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To: Joint Conference Committee (JCC) Members

From: Sunny T. Cooper, Chief Compliance Officer
Date: March 6, 2026

Report Title: CCHP Compliance Quarterly Report

RECOMMENDATIONS

ACCEPT report from Compliance, RECOMMEND APPROVAL, and FORWARD the Report to the Contra Costa County Board of Supervisors for approval

FISCAL IMPACT

N/A

BACKGROUND

Purpose

This Contra Costa Health Plan's (CCHP or "Plan" or "Division") compliance report is being submitted to provide the Joint Conference Committee (JCC) with required oversight information on the effectiveness of the Plan's Compliance Program, the status of key compliance activities, and any significant risks or issues that warrant JCC attention, in accordance with Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) contractual obligations and Knox Keene Act of 1975 for Medi-Cal, Commercial and Medicare D-SNP managed care regulations.

Executive Summary

During this period, the Compliance Department strengthened regulatory readiness across Medi-Cal, Medicare D-SNP, and Commercial lines of business while stabilizing the D-SNP Care Plus program launched on January 1, 2026. Key highlights:

- **Regulatory Monitoring:** All required submissions were timely except for a few remediated delays. No critical findings were identified. A $40,000 DMHC sanction for 2018 audit deficiencies was resolved in January 2026.
- **Audit Preparation:** DMHC Financial Audit preparations missed initial internal deadlines due to competing priorities; revised timelines were set for February.
- **Compliance Initiatives:** Compliance Performance Improvement Workgroup (CPIW) projects are underway to enhance audit readiness and regulatory compliance.

- **CalAIM Oversight:** Enhanced Care Management (ECM) and Community Support Services (CSS) provider audits remain on schedule; corrective actions are in progress.
- **Fraud, Waste & Abuse:** No emerging risks; investigations and recoveries are in progress. Workforce training materials are in development.
- **Privacy & Security:** Low incident volume; no reportable breaches. Workforce training materials are in development.

1. Compliance Program Performance Dashboard (CPPD)

In an effort to monitor the health of our compliance posture, we plan to design and implement a comprehensive CPPD to track & trend critical Key Performance Indicators (KPIs) in the next few years. This initiative has been included as part of the CPIW workplan. Due to competing priorities, we plan to design and implement these dashboards in a phased approach. We are highlighting each dashboard as they become available in our upcoming reports. Currently, staff are working on the mandatory compliance training attainment and regulatory notices trending dashboards.

- **Mandatory Compliance Training**

  Mandatory Compliance Trainings are defined as those trainings that are specifically required by regulatory agencies via contractual requirements or codified in relevant laws governing the Plan. As reported previously, CCHP Workforce, which includes employees, contractors/temps, IT and Finance personnel designated for CCHP, are required to complete mandatory compliance training within 60 days of hire and annually thereafter. The required compliance training courses for all CCHP Workforce members are:
  - General Compliance and Fraud, Waste & Abuse
  - HIPAA Privacy & Security
  - Diversity, Equity & Inclusion (DEI)
  - Code of Conduct
  - Conflict of Interest

  The table below is the preliminary Compliance Training Attainment Dashboard. This dashboard will evolve as we enhance our current Learning Management System (LMS) to capture critical data elements.

Table 1: Training Completion for CCHP staff for Reporting Period 1/1/25 – 12/31/25

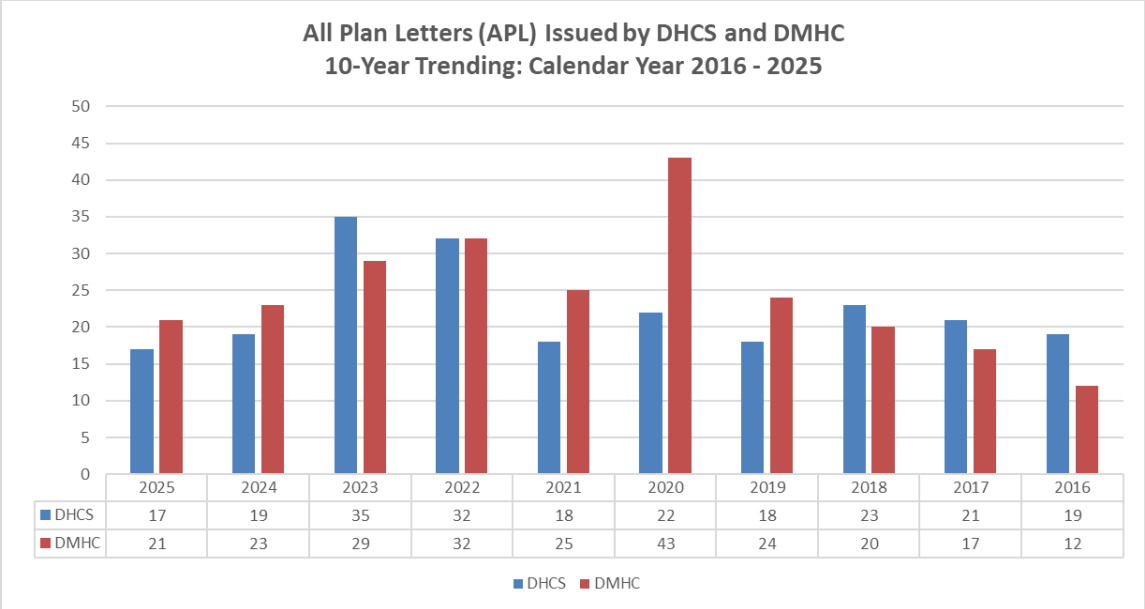
Training Topics	Complete	Incomplete
General Compliance and Fraud, Waste, and Abuse (FWA)*	96%	4%
HIPAA Privacy & Security	95%	5%
Diversity, Equity & Inclusion (DEI)	98%	2%
Transgender, Gender Diverse, and Intersex Training	98%	2%
D-SNP Model of Care Training	95%	5%

*Due to a curriculum change during 2025, an updated FWA training was rolled out mid-year and therefore, this number does not capture individuals who had completed the first version resulting in a completion percentage that is lower than actual.

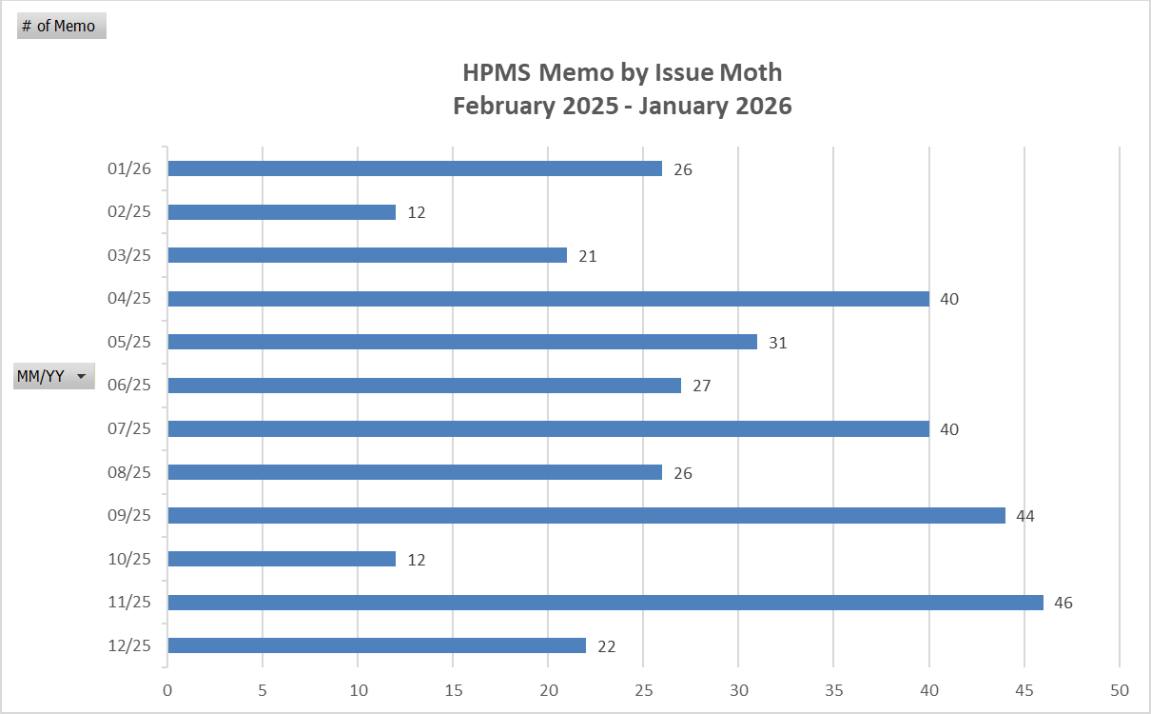
Code of Conduct training was released to all CCHP Personnel on January 15, 2026, with a required acknowledgement date of February 15, 2026. As of February 2, 2026, 59% of required staff attested to having read and understood the Code of Conduct. Compliance is working with business leads to ensure that anyone who has not yet completed the mandatory training remains on track to fulfill the requirements.

- **Regulatory Notice Trending: HPMS and DHCS/DMHC APLs**
  CCHP receives regulatory notices via Health Plan Management Services (HPMS) memos published by Centers for Medicare and Medicaid Services (CMS) and All Plan Letters (APLs) published by Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC). Upon receipt of the regulatory notices, Compliance Department:
    - Tracks and maintains HPMS memos and APLs
    - Provides initial executive summary of these regulatory notices to the impacted business units and assigned leads
    - Performs gap analysis and collaborates with business leads on finalizing workplans to bridge gaps
    - Assists in the implementation of these regulatory notices
    - Collects evidence of compliance & conducts regulatory QA
    - Submits relevant documents to the corresponding regulator
    - Fulfills Q&A and/or manages non-compliance filings with the regulator, as needed

Therefore, a Regulatory Notice Dashboard that tracks and monitors not only the volume of regulatory notices but also the status of each notice is essential to ensuring timely and effective compliance with all regulatory and contractual requirements. Below is the first draft of the Regulatory Notice Trending Dashboard, which currently focuses on tracking notice volume over time. The ultimate goal is to expand this dashboard to also track and monitor the status of each regulatory notice, in addition to overall volume.



	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
DHCS	17	19	35	32	18	22	18	23	21	19
DMHC	21	23	29	32	25	43	24	20	17	12



2. Program Integrity & Fraud, Waste and Abuse Prevention Program

Our Fraud, Waste, and Abuse (FWA) Prevention Program is designed to prevent, detect, and correct improper activities that could harm members, providers, or program integrity. The program includes policies, mandatory training, data monitoring, auditing, and processes for reporting and investigating suspected FWA. We partner with internal teams, delegated entities, and regulators to ensure timely identification of risks and implementation of corrective actions. This program helps safeguard financial resources, uphold regulatory requirements, and protect the integrity of our health care services. As such, we perform regular FWA prevention analyses and FWA investigations for irregular billing practices observed and complaints received.

- **Mandatory Compliance Training**

  Between January 1, 2025, and December 31, 2025, a total of 44 FWA incidents were received and investigated. Fifteen (15) cases were closed during the same period. Per contractual requirements, CCHP is required to file these FWA cases with DHCS within 10 business days. During the same period of time, 40 credible FWA cases were filed with DHCS. Untimely filing was noted in 11% (4) cases. Below tables outline the FWA incidents in more detail.

  Table 1: Cases Received and Closed by Month for Reporting Period 1/1/25 – 12/31/25

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Received	1	0	1	1	4	5	7	7	5	6	5	2	44
Closed	0	0	0	2	1	1	2	1	2	2	4	0	15

  We monitor and track the timely filing of our FWA incidents as well as the types of cases in question. Based on the monitoring results, we remediate our processes for any deficiencies. Tables 2 and 3 summarize FWA statuses and results for Calendar Year 2025.

Table 2: Timely Regulatory Reporting of FWA Incident for Reporting Period 1/1/25 – 12/31/25

Filing Status	Count	% of Total
Timely Filing *(within 10 working days of incident)*	33	89%
Untimely*	4	11%
N/A (Reported by DHCS) – not factored into the % calculation	7	N/A
Total	**44**	**100%**

Table 3: FWA Case Type (Closed Cases) for Reporting Period 1/1/25 – 12/31/25

Filing Status	Count	% of Total
Services Not Rendered	2	13%
Medically Unnecessary Services	1	6%
Not FWA	12	80%
Total	**15**	**100%**

- **Federal Initiatives on Fraud, Waste & Abuse**
  On January 8, 2026, President Trump announced the creation of the Department of Justice's new "Division for National Fraud Enforcement". The Division is designed to enforce federal criminal and civil laws against fraud affecting:
    - Federal government programs and federally funded benefits
    - Businesses and nonprofits
    - Private citizens nationwide

  It aims to coordinate multi-district and multi-agency fraud investigations, develop national enforcement priorities, and recommend legislative and regulatory reforms to address systemic vulnerabilities. While the division has a nationwide mandate, the rollout was catalyzed by alleged fraud scandals in Minnesota involving government programs, prompting heightened federal enforcement resources there. The creation of this division signals an expanded federal focus on fraud enforcement, especially in areas involving government funds and benefits, and reflects a shift toward more centralized, high-priority national fraud prosecutions.

  Following this announcement, the Administrator for CMS, Dr. Mehmet Oz, issued a letter to Governor Newsom on January 27, 2026. In this letter, Dr. Oz shared concerns regarding the Medi-Cal program, its expenditures, and expansion of coverage. The letter also touched on the FWA activities that have been the focus in Minnesota and requested California provide a description of its activities to address those high-risk services. The letter also requested a comprehensive program integrity action plan addressing the following categories and the state has 21 days from receipt of the letter to respond:
    - Fraud, Waste, Abuse, and Improper Payments
    - Eligibility Determination and Immigration Status Controls
    - Provider Screening, Enrollment and Validation
    - Program Integrity Infrastructure and Accountability
    - IHHS- Program Specific Oversight

"FWA & Improper Payments – Program Level Oversight" is featured prominently in this letter with 14 categories of concerns directed towards DHCS oversight responsibilities of Medi-Cal Managed Care Plans (MCP). In summary, the topics are:

1. Establish threshold dollar targets for MCPs fraud recoveries
2. Case referral tracking over 5-year period
3. Medicaid Fraud Control Unit (MFCU) referrals over a 5-year period
4. MCP per capita rate of recovery
5. Service type and geographical consideration identification
6. Monetary recoveries tracking
7. MCP internal controls to identify and recover fraudulent payment
8. Focus on 14 high-risk services identified in MN
9. Validate encounter data reflecting services delivered
10. Immigration enumerators for Medi-Cal eligibility
11. Medi-Cal enrolled provider verification
12. Medi-Cal provider enrollment forms over a 5-year period
13. Payment suspension for credible allegations of fraud over a 5-year period
14. Audit MCP FWA program and its adherence to the federal laws and regulations

The 14 high-risk services (#8 above) that have been the focus in Minnesota are listed below:

1. Adult Companion Services
2. Adult Day Services
3. Adult Rehabilitative Mental Health Services
4. Assertive Community Treatment
5. Early Intensive Developmental and Behavioral Intervention
6. Housing Stabilization Services
7. Individual Home Supports
8. Integrated Community Supports
9. Intensive Residential Treatment Services
10. Night Supervision
11. Non-Emergency Medical Transportation (NEMT)
12. Peer Recovery Services
13. Personal Care Assistance/Community First Services and Supports
14. Recuperative Care

All topics above impact CCHP's FWA program with the exception of #10 and possibly #12 above. We believe this will lead to more intensified scrutiny from both state and federal regulators. CCHP has put in place an action plan as part of the Compliance PIW effort to enhance our current FWA program already. The action plan includes, but are not limited to:

- Continuous monitoring and auditing of our Enhanced Care Management (ECM) and Community Support Services (CSS) providers.
- Initiated data mining activities related to the 14 high-risk services identified in the letter in addition to the regular data mining activities.
- Timely filing of suspected FWA incidents and include Medicaid Fraud Control Unit (MFCU) referrals.
- Collect overpayment at risk and recoupment amount per case.

- Identify business process gaps and work with business leads to bridge gaps, e.g., implement a policy to validate claims/encounter data reflecting services delivered, provider verification & exclusion monitoring, credentialing/recredentialing, delegation oversight, etc.
- Implementing a formal FWA Program and its governing committee structure

Shortly after the issuance of this letter, CCHP received five (5) letters from the DHCS Audits and Investigations Division, which requested claims data for different providers where in the previous quarter, no requests were received.

3. Privacy, Security & HIPAA Compliance

Our HIPAA Privacy Program is designed to protect member information, ensure compliance with federal and state regulations, and safeguard members' Protected Health Information (PHI), Personally Identifiable Information (PII), and other confidential information relevant to privacy laws. The Program establishes policies, workforce training, ongoing monitoring, incident response procedures, and risk-based security controls to prevent unauthorized access, use, or disclosure of protected information. It also ensures we continuously evaluate risks, strengthen safeguards, and maintain transparency with regulators and stakeholders. Together, these efforts help maintain member trust and support the organization's commitment to securing confidential information and adherence with regulatory requirements.

Between January 2025 and December 2025, we received and investigated a total of 43 cases. Of the 32 cases investigated that required reporting to DHCS, 27 (84%) cases were reported timely within 24 hours of discovery while 5 (16%) were reported untimely. Cases that do not require reporting to DHCS include internal errors and patient requests. To date, 98% of the HIPAA incidents reported did not result in any reportable breach. The only incident that required additional remediation effort took place with one of our delegates, which impacted 244 Commercial members. The incident involved a data processing error which resulted in our members' PHI being sent to another health plan client. The file containing our members' PHI was deleted by the receiving plan and the delegate confirmed that the deficiency was remediated on July 22, 2025. Tables below summarize the HIPAA investigation monitoring activities between January 2025 and December 2025.

Table 4: DHCS Regulatory Reporting of HIPAA Incidents for 01/01/25 – 12/31/25

Report within 24 Hours	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Not Timely	1		1		1	1		1					5
Timely	7	5	1	1	3	1	4		1		2	2	27
Not Reported			1		2					3	2	3	11
Grand Total	**8**	**5**	**3**	**1**	**6**	**2**	**4**	**1**	**1**	**3**	**4**	**5**	**43**

Table 5: Internal Reporting Delays between Breach Date and Compliance Receipt Date

Internal Reporting Delays	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Not Timely	1		1		2	1		1				2	8
Timely	7	5	2	1	4	1	4		1	3	4	3	35
Grand Total	**8**	**5**	**3**	**1**	**6**	**2**	**4**	**1**	**1**	**3**	**4**	**5**	**43**

Table 6: HIPAA Incident by Breach or No Breach Categories

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Breach					1							-	1
No Breach	8	5	3	1	5	2	4	1	1	3	4	5	40
Members Impacted	8	5	3	12	256	6	5	1	1	3	4	5	309
Total	**8**	**5**	**3**	**1**	**6**	**2**	**4**	**1**	**1**	**3**	**4**	**5**	**43**

4. Internal Audits & Investigations

We plan to design and implement an Internal Audit Program between Q4 2026 and Q2 2027.

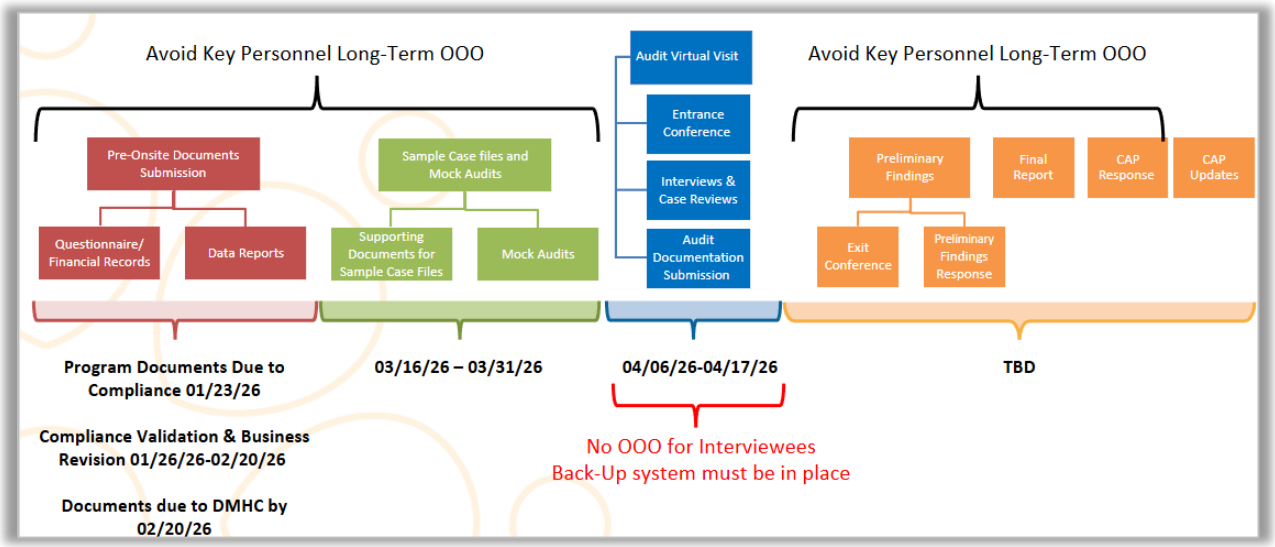
5. Policies & Culture of Compliance

Policy Review: We are currently developing & implementing a Policy Management Program (PMP) including the establishment of a Policy Management Committee (PMC) between Q1 2026 and Q3 2026 as part of the CPIW effort. While we establish a PMC, Compliance Committee will continue to review and approve new and revised policies. Four additional policies have been submitted for review and approval in the February Compliance Committee on 2/6/26. The policies are listed below:

Compliance	COMP 3.006	Anti-Fraud Program Policy	Revised	Updated policy to remove definitions and streamline to
Compliance	N/A	CCHP FWA Plan	New	New FWA Plan
Compliance	COMP 3.XXX	Key Personnel	New	Policy confirming required process for notifying regulators of key personnel changes.
Business Operations	BOPS 1.059	Professional Development Participation	New	Policy establishing a clear process for requesting, reviewing and approving employee participation in training, conferences and other professional development activities.

6. Regulatory Audits

- **2026 DMHC Financial Audit**
  Compliance program managers are communicating regularly with responsible department leads and monitoring progress of the preparation of required documents and information. Compliance has built in internal due dates that allows for ample time to provide quality assurance review and before final submission to DMHC. The overall audit process and timeline are summarized below:



The first mock audit was conducted on 2/5/26 focusing on claims processing. The overall health of the project is currently at risk due to competing priorities within the Claims and Finance departments in addition to data issues, which may impact timely submission of Pre-Audit Documentation. This is being mitigated by reprioritizing work to ensure DMHC submission timeline (2/23/26) is met. The audit team has identified the following risk and mitigation plan to ensure that we are able to meet the regulatory timeline.

- **2026 CMS Triennial Network Adequacy Review**
  CCHP was notified by the Centers for Medicare & Medicaid Services (CMS) on January 6, 2026, for a "formal" Triennial Provider Network Adequacy Review, as required under § 422.116 and described in the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance (last updated in December 2024). Per the notice, we will receive instructions regarding how to begin the formal review by uploading the entire network for this contract into CMS' Network Management Module (NMM) for an Automated Criteria Check (ACC) and additional instructions on submitting exception requests after the ACC is completed.

  In addition to the "formal" review in June 2026, CMS also offered the opportunity to several California Managed Care Plans (MCPs), including CCHP, to participate in a voluntary network review prior to the actual review in June 2026. CCHP has accepted to proceed with the "informal" CMS review. Health Service Delivery (HSD) tables were submitted to the CMS portal on 1/21/26. On 1/23/26, the Plan received the ACC report which identified several gaps. The network gaps identified are related to specialty provider and facility networks as listed in the table below:

Network Type	Specialty
Provider	• Neurosurgery • Psychiatry • Vascular Surgery • Clinical Psychology
Facility	• Acute Inpatient Hospitals • Cardiac Catheterization Services • CCU/ICU • Surgical Services • Speech Therapy • Inpatient Psychiatric Facility Services

Provider Contracting and supporting teams are working with Compliance on bridging the identified gaps and preparing for the next steps in the upcoming "formal" review in June 2026.

- **2026 DMHC Medical Loss Ratio (MLR) Audit**
  On January 13, 2026, the Department of Managed Health Care (DMHC) issued a Notification Letter which informed the Plan of DMHC's intention to conduct a routine examination of Plan's Annual MLR Reporting Form for the 2024 reporting year. The Finance Department is leading this technical audit and participated in the DMHC Entrance Conference on 1/22/26. This audit is focused on the Commercial line of business only.

7. Risk Assessment & CAP Tracking

- **2024 Medical Survey CAP Status Update**
  As previously reported, there were a total of 19 deficiencies identified from the 2024 DHCS Medical Survey. Of the 19 deficiencies identified, one remaining deficiency, "2.6 ECM assessment is not comprehensive", is still being remediated along with our ECM providers. This remediation process is long and arduous due to ECM providers:
    - Lack of knowledge in Medi-Cal program requirements
    - Lack of resources to fulfill the CAP timely

  To mitigate, Compliance and business unit are closely monitoring each ECM provider to ensure that they provide monthly update of progress and submit supporting documentation to the Plan timely until deficiency is remediated.

- **2025 DHCS Medical Survey**
  The Exit Conference was held on February 5, 2026. DHCS has shared their draft report that identifies ten (10) preliminary findings. Several deficiencies identified have already been remediated. Next steps will be for Compliance to work with each business lead to collect evidence of compliance or implement a remediation action plan and submit our "Audit Report Response" to DHCS by February 20, 2026. We expect to include the final results in our next quarterly report.

8. Enforcement Matters

DMHC Enforcement Matter 23-348: As reported in our last monthly update, the Plan received a Letter of Admonishment along with a Letter of Agreement requiring a Corrective Action Plan (CAP) and payment of an administrative penalty of $40,000. The Plan accepted the administrative penalty as assessed. The check was issued by the County Auditor's Office and was sent to DMHC on January 6, 2026. The Plan submitted the requested CAP responses timely on January 29, 2026.

9. Compliance Performance Improvement Workgroup Update

Starting in the November 2025 Staff Report, Plan has started providing a progress update related to the Compliance Performance Improvement Workgroup initiative. Compliance PIW continues to leverage the 7 Elements of an Effective Compliance Program as the guiding principles to establish an effective compliance program enabling an organization-wide culture of compliance and audit readiness.

Starting with this report, we will be updating the PIW progress by category. The update will primarily focus on current initiatives and ongoing projects. Additional updates will be included in future reports as we take on additional initiatives or projects. In summary, the table below outlines the overall status of current initiatives and ongoing projects.

The CPIW team determined that it may not be able to achieve the "staffing level" metric outlined under PIW 1.0 due to federal budget cut. Therefore, it is noted in the red status currently. For PIW II.0, due to the delay in contract execution, CPIW team anticipates its inability to meet one of the technology solutions go live date outlined in the metric.

Initiative/Project	Timeline	Status*
PIW I.0 Implement Effective Organizational Structure & Staffing level	Q1/26 - Q4/26	50% Complete
PIW III.01 Implement Effective Compliance Program for All LOBs including III.02 Compliance Leadership & Governance	Q3/25 – Q4/26	63% Complete
PIW III.01 Implement a Policy Management Program (PMP)	Q1/26 – Q3/26	33% Complete
PIW III.03 Develop & Conduct Effective Compliance Training & Education	Q1/26 – Q2/27	14% Complete
PIW III.05 Develop & Implement an Effective Lines of Communication	Q4/25 – Q4/26	0% Complete
PIW II.0 Implement Technology Solutions	Q3/25 – Q4/27	33% Complete
PIW III.04 Enforce standards through well-publicized disciplinary guidelines	Q2/26 – Q3/26	TBD
PIW III.06 Conduct internal monitoring and auditing	Q1/26 – Q2/27	TBD
PIW III.07 Respond promptly to detected offenses and undertake corrective action	Q1/26 – Q2/27	TBD

*% Completion = Total Number of Completed Milestones ÷ Total Number of Milestones per Initiative or Project.

10. Regulatory & Contract Updates - Issue Dates: December 26, 2025, to Present

Number	Title or Subject	Issue Date	Executive Summary
DHCS APL 26-002	Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 22-006)	02/02/26	DHCS clarifies Medi-Cal managed care plan responsibilities for providing and arranging Non-Specialty Mental Health Services (NSMHS) and outlines mental health parity requirements for initial assessments. • Effective April 1, 2026, providers must use only DHCS-approved tools when a youth trauma screening is necessary to identify eligibility for Specialty Mental Health Services • Managed Care Plans must provide or arrange for Non-Specialty Mental Health Services, including psychotherapy and psychiatric consultations, for specified member populations, including those under 21 years of age • Managed Care Plans must not require prior authorization or a Primary Care Provider referral for a member to receive an initial mental health assessment from a network provider • Managed Care Plans must ensure effective care coordination with the County Mental Health Plan for members receiving specialty mental health services, including medication reconciliation and transitional care services.
DHCS APL 26-001	Initial Health Appointment	01/01/26	DHCS updates Initial Health Appointment (IHA) requirements for all Medi-Cal managed care members, replacing the Initial Health Assessment and removing the IHEBA/SHA components. • Managed Care Plans must ensure an Initial Health Appointment (IHA) is completed for all members by a provider in a primary care setting and documented in the member's medical record. • The IHA must include a member's physical and mental health history, risk identification, assessment for preventive services, health education, and a diagnosis and treatment plan for any diseases. • Plans must review their policies and procedures to comply with this guidance, ensure subcontractor and provider compliance, and are subject to enforcement actions for non-compliance.
DHCS APL 25-017	2025-2027 Medi-Cal Managed Care Health Plan MEDS/834 Cutoff and Processing Schedule	12/26/25	DHCS has released the critical 2025-2027 MEDS/834 cutoff and processing schedule, which all Medi-Cal managed care plans must follow to ensure timely eligibility processing and payments. • Medi-Cal managed care plans must adhere to the enclosed 2025-2027 MEDS/834 cutoff and processing schedule to ensure timely eligibility processing and payments. • Plans must notify the Managed Care Operations Division Systems Support Unit of any MCP/MEDS/834 changes via email prior to the 15th of any given month.

Number	Title or Subject	Issue Date	Executive Summary
			• Where applicable, plans must submit all enrollments and disenrollments on a daily basis to allow for adequate processing time by DHCS.
DMHC APL 26-002	Delegation of Risk for COVID-19 Testing or Immunizations. Applicability of SB 510 (Pan, 2021) to Medi-Cal Managed Care Plan)	01/15/26	Plans must negotiate with and obtain agreement from providers before delegating the financial risk for COVID-19 testing and immunizations, with specific rules outlined for Medi-Cal plans. • Health plans are prohibited from delegating the financial risk for COVID-19 testing or immunizations to a provider unless the parties negotiate and agree upon a new contract provision for that purpose. • For COVID-19 services with dates of service prior to June 30, 2025, Medi-Cal managed care plans must comply with the prohibition on delegating financial risk without a specific, negotiated agreement. • For dates of service on or after June 30, 2025, Medi-Cal managed care plans are exempt from this rule and must instead cover COVID-19 services in accordance with guidance from the Department of Health Care Services (DHCS).
DMHC APL 26-004	Plan Year 2027 QHP, QDP, and Off-Exchange Filing Requirements	01/30/26	DMHC provides guidance on Plan Year 2027 filing requirements for all individual and small group health and dental plans, both on and off the Covered California exchange. • The Department holds primary responsibility for the regulatory review and good standing recommendations for Qualified Health Plans and Dental Plans offered through Covered California. • Health plans offering non-grandfathered products outside of the Exchange must secure Department approval for all necessary filings, including benefit design and rates. • All health plans must review the checklists and attachments on the Department's website for detailed PY 2027 regulatory requirements, deadlines, and expectations.
DMHC APL 26-003	Large Group Notice Requirements	01/29/26	The DMHC clarifies mandatory content and timing for large group renewal notices, including specific rate comparisons and information on how contract holders can request a rate review. • Health plans must deliver written notice of any premium or coverage changes to large group contract holders at least 120 days before the contract renewal effective date. • Renewal notices must include a statement comparing the proposed rate change against average increases for Covered California, CalPERS, and the large group market using state-provided figures. • Notices must also provide information on how contract holders can request a rate review from the DMHC and how to obtain the plan's required rate filing information.

Number	Title or Subject	Issue Date	Executive Summary
DMHC APL 26-001	National Committee for Quality Assurance Accreditation Compliance Filing	01/02/26	Health plans must submit documentation proving NCQA accreditation to the DMHC by February 2, 2026, to comply with state law; this letter outlines the specific filing requirements and process. • Health plans must submit a Health Equity and Quality filing to the DMHC via its e-Filing Web Portal to demonstrate compliance with the state-mandated NCQA accreditation requirement. • The filing must include a completed NCQA Accreditation Compliance Form, an Exhibit E-1 summary with specific affirmations, and supporting documentation such as an NCQA Decision Letter. • Plans must affirm that all applicable Commercial and Exchange products and delegated functions are NCQA-accredited and provide explanations for any that are not.
DMHC APL 25-021	Implementation of Senate Bill 729 (2024)	12/30/25	Full-service commercial plans must provide or offer coverage for infertility diagnosis and treatment for contracts issued, amended, or renewed on or after January 1, 2026, to comply with SB 729. • Large group health plans shall cover, and small group health plans shall offer the diagnosis and treatment of infertility and medically necessary fertility services effective January 1, 2026 • Health plans must provide coverage for infertility treatment without discrimination based on characteristics such as age, domestic partner status, gender identity, or sexual orientation • Coverage must include specific services such as limited retrieval attempts and five years of cryopreservation, and plans shall not deny coverage based solely on prior elective sterilization • Plans must include mandatory disclosure language in Evidence of Coverage forms and provide enrollees with written notices regarding cryopreservation storage periods.

CONSEQUENCE OF NEGATIVE ACTION

If this action is not accepted, it could lead to noncompliance under the federal and state regulations.