and implement all Sanctions and shall oversee and monitor all Sanctions imposed.

3. The Compliance Committee shall determine the severity of the Sanction based upon findings of deficient performance or non-compliance with applicable state and federal laws and regulations. Sanctions will vary in severity based on the extent and type of finding, including, but not limited to, findings in audits, investigations, contractual obligations, quality improvement system monitoring, routine monitoring, corrective action plan requirements, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, reviews of utilization data, complaints from Members and other stakeholders, whistleblowers, and self-disclosures. Actions that are determined to endanger a Member or prevent access to Covered Services will be reviewed and acted upon immediately by the Office of Compliance. Sanctions shall be designed to correct the underlying issue and prevent future occurrence. Sanctions imposed may include, but not be limited to, termination of the contract between the FDR and CalOptima Health.

4. The Compliance Committee shall consult with legal counsel on the imposition of Sanctions including, but not limited to, contract terminations, as necessary and appropriate.

C. Types of Sanctions

1. CalOptima Health may impose any one or a combination of the following Sanctions:

   a. Financial penalties defined in the contract;

   b. Enrollment freeze - Auto Assignment, Member selection, or both;

   c. De-delegation of delegated function(s);

   d. The requirement to engage and pay for an external auditor, or other consultant, acceptable to and approved by CalOptima Health, in order to correct the identified deficiency(ies), non-compliance, or FWA to CalOptima Health's satisfaction;

   e. Termination of the contract, or agreement, with the non-compliant organization;

   f. Forfeiture of FDR financial security;

   g. Capitation deduction; and/or

   h. Any other action CalOptima Health deems appropriate and reasonable.

2. Monetary Sanctions

   a. Monetary Sanctions are imposed independently and are in addition to any other sums owed to CalOptima Health, such as refunding of Overpayments. Monetary Sanctions will be assessed and determined independently using the following guidelines:

      i. Monetary Sanctions may be separately and independently assessed and may also be assessed for each day the FDR fails to correct an identified deficiency.

      ii. For deficiencies that impact Members, each impacted Member may constitute a separate violation. For example, CalOptima Health may calculate a violation, which directly impacts a Member's access to Covered Services, in the following terms:

1) A limit of $25,000 per Member in which the FDR failed to provide Medically Necessary services that the FDR is required to provide, under law, or under its contract.

2) Per Member penalties may be assessed when there is adverse impact to the Member for the following situations:

a) Inappropriate delay/denial of covered medical services/ drugs, and/or Appeal rights;

b) Incorrect premiums charged, or unnecessary out-of-pockets costs incurred; or

c) Inaccurate or untimely plan benefit information (e.g., wrong denial notices) provided.

b. Monetary Sanctions may also be applied in aggregate based on capitation on a per determination basis. For example, Monetary Sanctions can be calculated in the following terms:

i. 1% off the monthly capitation amount for a first violation.

ii. 2% off the monthly capitation amount for a second violation.

iii. 3% off the monthly capitation amount for each subsequent violation.

iv. If CalOptima Health does not have the Member-specific data or the per Member impact cannot be clearly analyzed, it may calculate the penalty under the per determination basis. Please note that CalOptima Health may choose to impose a per determination penalty for a violation when the FDR has provided CalOptima Health with an impact analysis and CalOptima Health determines that Members were adversely affected by the violation.

c. Parties with pending monetary Sanctions are responsible for paying monetary Sanctions in the time and manner required by CalOptima Health. Failure to render payments in the time and manner outlined by CalOptima Health may result in capitation deduction or payment withhold.

D. Notification of Sanction

1. CalOptima Health shall notify an FDR, in writing. Such notice shall:

a. Detail the findings of non-compliance;

b. Reference the applicable statutory, regulatory, contractual, CalOptima Health policies, or other requirements that are the basis of the findings;

c. Provide detailed information describing the Sanction, including the effective date, duration of, and reason for each sanction proposed;

d. Identify time frames by which the FDR shall be required to achieve compliance, as applicable;

e. Inform the FDR that CalOptima Health may impose additional Sanctions if compliance is not achieved in the manner and time frame specified; and

f. Provide notice of the FDR's right to file a Complaint, in accordance with CalOptima Health policy.

2. In the event that CalOptima Health imposes a financial Sanction on an FDR as a direct consequence of an Immediate Corrective Action Plan (ICAP) and with respect to the CalOptima Health Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima Health's DHCS Contract Manager for Medi-Cal within three (3) business days of imposition.

E. Provider Complaint Process

1. If an FDR disagrees with the Sanction, the FDR may file a complaint with CalOptima Health's Grievance and Appeals Resolution Services (GARS) department, as per CalOptima Health Policies MA.9006: Contracted Provider Complaint Process, or HH.1101: CalOptima Health Provider Complaint.

F. The Compliance Committee shall oversee and monitor the FDR's response to the Sanctions letter.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health, Health Network Service Agreement, Delegation Agreement Exhibit F
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy GG.1619: Delegation Oversight
H. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
I. CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection
J. CalOptima Health Policy HH.2005: Corrective Action Plan
K. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
L. CMS Civil Monetary Penalty Calculation Methodology
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
N. Medicare Managed Care Manual, Chapter 21
O. Medicare Prescription Drug Benefit Manual, Chapter 9
P. Title 22, California Code of Regulations (CCR), §51301 et. seq.
Q. Title 42, Code of Federal Regulations (CFR), §455.2
R. Title 18, United States Code (USC), §1347
S. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/11/2013	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	HH.2002	Health Network Sanctions	Medi-Cal
Revised	10/01/2002	HH.2002	Health Network Sanctions	Medi-Cal
Revised	07/01/2004	HH.2002	Health Network Sanctions	Medi-Cal
Revised	01/01/2008	HH.2002	Health Network Sanction	Medi-Cal
Revised	04/01/2013	HH.2002	Health Network Sanction	Medi-Cal OneCare
Revised	09/01/2015	HH.2002	Sanctions	Medi-Cal
Revised	12/01/2016	HH.2002	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2002	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2002	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2002	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2002	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2002	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2002	Sanctions	Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2023	HH.2002	Sanctions	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2002	Sanctions	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Compliance Committee	The CalOptima Health committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima Health's Compliance Program.
Compliance Program	Medi-Cal: The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, employees, contractors, and providers comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	Medi-Cal: A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee.

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Encounter	Medi-Cal: Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services. OneCare: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

Term	Definition
Member	A beneficiary enrolled in a CalOptima Health Program.
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.