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To: Joint Conference Committee (JCC) Members

From: Sunny T. Cooper, Senior Director of Compliance and Regulatory Affairs (Interim)
Compliance Department
Date: December 19, 2025

Subject: Quarterly Compliance Activity Report

PURPOSE

This 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.

I. Executive Summary

During this reporting period, the Compliance Department continued to strengthen the organization's overall compliance posture across our Medi-Cal and Commercial lines of business while preparing for the D-SNP go live date of 01/01/2026. Our efforts focused on maintaining regulatory readiness, improving coordination between operational teams, and ensuring timely identification and remediation of compliance risks.

Regulatory monitoring remains stable. All required Medi-Cal and Medicare submissions were completed on time, and no critical findings were identified in ongoing state or federal monitoring activities. Preparations for the upcoming Department of Managed Health Care (DMHC) Financial audit are on track, with targeted workgroups addressing documentation, reporting, and operational control enhancements. The design and implementation of various compliance programs to strengthen regulatory compliance and audit readiness are also underway, prioritizing high-risk areas such as fraud prevention, privacy safeguards, and timely regulatory filings and responses.

CalAIM oversight activities are progressing as planned. All annual audits of Enhanced Care Management (ECM) and Community Support Services (CSS) entities are on schedule, and corrective action plans for identified issues are in progress. Enhanced monitoring of high-risk delegates, such as Pharmacy Benefit Manager (PBM), continues to reduce operational and regulatory exposure.

Fraud, Waste, and Abuse (FWA) monitoring shows no emerging risks; investigations are being completed within required timeframes in this past quarter, and overpayment recovery processes remain compliant. Privacy and security events remain low in volume, with no reportable breaches this period. Ongoing staff training and updated technical safeguards continue to strengthen our overall security posture.

Overall, the organization's compliance health is stable and trending positively. While there were several compliance gaps identified, a concerted effort, a.k.a., Compliance Performance Improvement Workgroup, has been put in place to tackle these gaps. The Compliance Department will continue to work collaboratively across the organization to maintain regulatory readiness, promote a culture of compliance, and ensure timely escalation of any emerging risks to the JCC members and to the Board of Supervisors (BOS) as needed.

II. Compliance Dashboard

In an effort to monitor the health of our Compliance Program Performance Dashboard (CPPD), we plan to design and implement a comprehensive Compliance Dashboard to monitor critical Key Performance Indicators (KPIs) in the next few years.

- A typical Compliance Program Performance Dashboard could include the following categories:
    - **Compliance Program Performance Dashboard**: Examples - compliance training completion rates, policies & procedures review status, etc.
    - **Delegation Oversight Dashboard**: Examples - number and types of delegated entities, annual audit statuses, compliance training rates, etc.
    - **Member Grievances & Appeals Dashboard**: Examples - total grievances and appeals by category, timeliness of resolution, D-SNP integrated grievance/appeal metrics, etc.
    - **Access & Network Adequacy Dashboard**: Examples - network adequacy, appointment availability test results, call center access metrics, etc.
    - **Fraud, Waste & Abuse (FWA) Dashboard**: Examples - FWA referrals and investigations, timely regulatory reporting, case aging and resolution timeliness, etc.
    - **Privacy & Security Dashboard**: Examples - HIPAA breach incidents & risk levels, Breach investigation timeliness, timely regulatory reporting, etc.

- **Audit & Regulatory Oversight Dashboard**: Examples – regulatory audits status & findings, submission, etc.
- **Clinical Quality & Performance Dashboard**: Examples - HEDIS performance and outliers, care coordination metrics (IHSS, LTSS, CS referrals, transitions of care), D-SNP health risk assessment (HRA) completion timeliness, etc.
- **Claims, Encounters & Payment Integrity Dashboard**: Examples - claims payment timeliness, encounter data submission timeliness and acceptance rates, overpayment identification and return compliance, etc.

Due to competing priorities, we plan to design and implement these dashboards in a phased approach. We will highlight each dashboard as they become available in our upcoming reports. Below is a highlight of our current mandatory Compliance Training Dashboard.

- **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. The chart below provides a summary of what we currently track and monitor on an ongoing basis.

Trainings (Due Dates)	CCHP
2025 Transgender, Gender Diverse or Intersex (TGI) Inclusive Care Act (01/31/25)	88%
2025 Diversity Equity & Inclusion (DEI) (10/31/25)	84%
2025 D-SNP Model of Care (MOC) (11/10/25)	**68%**
2025 General Compliance & FWA (12/31/25)	98%
2025 HIPAA Privacy & Security (12/31/25)	76%

The targeted threshold for attainment is >95%. A discussion topic on how to increase the training attainment rate is planned for our next Compliance Committee meeting which is scheduled to be held on 12/15/25.

III. 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 clear 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.

Between January 1, 2025, and October 22, 2025, a total of 35 FWA incidents were received and investigated. Ten (10) 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, 33 credible FWA cases were filed with DHCS. Untimely filing was noted in 10% (3) cases. Below tables outline the FWA incidents in more detail.

Table 1: Cases Received and Closed by Month for Reporting Period 1/1/25 – 10/22/25

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
# Received	1	0	1	1	4	5	7	7	5	4	-	-	35
# Closed	0	0	0	2	1	1	2	1	2	1	-	-	10

Per DHCS contractual requirements, preliminary reports must be filed with DHCS' Program Integrity Unit (PIU) detailing any suspected FWA identified by or reported to us and our third-party entities including contracted providers within 10 working days. 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 to date.

Table 2: Timely Regulatory Reporting of FWA Incident for Reporting Period 1/1/25 – 10/22/25

Filing Status	Count	% of Total
Timely Filing *(within 10 working days of incident)*	27	90%
Untimely*	3	10%
N/A (Reported by DHCS)	3	N/A
Total	**33**	**100%**

*Untimely filing is about 10% and 90% timely. Threshold target is 100%.

Table 3: FWA Case Type (Closed Cases) for Reporting Period 1/1/25 – 10/22/25

Filing Status	Count	% of Total
Services Not Rendered	3	30%
Medically Unnecessary Services	1	10%
Other	1	10%
Not FWA	5	50%
Total	**10**	**100%**

IV. Privacy, Security & HIPAA Compliance

Our HIPAA Privacy Program is designed to protect member information, ensure compliance with federal and state regulations, and safeguard the member's Protected Health Information (PHI), Personally Identifiable Information (PII), and other confidential information relevant to privacy laws. The Program establishes clear 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 ethical and compliant operations.

Between January 2025 and November 2025, we received and investigated a total of 38 cases. Of the 38 cases investigated, 25 (83%) cases were reported timely within 24 hours of discovery while 5 (17%) were reported untimely. One of the primary reasons for untimely reporting was the delay in reporting to Compliance (16%). This may indicate the need to generate awareness within the organization to ensure that any observed HIPAA violation is reported immediately to Compliance without delay. Compliance is currently working on developing a Compliance Awareness training series to educate and remind CCHP Workforce to report non-compliance incidents timely.

To date, 97% of the HIPAA incidents reported did not result in any reportable breach. The only incident that required additional remediation effort took place with our Pharmacy Benefit Manager (PBM) 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 PBM confirmed that the deficiency was remediated on July 22, 2025. Tables below summarize the HIPAA investigation monitoring activities between January 2025 and November 2025.

Table 4: Timely Regulatory Reporting of HIPAA Incident for Reporting Period 01/01/25 – 11/30/25

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	-	25
Grand Total	**8**	**5**	**3**	**1**	**6**	**2**	**4**	**1**	**1**	**3**	**4**	**-**	**38**

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				-	6
Timely	7	5	2	1	4	1	4		1	3	4	-	32

Internal Reporting Delays	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Grand Total	**8**	**5**	**3**	**1**	**6**	**2**	**4**	**1**	**1**	**3**	**4**	**-**	**38**

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	-	37
Grand Total	**8**	**5**	**3**	**1**	**6**	**2**	**4**	**1**	**1**	**3**	**4**	**-**	**38**

V. Compliance Investigations & Internal Audits

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

VI. Policies & Culture of Compliance

We plan to develop & implement a Policy Management Program (PMP) including the establishment of a Policy Review Committee between Q1 2026 and Q3 2026. This effort also includes establishing a Compliance Awareness training series within CCHP and the participation of the nationwide Compliance Week celebration in the first week of November in 2026 to instill a culture of compliance within the organization.

Dept	Number	Policy	Approved	Type	Description
Business Operations	1.052	Community Reinvestments	7/29/2025	New	Establish and implement Contra Costa Health Plan's approach to Community Reinvestment requirements to reinvest a minimum level of their net income into their local communities. DHCS requires an additional investment by MCPs that do not meet quality outcome metrics.
Business Operations	1.054	Medical Loss Ratio	7/29/2025	New	Explain how CCHP will impose the MLR reporting and remittance requirements as outlined in APL 24-018 on Subcontractors and Downstream Subcontractors of CCHP.
Compliance	3.002	All Plan Letters	7/29/2025	Modified	Assure that all CCHP departments are informed and aware of APLs issued from the DMHC and DHCS in a timely manner and that CCHP is compliant with all regulatory requirements.
Compliance	3.006	Anti-Fraud Program	7/29/2025	Modified	Establishes an FWA Plan of Action to comply with DHCS APL 22-005, Section 1348 (SB 956) as it affects CCHP relationship with members, providers, payers, staff, and various regulatory agencies. The purpose of this unit is to minimize our vulnerability to an enrollee, Marketing, and Plan fraud.

Dept	Number	Policy	Approved	Type	Description
Compliance	3.007	Enforcement Actions Policy	7/29/2025	New	To establish procedures for identifying, responding to, and remediating violations of contractual and regulatory obligations that may result in enforcement actions by the DHCS, pursuant to APL 25-007.
Compliance	3.022	Health Plan Documentation	7/29/2025	Retired	Contra Costa Health Plan (Medi-Cal Plan) and Contra Costa Health Plan – Community Plan (Commercial Plan) must maintain all required documentation to sustain each plan's legal existence.
Compliance	3.039	HIPAA - Reporting of Improper Disclosures	7/29/2025	Modified	Outlines the responsibility of the Compliance Department to ensure the protection of patients' rights to confidentiality, and to outline the process CCHP Compliance Staff will follow when a potential HIPAA concern is reported. To comply with DHCS, DMHC, and CMS contracts.
Compliance	3.040	Compliance Program	7/29/2025	Modified	Outlines the responsibility of the Compliance Department in ensuring CCHP is adhering to the DHCS contract and fulfilling its obligations under the Knox-Keene Act and CMS regulations.
Compliance	3.502	Investigation Compliance	7/29/2025	Modified	Outlines the investigation compliance with investigations or prosecutions conducted by Division of Medi-Cal Fraud and Elder Abuse and/or the U.S. Department of Justice and/or the Center for Medicare and Medicaid Services and/or the Department of Health Care Services.
Member Services	8.053	Changes in Member Circumstances	7/29/2025	New	Outlines the DHCS requirements re. reporting and processing changes in a member's circumstances that may affect income, insurance states, and death.
Claims	4.007e	Claim Processing, Determination Timeliness Internal Monitoring	7/29/2025	Modified	Provides guidance for processing and reimbursement of health care services claims. Beginning January 1, 2026, Sections 1371 and 1371.35 require a health plan to reimburse a complete claim, or portion thereof, as soon as practicable but no later than 30 calendar days after receipt.
Claims	4.159e	Recovery of Provider Overpayment	7/29/2025	Modified	APL 23-011 requires Contractor to notify DHCS of any identified or recovered overpayments to a Provider due to potential fraud, waste or abuse.
Claims	4.573e	Sensitive Services	7/29/2025	Modified	Per SB 729: Effective July 1, 2025, Coverage for the treatment of infertility and fertility services shall be provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

Dept	Number	Policy	Approved	Type	Description
Claims		Claims Payment Requirements	7/29/2025	New	Establishes procedures for processing claims in accordance with AB 2129, AB 2843, AB 3275, SB 1180, and SB 1320, ensuring timely reimbursement, appropriate cost-sharing waivers, and adherence to regulatory standards.
Member Services	8.005	Quality Monitoring	10/6/2025	Updated	Update - Added to Quality Assurance for Telephone Calls: 6. Any complaint made by an enrollee to CCHP about a delay or denial of a payment of a claim shall be treated as a grievance, regardless of whether the enrollee uses the term "grievance" as part of the complaint.
Sales and Marketing	12.101	Marketing and Communication Standards	10/6/2025	New	New Policy - establish requirements for the creation, approval, distribution, and oversight of all sales and marketing communications related to the D-SNP product line.
Sales and Marketing	12.102	Sales Activities and Member Contact	10/6/2025	New	New Policy – establish standards and procedures governing beneficiary contact, sales presentations, sales events, and the submission of enrollment applications during authorized sales interactions for D-SNP
Sales and Marketing	12.103	Agent, Broker, FMO, and TPO Oversight	10/6/2025	New	New Policy - establish standards and procedures for the oversight of sales channels, including employed gents, contracted brokers, Field Marketing Organizations (FMOs), and Third-Party Marketing Organizations (TPMOs)
Business Operations	1.047	Fast Healthcare Interoperability Resources	11/5/2025	New	New – Guidelines adopted by CCHP to ensure compliance with the CMS Interoperability and Patient Access Final Rule – required to make members' ePHI accessible through a secure standards-based Application Programming Interface
Business Operations	1.050	Downtime and Business Continuity	11/5/2025	New	New – Outlines the procedures and guidelines that CCHP will follow to maintain business during period of downtime
Business Operations	1.051	CCHP Dress Code	11/5/2025	New	New – Outlines dress code standards
Business Operations	1.055	Remote Work Location	11/5/2025	New	New – Outlines rules and standards of remote work from home guidelines
Business Operations	1.057	CCHP Overtime	11/5/2025	New	New – Establish consistent standards for authorization, tracking, and management of overtime
Business Operations	1.058	CCHP Staff Policy for Vacation - Administration Leave - Personal Leave Requests or Holiday Comp Leave	11/5/2025	New	New – Establish a standardized and timely process for requesting, reviewing, and approving or denying leave

Dept	Number	Policy	Approved	Type	Description
Personnel, Facilities & Safety	2.032	Personnel Interviewing Hiring and Onboarding	11/5/2025	Updated	Establish standardized, fair, and transparent process for recruiting, interviewing, hiring, conducting background checks, and onboarding staff
Personnel, Facilities & Safety	2.044	CCHP Emergency Operations	11/5/2025	New policy number	Define CCHP's emergency response framework and operational protocols in the event of a declared state of emergency
Compliance	3.006	Anti-Fraud Program policy	11/5/2025	Updated	Describes the FWA program and the responsibilities of CCHP's FWA staff and contracted SIU regarding the program objectives
Member Services	8.028	Information on Plan Covered Services	11/5/2025	Updated	CCHP provides covered benefits as defined by DHCS, the contract and the standardized EOC template. CCHP does not apply plan-specific benefit limitations, caps, or restrictions.

VII. Risk Assessment & CAP Tracking

- **2024 Medical Survey CAP Status Update**

There was a total of 19 deficiencies identified from the 2024 DHCS Medical Survey. Of the 19 deficiencies identified, one remaining deficiency is being remediated along with our ECM providers. The status of this deficiency is included below:

ID & Deficiency	Progress Update	Business Owner
2.6 ECM assessment is not comprehensive	1) Corrective Action Plans proposed for the deficiencies were partially accepted by DHCS. 2) Follow-up requests were focused on audits of ECM providers - ***in progress***. 3) CCHP provided the required monthly update to DHCS on 11/07/25. 4) Currently awaiting DHCS confirmation of next update submission date but anticipate first week of December.	ECM

- **2025 DHCS Medical Survey (closing conference held on 8/26/25)**

  Pending final DHCS audit report.

- **2022 Financial Audit CAP**

The Department of Managed Health Care (DMHC) conducts financial auditing of Medi-Cal Managed Care Plans (MCPs) every 3 years. Our last financial audit was conducted in 2022. We are currently gathering evidence of remediations in preparation for the upcoming 2026 Financial Audit which is in progress currently. The table below outlines the deficiencies identified in 2022.

ID	Deficiency	Business Owner
1	**Balance Sheet Incurred But Not Reported (IBNR) Claims Liability - G/L 0561** The Plan under accrued its IBNR liability. The Plan is advised to review its IBNR calculation methodology and add a cushion to its IBNR liability.	Claims
2	**INCOME STATEMEN T** The Plan reported $60,247,096 of inpatient per diem medical expenses and $23,962,109 of inpatient fee-for-service medical expenses on line 12: Inpatient Services - Capitated. These expenses should be reported on line 13: Inpatient Services – Per Diem and line 14: Inpatient Services – FFS, respectively.	Finance
3	**Tangible Net Equity (TNE)** TNE was overstated by $15,006,181 due to underreporting of IBNR liability.	Finance
4	**Required TNE Required** TNE was understated by $12,780,997 due to inpatient per diem and fee-for-service medical expenses being incorrectly reported as capitated expenses.	Finance
5	**Administrative Capacity** The Plan lacks adequate administrative capacity. The Plan did not provide requested documents and responses in a timely manner, prolonging the examination. For example, documents pertinent to the exam were requested by the Department on March 1, 2022, with a due date of June 9, 2022, but were not submitted until the middle of July.	Compliance
6	**Management Changes** The Plan did not file with the Department the appointments of Dennis Hsieh as Chief Medical Officer and Angela Choy as Chief Operating Officer in timely manner.	Compliance
7	**Claims Reviewer Compensation** The Plan's contract with Health Risk Resource Group, Inc. (HRG) for claims processing and negotiation services includes compensation based on a percentage of savings to the Plan	Claims
8	**Provider Contracts** The Plan did not file the following provider contracts revised in 2014 with the Department: Medical Specialist Provider Contract, Non-Physician Provider Contract, Primary Care & Physician Provider Contract. These contracts were filed with the Department during the exam.	Provider Relations

ID	Deficiency	Business Owner
9	**Anti-Fraud Plan** The Plan did not file its revised anti-fraud plan with the Department. The revised antifraud plan was filed with the Department during the exam.	Compliance
10	**Required Reports – AB 1455 Quarterly Claims Settlement Practices Report** The Plan has reported claims payment deficiencies in the Department's AB 1455 Quarterly Claims Settlement Practices Reports for several quarters since Q1 of 2019, although the deficiencies did not exist. The Plan disclosed to the Department that it is not able to accurately capture and report claims data to the Department due to the lack of capacity and system functionality.	Claims

VIII. Compliance Performance Improvement Workgroup Update

To ensure sustainability and operational excellence amid various pressures, CCHP established a structured framework of Performance Improvement Workgroups (PIWs). These cross-functional teams will identify and implement opportunities for improvement across departments and functions — enhancing efficiency, accountability, and alignment within the integrated system. Identified as one of the workgroups supporting these goals, Compliance Performance Improvement Workgroup (CPIW) is put in place with the following team members.

Compliance PIW	Team Members
Executive Sponsor	Irene Lo
Chair	Sunny Cooper
Project Manager	Jessica Stillman
Finance Lead	Shulin Lin/TBD
Data Lead/IT	• Bhumil Shah • Zach Withers
Subject Matter Expert(s)	• Elizabeth Hernandez - Interim COO • Nicolas Barcelo - Deputy CMO • Sara Levin - Deputy CMO
Compliance Support	• Chanda Gonzales • Jeanine Yang
Project Manager	• Jessica Stillman

Compliance PIW will leverage the **7 Elements of an Effective Compliance Program**, published in the US Sentencing Guidelines, as our guiding principles to establish an effective compliance and

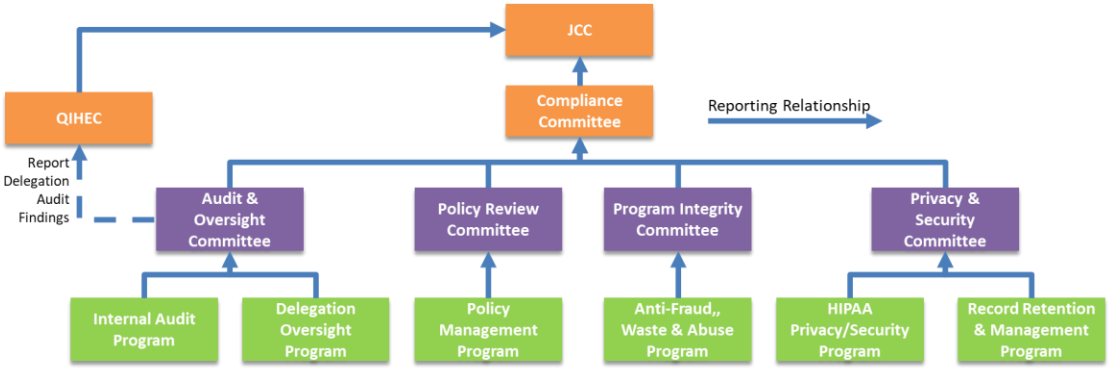
ethics program. In addition, per DHCS Contract Section 1.3.1, 42 CFR §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi), CCHP must have a Compliance Program in place which adopts these 7 elements.

- **Written Policies and Procedures:** Establish clear, written guidelines for conduct (Code of Conduct) and compliance across the organization.
- **Compliance Leadership & Governance:** Designate a compliance officer and a Compliance Committee with authority and oversight to manage the Program involving the highest levels of leadership.
- **Training and Education:** Provide regular, effective training and educational programs to all employees to ensure they understand their compliance obligations.
- **Effective Communication:** Develop clear and accessible channels for employees to report concerns and ask questions without fear of retaliation.
- **Monitoring and Auditing:** Conduct regular internal/delegate monitoring and auditing to assess the Program's effectiveness and identify potential areas of non-compliance.
- **Enforcement & Discipline:** Implement and publicly communicate disciplinary standards and consequences for non-compliance to ensure accountability across the organization.
- **Response to Offenses:** Establish a system for promptly responding to detected offenses, including investigating issues and taking appropriate corrective action to prevent recurrence.

In this report, we are highlighting our Plan related to the second element - "**Compliance Leadership & Governance".** The governance structure planned includes:

- JCC Oversight via regular Compliance Officer updates.
- A Compliance Committee, chaired by the Compliance Officer, consists of CCHP leadership team members with the authority and oversight to manage the Compliance Program.
- Sub-committees consist of members from both Compliance and business Subject Matter Experts (SMEs) within the organization to resolve escalated non-compliance risks and propose and/or implement remediation steps.
- Compliance programs monitor day-to-day operational tasks and mitigate non-compliance incidents in real time or via structured audit workplan.

The plan to structure CCHP's Compliance Governance is depicted below.


JCC
QIHEC
Compliance Committee
Reporting Relationship
Report
Delegation
Audit
Findings
Audit & Oversight Committee
Policy Review Committee
Program Integrity Committee
Privacy & Security Committee
Internal Audit Program
Delegation Oversight Program
Policy Management Program
Anti-Fraud,, Waste & Abuse Program
HIPAA Privacy/Security Program
Record Retention & Management Program

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IX. Regulatory & Contract Updates

Number	Title or Subject	Date of Issue	Executive Summary
DHCS APL 25-012	Targeted Provider Rate Increases	8/19/2025	Increases and updated family planning rates, effective for services starting January 1, 2024. • Managed Care Plans must pay eligible network and out-of-network providers for specified services at newly defined rates based on the Targeted Rate Increases (TRI) and Legacy Fee Schedules. • Payments to contracted FQHCs and RHCs must adhere to the Payment Parity Requirement, which now incorporates the TRI minimum fee schedule for applicable services. • Plans must ensure providers under capitated arrangements receive reimbursement that is at least equal to the TRI Fee Schedule rate and attest to compliance with all payment requirements in a manner specified by DHCS. • MCPs must communicate these new payment requirements and processes to their Network Providers, including itemized details for any retroactive adjustments.
DHCS APL 25-013	Medi-Cal Rx Pharmacy Benefits, And Cell and Gene Therapy Coverage (Supersedes APL 22-012) Appendix A - Medi-Cal Rx Transition and NCQA Requirements	9/18/2025	DHCS clarifies MCP responsibilities for the Medi-Cal Rx pharmacy benefit, including new coverage rules for cell and gene therapy and ongoing duties for care coordination and utilization review. • Managed Care Plans must not subject specified carved-out cell and gene therapies for sickle cell disease to utilization management but must cover associated medical services and care coordination. • MCPs remain responsible for covering Physician Administered Drugs (PADs) as a medical benefit and must publish their policies and procedures for provider access.

Number	Title or Subject	Date of Issue	Executive Summary
			• MCPs are required to perform retrospective Drug Utilization Review (DUR), participate in the Global Medi-Cal DUR Board, and submit an annual DUR report to DHCS. • All contracted MCPs must establish data sharing arrangements with their Network Providers and Subcontractors to support pharmacy adherence and medication management activities.
DHCS APL 25-014	Update to Provider Directory Requirement	9/26/2025	Medi-Cal Managed Care Plans must update public provider directories with new provider data, such as telehealth availability and disability access, effective July 1, 2025, to comply with federal law. • Effective July 1, 2025, Medi-Cal managed care plans must update their public, online searchable, and printed provider directories to include provider group affiliation, telehealth availability, disability accommodations, and CHIP patient acceptance status. • Plans must include links on their provider directory websites to the separate Medi-Cal Rx, Denti-Cal, and Fee-for-Service provider directories to help members locate carved-out services. • Plans are responsible for ensuring their subcontractors comply with all provider directory rules and must maintain policies and procedures demonstrating directory accuracy and compliance, which DHCS may request at any time.
DHCS APL 25-015	Data Sharing and Quality Rate Production for Directed Payment Initiatives and Alternative Payment Methodology Programs	10/2/2025	Medi-Cal Managed Care Plans must adhere to new requirements for producing quality rates and sharing data with providers involved in directed payment and alternative payment methodology programs. • Managed Care Plans must either produce quality performance rates on behalf of providers or supply them with specified data to calculate their own rates, adhering to required formats and turnaround times. • Plans must establish a formal dispute resolution process for providers regarding data accuracy, resolve disputes within 90 days, and designate program-specific subject matter experts for inquiries. • To demonstrate compliance, MCPs must review their Policies and Procedures and, within 90 days, submit either the updates or an attestation of no changes to the MCOD-MCP Submission Portal. • MCPs are responsible for communicating these requirements to, and ensuring compliance from, all subcontractors, downstream subcontractors, and network providers.

Number	Title or Subject	Date of Issue	Executive Summary
DHCS APL 25-016	Alternative Format Selection for Members with Visual Impairments (Supersedes APL 22-002)	11/13/2025	DHCS is updating requirements for providing materials in alternative formats to members with visual impairments, which will require plan operational and policy changes. • Managed Care Plans must transition from using the AFS Screens to relying solely on the 834-enrollment data file for members' alternative format preferences. • Upon request, plans must provide materials in alternative formats, including encrypted electronic files, and ensure any notices impacting benefits are delivered in the member's selected format. • Plans are required to review their policies and procedures, submitting either the updated documents or an attestation of no changes to the DHCS portal.
DMHC APL 25-016	Request for Health Plan Information Revisions	10/31/2025	The DMHC has revised the Request for Health Plan Information (RHPI) form, which all health plans must use for consumer complaints starting December 1, 2025. • The Department of Managed Health Care has revised the Request for Health Plan Information (RHPI) form to improve clarity, support more effective data capture, and promote interoperability • Health care service plans are expected to accurately complete each RHPI field and provide thorough written responses that address all issues in the consumer's complaint • All health care service plans are required to use the revised RHPI form.
DMHC APL 25-015	Assembly Bill 144 and Coverage of Preventive Care Services	09/18/2025	California Assembly Bill 144 expands health plan obligations to cover preventive services, including immunizations recommended by federal bodies as of January 1, 2025, and new recommendations by the California Department of Public Health (CDPH). • Health plans must cover without cost-sharing or utilization management all preventive items, services, and immunizations recommended by the USPSTF or ACIP as of January 1, 2025. • Plans are required to cover any modifications or supplements to federal preventive care recommendations made by the California Department of Public Health (CDPH) within 15 business days of publication. • Health plans must cover CDPH-recommended immunizations for COVID-19, influenza, and RSV without cost-sharing or utilization management, even if doing so is considered 'off-label' use.
DMHC APL 25-014	Provider Appointment Availability Survey Manual and	09/04/2025	Health plans must adopt amended Provider Appointment Availability Survey (PAAS) manuals and forms for reporting on timely access compliance, effective for Measurement Year 2026.

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	Report Form Amendments Beginning RY 2027/MY 2026 and Continuing Thereafter		• Health plans must use the amended Provider Appointment Availability Survey (PAAS) Manual, Report Forms, and TA Instruction Manual for compliance reporting submissions beginning May 1, 2027. • Plans are required to review and update internal policies and procedures to ensure alignment with the updated timely access regulations and associated manuals. • If revisions are made to documents filed as part of the health plan's license, such as Exhibit J-13-A, the plan must submit these changes to the DMHC for review.
DMHC APL 25-013	Amendments to Rules 1300.51, 1300.52, 1300.52.4, and 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2026 and Continuing Thereafter	09/04/2025	DMHC has amended rules for the RY 2026 Annual Network Report, impacting all health plans with new definitions like 'combination networks,' updated instructions, and revised reporting forms. • Health plans must comply with amended rules for Annual Network Report submissions for Reporting Year 2026, which include updated network definitions, standardized terminology, and revised report forms. • Health plans seeking to offer 'combination networks' must file a Notice of Material Modification, receive DMHC approval, and use a new specific report form for annual filings. • Plans must revise existing policies and procedures on file with the DMHC, such as Annual Network Data Collection Policies, to align with the new requirements.
AB 260	Sexual and Reproductive Health Care	09/26/25	This bill protects California providers, pharmacists, health facilities, and health plans from legal and disciplinary action related to prescribing, dispensing, and covering mifepristone, safeguarding medication abortion access. • Healing arts practitioners, pharmacists, clinics, and health facilities shall not face civil, criminal, professional, or licensing actions for lawful activities involving medication abortion drugs in California. • Health care service plans and health insurers are prohibited from limiting coverage for mifepristone based on its off-label use and must cover it even if not FDA-approved under certain conditions. • Providers and health plans shall not knowingly disclose an individual's identifiable medical information related to a lawful abortion to out-of-state entities via electronic health systems, subject to limited exceptions.

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			• Pharmacists dispensing medication abortion drugs without standard labeling information must maintain a specific log that is protected from law enforcement inspection without a subpoena.
AB 951	An act to amend Section 1374.73 of the Health and Safety Code, and to amend Section 10144.51of the Insurance Code, relating to health care coverage: Behavioral Diagnoses	07/30/25	California law now prohibits health plans from requiring a re-diagnosis for members with autism to maintain their behavioral health treatment coverage, effective for 2026 plan years. • For contracts issued, amended, or renewed on or after January 1, 2026, health plans and insurers shall not require a member previously diagnosed with autism to get a re-diagnosis to maintain coverage for behavioral health treatment • Plans and insurers shall not discontinue or delay a member's existing behavioral health treatment while waiting for a re-diagnosis to be completed • While a re-diagnosis cannot be mandated to maintain coverage, plans may require the treating provider to make the member's treatment plan available upon request.
AB 1041	Health care coverage: health care provider credentials.	10/11/25	This bill requires health plans & insurers to adopt the standard CAQH form for provider credentialing and to process complete applications within 90 days, or grant provisional approval, simplifying and accelerating network access for providers. • Health care service plans and health insurers must make a credentialing determination within 90 days of receiving a completed application, otherwise the applicant is provisionally approved for 120 days under specified conditions • On and after January 1, 2028, all full-service health plans and insurers must subscribe to and use the Council for Affordable Quality Healthcare (CAQH) credentialing form and processes • Plans must notify an applicant within 10 business days regarding application receipt and completeness and activate and notify the provider within 10 days of successful approval.
SB 40	Health Care Coverage Insulin Modifies the statutory requirements for health plans (under the Knox-Keene Act and the Insurance Code) with respect to coverage of insulin.	10/13/25	California caps patient cost-sharing for a 30-day insulin supply at $35 and prohibits step therapy, mandating changes to health plan and insurer benefit design, cost-sharing structures, and formularies. • Health plans and insurers must limit member cost-sharing for a 30-day supply of covered insulin prescription drugs to no more than $35 • Health plans and insurers are prohibited from imposing step therapy protocols as a prerequisite to authorizing coverage of insulin prescription drugs

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			• Large group plans must place at least one insulin of each drug type on their formularies, while individual and small group plans must do so on Tier 1 or Tier 2.
SB 41	Pharmacy benefits. • Health and Safety Code: Adds § 1367.2075, Amends § 1367.243 and adds § 1367.2431, Adds (or amends) Article 6.1, commencing with § 1385.001, Adds § 1385.0031 (and related sections) • Insurance Code: Adds § 10123.2045 (and related: § 10123.2051) & Amends § 10125.2	10/11/25	This bill overhauls Pharmacy Benefit Manager (PBM) operations in California, introducing strict licensing, pricing transparency, and fiduciary requirements intended to lower drug costs and protect consumers. • Pharmacy benefit managers must use a passthrough pricing model, shall only derive income from a defined management fee, and must direct all manufacturer rebates to the payer to reduce plan participant costs. • Health care service plans and health insurers are prohibited from calculating an enrollee's cost-sharing at an amount exceeding the actual rate paid for a drug, and their contracts with PBMs shall not authorize spread pricing. • Pharmacy benefit managers shall not discriminate against nonaffiliated pharmacies, require participants to use only an affiliated pharmacy, or retroactively deny or reduce claims except in cases of fraud or error. • A pharmacy benefit manager has a fiduciary duty to its payer client, and contracts issued on or after the specified effective date must require the PBM to be licensed by the Department of Managed Health Care.
SB 62	Health care coverage: essential health benefits. • Health and Safety Code — Section 1367.005 • Insurance Code — Section 10112.27	10/13/25	California will expand its Essential Health Benefits benchmark plan for 2027 to include coverage for fertility services, specific durable medical equipment, and hearing aids, impacting individual and small group health plans. • Commencing January 1, 2027, and contingent on federal approval, the state's essential health benefits benchmark plan shall expand to include coverage for specified fertility services, certain durable medical equipment, and hearing benefits • Health care service plans are prohibited from marketing or selling any individual or small group product as compliant with federal essential health benefits law unless it meets all requirements of this section • Individual and small group health care service plan contracts must provide, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act and as outlined in this section.
SB 306	Health care coverage: prior authorizations.	10/06/25	California will require health plans and insurers to eliminate prior authorization for routinely approved services based on data that plans must begin reporting.

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	• Adds Section 1367.025 to the Health and Safety Code. • Adds Section 10133.52 to the Insurance Code.		• Health care service plans and insurers must report statistics to the state on services subject to prior authorization and their approval rates. • The state departments will evaluate the data and publish a list of services with an approval rate meeting or exceeding a 90% threshold. • Plans and insurers must then cease requiring prior authorization for all services on the published list but may reinstate it for a specific provider upon evidence of fraud or clinically inappropriate care.
SB 386	Dental providers: fee-based payments. Adds new sections to both the Health & Safety Code and Insurance Code to ensure transparency, provider choice, and cost protections.	10/01/25	1) **Default payment must be *non–fee-based*** Plans or their payment vendors must use a **fee-free** payment method as the default when paying dental providers (e.g., EFT/ACH, check). Providers cannot be automatically placed into a payment method that charges them a fee. 2) **Fee-based payment methods require affirmative consent:** If a plan wishes to use a virtual credit card or any payment method involving fees: a) The provider must give **explicit, affirmative consent**. b) Silence, inaction, or pre-checked options **cannot** be treated as consent. 3) **Providers may opt out at any time:** Dental providers can revoke their consent to a fee-based payment system at any time, and the plan or vendor must honor that opt-out. 4) **Consent applies across the provider's entire practice** a) A provider's payment-method decision applies to: b) All locations of the practice c) All products and services under the plan contract 5) **Exception for specific contractual arrangements** If a plan already has a direct contract with a dental provider that **explicitly allows them to choose** payment methods, SB 386 does not impose additional requirements. 6) **Enforcement** A willful violation constitutes a crime under health-plan regulatory statutes, meaning plans must comply or face regulatory penalties.
SB 402	Health care coverage: autism. California Health and Safety Code and to the Insurance Code (respectively, Section	10/06/25	• Default Payment Method Must Be Non–Fee-Based: For health care service plans or insurers that cover dental services and provide payment (directly or via a vendor) to dental providers, the default method of payment must be a non–fee-based method (i.e., payment that does not impose a fee or cost on the provider).

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	1371.11 and Section 10123.146).		• Affirmative Consent Required for Fee-Based Payments: If a plan or insurer (or vendor) wants to use a fee-based payment method (e.g., virtual credit card, or any payment method where the provider incurs a fee to access the money), they must first obtain *affirmative consent* from the dental provider. • Right to Opt Out Anytime: Dental providers may opt out of a fee-based payment method at any time. • Consent Applies to Entire Practice & All Covered Services: If a provider opts in or out, that choice applies to the provider's entire practice *and* all products/services covered under the contract with that provider. • Exception for Direct Contracts with Alternative Payment Method: The law does not apply if the plan/insurer already has a direct contract with a provider that explicitly allows the provider to choose payment methods (including a non–fee-based method). • Effective Date: The law becomes operative on April 1, 2026, and applies to all plan contracts or insurance policies issued, amended, or renewed on or after that date. Enforceability / Penalty: A willful violation of these requirements (e.g., using a fee-based payment by default without consent) is a crime under the regulatory framework of the relevant health-plan laws.
SB 439	California Health Benefit Review Program: extension.	10/03/25	California extends the Health Benefit Review Program through 2033, continuing analysis of benefit mandates and increasing the annual assessment cap on health plans and insurers to $3.2 million. • This bill extends the operation of the California Health Benefit Review Program and its associated Health Care Benefits Fund until July 1, 2033. • The total annual assessment on health care service plans and health insurers is increased to $3,200,000. • The continued assessment of an annual fee on health care service plans and insurers is authorized for the 2026-27 through 2032-33 fiscal years.
SB 497	Legally protected health care activity.	10/13/25	California Senate Bill 497, concerning "Legally protected health care activity," strengthens the state's "transgender shield laws" to prevent cooperation with out-of-state efforts to penalize gender-affirming care that is legal in California. Key provisions include prohibiting the release of medical information in response to out-of-state actions and restricting the sharing of CURES database data without specific legal orders