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Discussion Item

D.4. ACCEPT report from Compliance, RECOMMEND APPROVAL, and FORWARD the Report to the Contra Costa County Board of Supervisors for approval

Sunny T. Cooper, Chief Compliance Officer

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Executive Summary of Compliance Health

- **Regulatory Monitoring:** All required submissions were timely, aside from a few minor delays that have since been corrected. No critical regulatory findings.
- **Enforcement Matter:** DMHC issued a follow-up subpoena related to Enforcement Matter 24-143. The Plan met the 4/13/26 submission deadline and continues to monitor this as an operational-risk area.
- **DHCS Audit Findings:** The 2025 DHCS Medical Survey Audit identified nine findings. Most corrective actions have already been implemented, and all CAPs were submitted on 4/20/26.
- **2026 DMHC Financial Audit:** Approximately 4,475 documents were submitted. Interviews occurred from 4/6 to 5/5. Exit conference is expected at the end of May.
- **2026 DMHC Follow-Up Survey:** DMHC has initiated a Follow-Up Review to assess outstanding deficiencies from the 2025 Final Report tied to the 2022 Full Scope Medical Survey, with virtual interviews scheduled to begin August 31, 2026. Plan must submit required questionnaires, logs, and evidence of compliance for sampled cases by 5/18 and 6/3.
- **Fraud, Waste & Abuse:** No new risks. Investigations are active, and recoupment letters totaling approximately $7.86M have been issued to four providers.
- **Privacy & Security:** Incident volume remains low with no reportable breaches. Workforce training materials are in development.
- **Compliance Initiatives:** The Policy Management Program is progressing but trending yellow due to resource constraints and competing priorities. Risk mitigation is ongoing.

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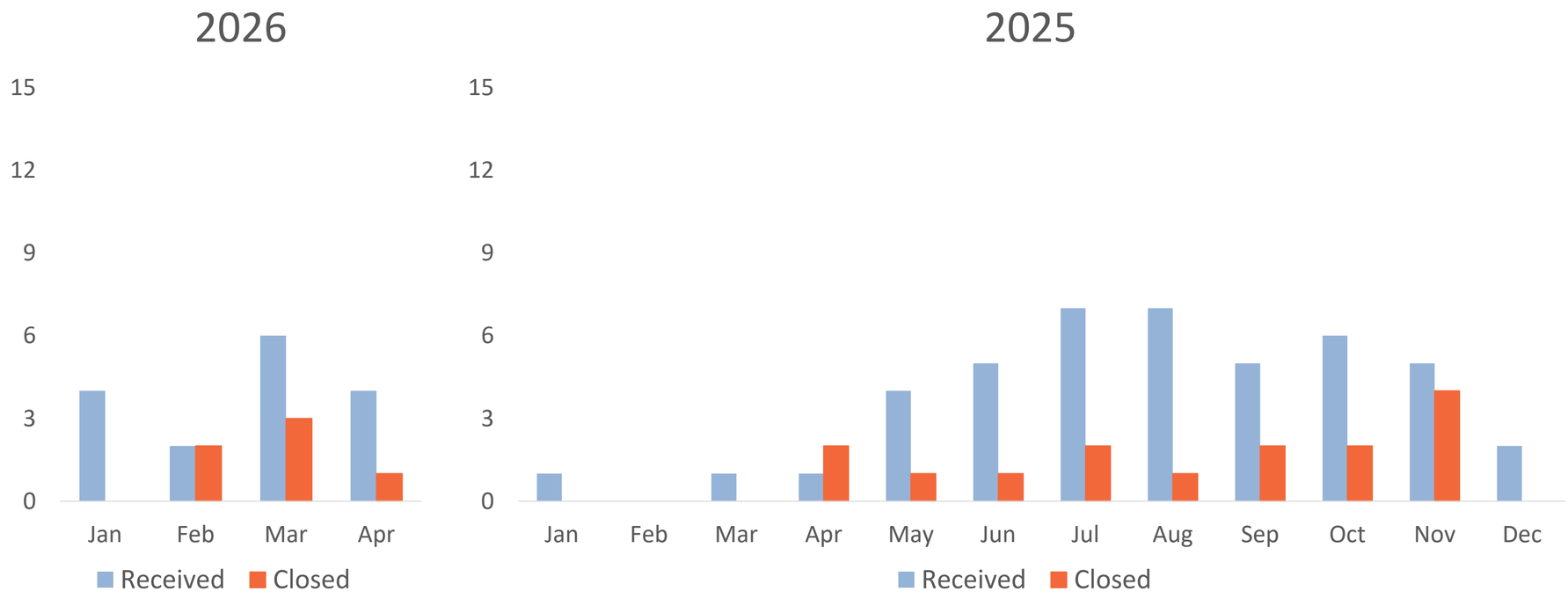
FWA Incident Trending Report

Total FWA Cases Received & Closed in Calendar Year 2026 vs 2025



35

total active Fraud, Waste and Abuse (FWA) cases as of May 13, 2026

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2026 FWA Incidents

Recoupment Amount Pending: $7,855,946.54

Table 2: Timely Regulatory Reporting of FWA Incident in Calendar Year 2026, as of April 30, 2026

FWA Filing Status	Count	% of Total
Timely Filing *(within 10 business days of incident)*	6	86%
Untimely	1	14%
Filings are Not Required*	9	N/A
TOTAL	**16**	**N/A**

*Includes cases that are not FWA-related, cases supporting DHCS or DOJ investigation and consolidation with previously filed cases.

Table 3: FWA Case Type (Closed Cases) for Reporting Period of Calendar Year 2026, as of April 30, 2026

Type of FWA	Count	% of Total
Bundling/Unbundling	0	0
Medically Unnecessary Services	0	0
Services Not Rendered	3	50%
Upcoding/Misrepresentation of Services	0	0
Not FWA	3	50%
TOTAL	**6**	**6**

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Continued Intensive Focus on FWA

On May 13, 2026, Vice President Vance announced $1.3 billion in Medicaid payments to California will be deferred over fraud concerns.
(click link to article here)

On April 23, 2026, Dr. Oz issued a demand letter to all state governors focusing on providers.

- ✓ States are directed to **immediately revalidate high-risk Medicaid providers** as part of federal program integrity obligations.
- ✓ **A broader provider revalidation strategy is due within 30 days, but this does not replace the urgent review of high-risk providers.**
- ✓ **States must respond within 10 business days** confirming whether they will conduct swift revalidation and provide a timeline. Failure to respond may factor into fraud risk evaluations.
- ✓ **Fraud, waste and abuse are costing billions**, particularly among providers with weaker enrollment controls, such as those without NPIs, making them priority targets.
- ✓ **CMS expects states to classify high-risk providers (including those without NPIs) and take rapid action to review, suspend, or terminate fraudulent actors.**
- ✓ Emphasis on **urgent, coordinated federal–state action** to strengthen Medicaid integrity and protect resources for vulnerable populations.

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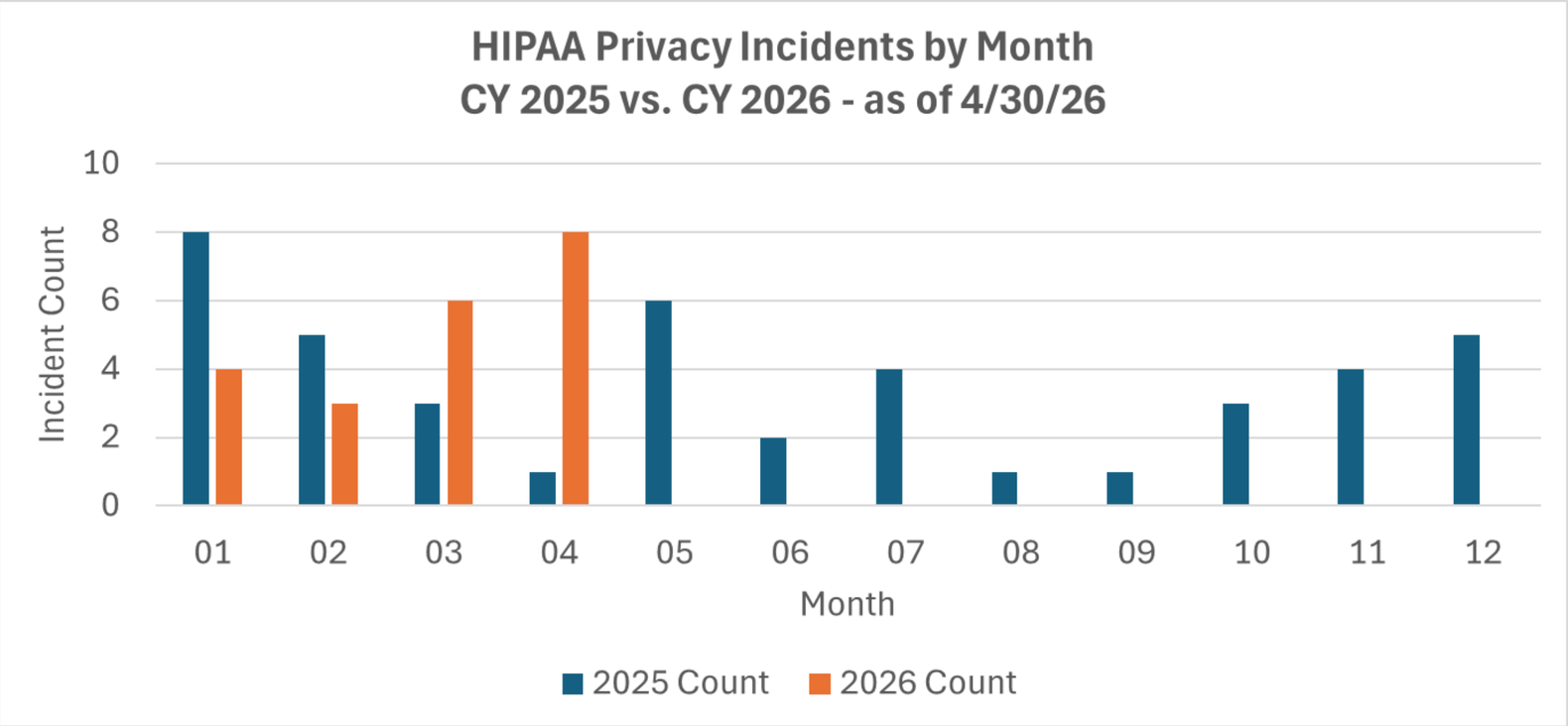
HIPAA Incident Trending Report



Month	01	02	03	04	05	06	07	08	09	10	11	12	Total
2025 Incident Count	8	5	3	1	6	2	4	1	1	3	4	5	43
2025 Member Impacted	8	5	3	12	256	6	5	1	1	3	4	5	309
2026 Incident Count	4	3	6	8									21
2026 Member Impacted	4	3	6	8									21

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HIPAA Incident Report

Table 1: Timely Regulatory Reporting of HIPAA Incident for Reporting Period January through April 2026

Report within 24 Hours	JAN	FEB	MAR	APR	Total
Not Timely	0	1	1	0	2
Timely	0	0	1	6	7
Not Reported	4	2	4	2	12
Grand Total	**4**	**3**	**6**	**8**	**21**

Table 2: Internal Reporting Delays between Breach Date and Compliance Receipt Date

Internal Reporting Delays	JAN	FEB	MAR	APR	Total
Not Timely	0	1	2	0	3
Timely	4	2	4	8	18
Grand Total	**4**	**3**	**6**	**8**	**21**

43

cases were investigated from January through April 2026

5

cases were not reported timely to Compliance

Compliance is currently working on developing a Compliance Awareness training series to educate and remind CCHP Workforce to report non-compliance incidents timely.

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DMHC Enforcement Matter 24-143

On March 13, 2026, the Plan received an Investigative Interrogatory—commonly referred to as a CAP Audit—about the Corrective Action Plan (CAP) the Plan submitted to address deficiencies identified in DMHC's 2021 investigation of the Plan's Mental Health and Substance Use Disorder (MH/SUD) services.

Investigative Interrogatories are formal enforcement actions, not routine audit questions.

In the final report dated August 31, 2023, the Plan was cited for eight deficiencies. DMHC has requested more evidence of compliance on four deficiencies:

- #2: The Plan failed to ensure the waiting time for enrollees to speak by telephone with a plan customer service representative did not exceed 10 minutes.
- #3: The Plan failed to consistently notify the requesting provider of authorization decisions within 24 hours of making the decision.
- #6: Failure of customer service to identify all grievances.
- #7: The Plan failed to timely pay claims.

We submitted all supporting documentation within 30 days of notice.

We are now waiting for DMHC to review, and we are prepared to provide more information if requested.

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2026 DMHC Financial Audit Update

As of April 16, 2026, we submitted approximately ~4,475 supporting documents to the auditors. During the “pre-onsite” period, Plan staff completed the following activities:

- ✓ Prepared and submitted 107 documents, including several universe file extracts, before sample files were selected.
- ✓ Prepared and submitted 3,583 supporting documents for 250 samples selected by the auditors.
- ✓ Prepared and submitted additional 785 supporting documents during the interviews as of April 16, 2026.

Virtual audit interviews started on April 6 and ended on May 5. The exit conference is expected at the end of May.

No major surprises. Some areas of concerns were already known and under remediation, such as claims interest calculation, late payment, etc.

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2026 DMHC Follow-Up Survey

Key Dates:

- **May 4:** Received formal notice from DMHC for a Follow-Up Survey on the Corrective Actions Plans (CAP) that we submitted on March 13, 2025.
- **May 4 to 18:** Submitted two questionnaires and 13 log files to DMHC.
- **May 19 to June 3:** Prepare and submit updated supporting documents reviewed during the 2022 audits.
- **May 18 to 22 (projected):** Receive sample case files from DMHC.
- **May 26 to June 12 (projected):** Prepare and submit additional supporting documents for the selected samples. Currently estimating 20 samples for each of the 13 topic categories.
- **August 2026:** Conduct internal mock audits.
- **August 31 to September 11:** Virtual/telephonic interviews

Almost all Business Units are participating.

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To: Joint Conference Committee (JCC) Members

From: Sunny T. Cooper, Chief Compliance Officer, CCHP Compliance Department

Date: June 5, 2026

Report Title: Compliance Report

RECOMMENDATIONS

D.4. ACCEPT report from Compliance, RECOMMEND APPROVAL, and FORWARD the Report to the Contra Costa County Board of Supervisors for approval.

FISCAL IMPACT

N/A

PURPOSE

Contra Costa Health Plan's (CCHP or "Plan" or "Division") submits this compliance report to the Joint Conference Committee (JCC). This is to provide JCC with the required information to oversee the effectiveness of the Plan's Compliance Program, the status of key compliance activities and any significant risks or issues that warrant JCC's attention. This is in accordance with our contractual obligations with the Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) 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 CCHP Compliance Department continues to strengthen regulatory readiness across Medi-Cal, Medicare D-SNP and Commercial lines of businesses. CCHP Compliance Department is also stabilizing the D-SNP Care Plus program launched on January 1, 2026. Here are key highlights:

A. **Regulatory Monitoring:** All required submissions were timely except for a few remediated delays. No critical findings were identified.

B. **Enforcement Matter:** On March 13, 2026, the Department of Managed Health Care (DMHC) issued a follow-up subpoena requesting additional information related to

Enforcement Matter 24-143. This interrogatory investigation sought the corrective action plans the Plan submitted in May 2023 to address deficiencies identified during the 2021 Mental Health and Substance Use Disorder investigation. The Plan submitted all requested supporting documents to DMHC timely, meeting the submission deadline on April 13, 2026. This remains an area of operational risk and the Plan continues to monitor it closely.

C. **Audit Findings:** DHCS has issued the final report for the 2025 Medical Survey Audit, identifying nine findings. The complete set of corrective action plans was submitted to DHCS on April 20, 2026. On May 4, 2026, DHCS responded by requesting additional supporting documentation. This is due back to DHCS on May 28, 2026.

D. **DMHC Financial Audit:** Plan staff submitted approximately 4,475 supporting documents in preparation for the DMHC Financial Audit. The audit team also conducted multiple mock audit sessions, along with internal reviews and discussions. This was to ensure readiness. Virtual interview sessions began with the entrance conference on April 6, 2026. The auditors completed their final interview session on May 5, 2026. An exit conference is expected at the end of May.

E. **DMHC Follow-Up Survey**: DMHC has initiated a Follow-Up Review to assess outstanding deficiencies from the 2025 Final Report tied to the 2022 Full Scope Medical Survey. Virtual interviews are scheduled to begin on August 31, 2026. Between May and early June, the Plan must submit required questionnaires, logs and evidence of compliance for sampled cases. Internal mock audits are planned for August. Compliance is coordinating preparation across all affected operational areas. The operational areas include Claims, Appeals and Grievances, Information Technology (IT), Member Services, Pharmacy, Quality and Health Equity, Provider Network Operations, Clinical QA and Utilization Management. The preparation with all operational areas is to ensure timely and complete responses are submitted to all pre-onsite requests.

F. **Compliance Initiatives:** Compliance Performance Improvement Workgroup (CPIW) initiatives are progressing. The priority is on establishing a Policy Management Program. While work is moving forward, the project is currently not on track due to competing organizational priorities, regulatory audits and limited resources. The project team continues to actively monitor and mitigate risks when identified.

G. **Third-Party Oversight:** Though slow, Enhanced Care Management (ECM) and Community Support Services (CSS) provider corrective actions are in progress. The team is working with these non-traditional providers closely to ensure progress is made. Staff plans to start more formal corrective discussions with select ECM providers who have

not completed their Corrective Action Plans (CAPs) on time. Continued noncompliance may result in contract termination.

H. **Fraud, Waste & Abuse (FWA):** No emerging risks; investigations and recoveries are in progress. The Plan has started issuing recoupment letters to four providers because of our FWA investigation. The total recoupment amount issued to the four providers was approximately $7,856,000.

I. **Privacy & Security:** There is currently a low incident volume. There are no reportable breaches. Compliance Department is developing workforce training materials.

Overall, compliance health is stable and trending positively. CPIW initiatives continue to address the identified gaps.

II. Compliance Program Performance Dashboard (CPPD)

To monitor the health of our compliance posture, we plan to design and implement a comprehensive CPPD. The dashboard aims to track and 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 are planning to accomplish this in phases. We are including each dashboard as it becomes available in our reports. Currently, staff are working on the mandatory compliance training attainment and regulatory notices trending dashboards.

A. Mandatory Compliance Training

Mandatory Compliance Trainings are those that are specifically required by regulatory agencies via contractual requirements or codified in relevant laws governing the Plan. As reported previously, the CCHP Workforce is required to complete mandatory compliance training within 60 days of hire and annually thereafter. The CCHP Workforce includes employees, contractors, temporary workers, and IT and Finance personnel designated for CCHP. The required compliance training courses for the CCHP Workforce are the following:

1. General Compliance and Fraud, Waste and Abuse
2. HIPAA Privacy and Security
3. Diversity, Equity and Inclusion (DEI)
4. Code of Conduct
5. Conflict of Interest

The Plan achieved 100% completion of these trainings in 2025. We are now monitoring our training compliance rate for 2026.

Table 1: CCHP Staff Training Completion Rates in Calendar Year 2025 and 2026 (as of May 4, 2026)

Course Title	Total	Incomplete	Complete	% Attainment	% Incomplete
2025 Fraud, Waste, and Abuse	280	0	280	100%	0%
2025 HIPAA Privacy Law Training	308	0	308	100%	0%
2025 Information Blocking	296	0	296	100%	0%
2025 CCHP: Diversity, Equity & Inclusion Training	315	3	312	99.0%	1.0%
2025 CCHP: D-SNP Model of Care Training - CCHP Staff	315	2	313	99.4%	0.6%
2025 CCHP: Transgender, Gender Diverse and Intersex (TGI) Training	323	2	321	99.0%	1.0%
2026 CCHP: Code of Conduct	**314**	**19**	**295**	**93.9%**	**6.1%**
2026 HIPAA Privacy Law Training (Due: 6/1/26)	**323**	**212**	**111**	**34.4%**	**65.6%**

On January 15, 2026, the CCHP Workforce was issued the Code of Conduct training to complete by February 15, 2026. As of May 4, 2026, approximately 94% of required staff have attested to reading and understanding the Code of Conduct. Compliance is actively working with non-compliant staff and their supervisors to ensure completion of this mandatory requirement.

In February, the CCHP Workforce was issued the 2026 HIPAA Privacy Law training to complete by June 1. Approximately 34% of the 323 workforce members have already completed the training.

This year, CCH IT and Finance staff who provide shared services to CCHP will also be required to complete the mandatory trainings. The table below highlights their completion rates. We plan to put them all in one dashboard in the future.

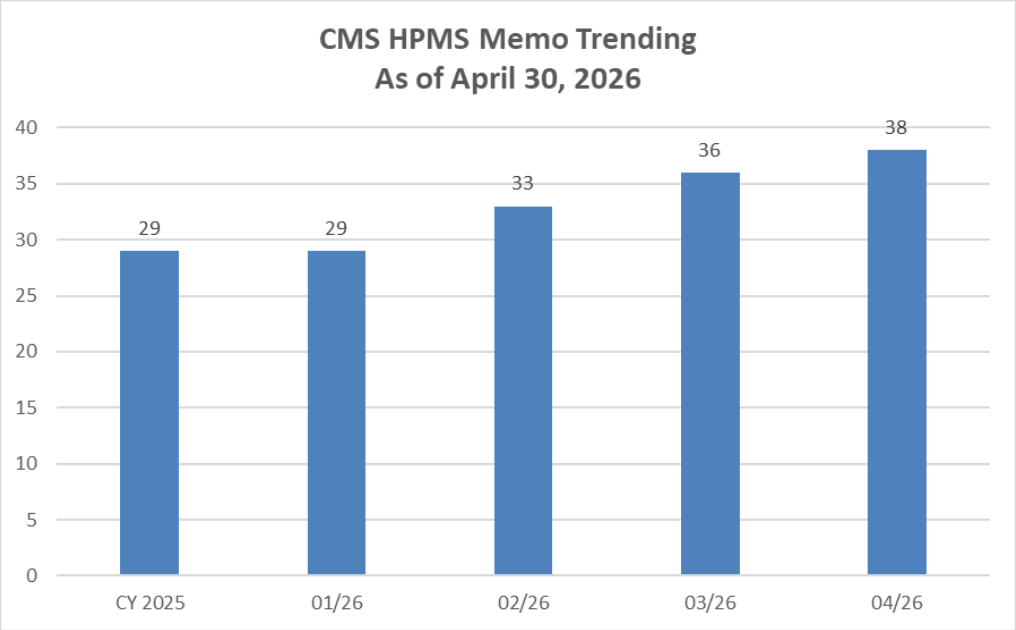
Course Title	Total	Incomplete	Complete	% Attainment	% Incomplete
2026 Code of Conduct	35	5	30	86%	14%
2026 HIPAA Privacy Law Training	35	16	19	54%	46%

B. Regulatory Notice Trending: HPMS and DHCS/DMHC APLs

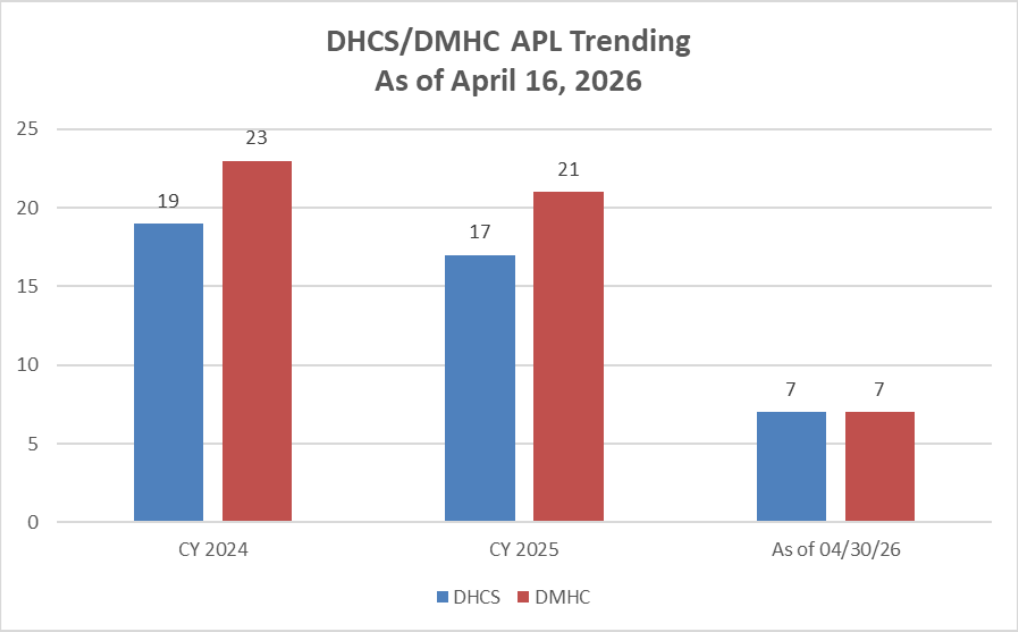
CCHP receives regulatory notices from Health Plan Management Services (HPMS) memos published by Centers for Medicare and Medicaid Services (CMS). We also receive All Plan Letters (APLs) published by Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC).

The charts below compare the monthly volume of regulatory notices compared to the monthly average volume in calendar year 2025. Here is the overall impression of the regulatory notices that were published during this reporting period:

- **HPMS:** The HPMS memo volume was a little bit higher in March 2026 compared to the previous two months. It was also higher compared to the average for calendar year (CY) 2025.



- **DHCS/DMHC:** DHCS and DMHC issued a few more APLs in the first quarter of 2026 compared to CY 2025. The State continues to increase their focus on FWA inquiries via email, in-person and virtual meetings.



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 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.

This quarter, we drafted and are reviewing two Desk Level Procedures (DLP). Revisions were made to our anti-fraud policy and Anti-Fraud, Waste and Abuse Plan. Both policies were approved by the Compliance Committee in February 2026. FWA Case Tracker has also been enhanced to include alerts when timely reporting is approaching or when the timeline has been missed. This helps the Compliance Department monitor and act on the alerts during regular reviews. Furthermore, the Plan has weekly meetings with our business leaders and Special Investigative Unit (SIU) vendor. The meetings are to discuss current and potential FWA cases so that we can monitor, audit and strategize on how best to identify and address risks.

CCHP has started issuing recoupment letters to four providers because of our FWA investigation results. The total recoupment amount issued to the four providers was approximately $7,856,000. Providers have the right to submit appeals to the Plan within 30 days of the issuing date on the recoupment letter.

A. Fraud, Waste and Abuse Summary

Between January 1 and April 30, 2026, CCHP received and investigated a total of 16 FWA incidents. During the same period, seven cases were closed and eight credible FWA cases were filed with DHCS.

Table 2: Cases Received and Closed by Month for CY 2025 compared to 2026 (January through April)

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
2025 Received	1	0	1	1	4	5	7	7	5	6	5	2	**44**
2025 Closed	0	0	0	2	1	1	2	1	2	2	4	0	**15**
2026 Received	4	2	6	4									**16**
2026 Closed	0	2	3	1									**6**

CCHP staff continue to monitor the timely filing of FWA incidents and the types of cases referred to Compliance. During this period, 14% of cases (1 case) were submitted after the required deadline. The main reasons why there were delays were because of limited FWA investigation experience and insufficient Compliance staff. The assigned staff member was also managing time-sensitive State Fair Hearings (SFH) and State Grievance workloads.

Compliance has brought on a part-time consultant to strengthen capacity and support this process. However, onboarding the consultant has taken longer than expected. In the interim, Compliance has enhanced its FWA Case Tracker and established regular, small-group meetings (also called huddles) to review all cases, process cases and submit them within ten working days as required.

The tables below provide more details on FWA incidents. Between January 1 and April 30, 2026, one of the seven cases was filed late. We anticipate a significantly lower untimely-filing rate as more cases are referred to Compliance in the coming months. Tables 2 and 3 summarize FWA statuses and outcomes for the current calendar year.

Table 3: Accumulative Timely Regulatory Reporting of FWA Incident: Calendar Year 2026 - as of 04/30/26

Filing Status	Count	% of Total
Timely Filing *(within 10 working days of incident)*	6	86%
Untimely	1	14%
Filings are Not Required*	9	N/A
Total	**16**	**N/A**

*Include cases that are not FWA-related, cases supporting DHCS/DOJ investigation and consolidation with previously filed cases.

Table 3: Accumulative FWA Case Type (Closed Cases): Calendar Year 2026 - as of 04/30/26

Filing Status	Count	% of Total
Bundling/Unbundling	0	0%
Medically Unnecessary Services	0	0%
Services Not Rendered	3	50%
Upcoding/Misrepresentation of Services	0	0%
Not FWA	3	50%
Total	**6**	**100%**

B. Federal Initiatives on Fraud, Waste and Abuse

Since our last report, we have engaged our Special Investigative Unit (SIU) vendor to analyze our contracted CalAIM providers. These are the providers who provided most of the 14 services named below. Compliance received the analysis from the SIU vendor and will perform the internal review to determine the next course of actions.

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

Shortly after receiving Dr. Oz's letter, CCHP began receiving an unusually high volume of data and documentation requests from the DHCS Audits and Investigations Division. There were four separate requests in total compared to zero requests received last quarter. These requests included Claims Detail Reports (CDRs) and Remittance Advice for paid claims. The requests were also various supporting documents, such as provider enrollment agreements, EFT agreements, submitter agreements and clearinghouse IP addresses. In addition, the California Department of Justice (DOJ) issued one request seeking certified copies of CDRs and Remittance Advice Details (RADs) for a specific provider.

The Compliance Department coordinated with Claims, IT, Finance and Provider Relations to gather the requested materials. Most documents have been submitted to the requesting agencies, except for the data validation certifications. We are working with each data owner to complete the certification process.

One more letter was issued by Senate committee that focused on the same topics listed above. Dr. Oz also issued a second letter to all governors focusing on provider validation requirements. Soon after Dr. Oz's second letter, Medi-Cal Rx informed Managed Care Plans that Medi-Cal Rx will no longer pay claims when they are prescribed by providers without NPIs. CCHP is analyzing the impact on our network providers and developing a plan to remediate as needed.

IV. Privacy, Security and HIPAA Compliance

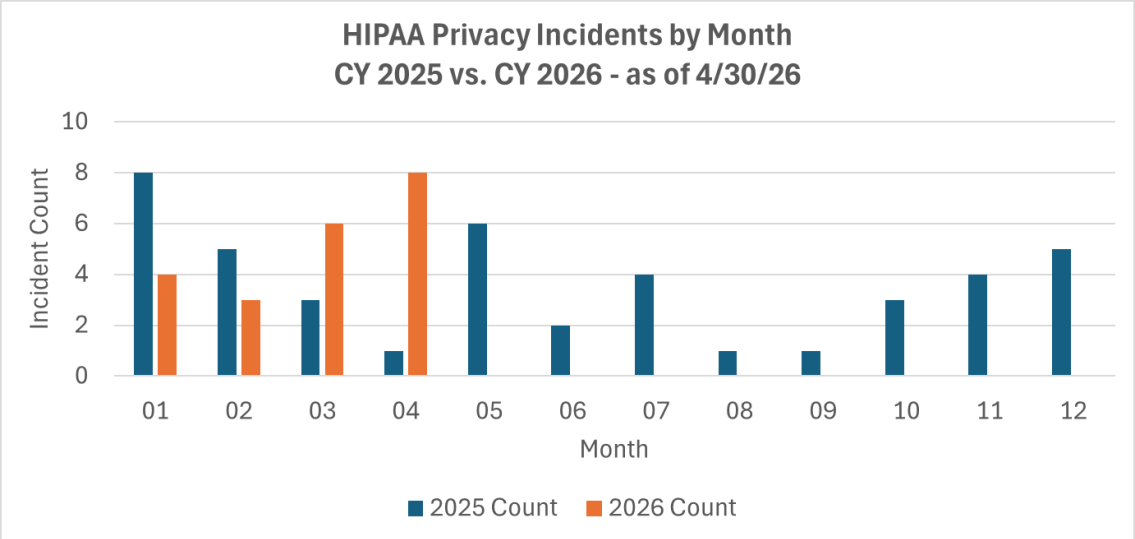
Our HIPAA Privacy Program is designed to protect member information and ensure compliance with federal and state regulations. The Program safeguards members' Protected Health Information (PHI), Personally Identifiable Information (PII) and other confidential information per privacy laws. The Program establishes policies, workforce training, ongoing monitoring, incident response procedures and risk-based security controls. This is 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 members trust us. It supports the organization's commitment to securing confidential information and adhering to regulatory requirements.

Between January 1 and April 30, 2026, we received and investigated a total of 13 cases. Of the four cases investigated that required reporting to DHCS, two cases were not reported to DHCS within 24 hours of discovery. This was because the reporter reported them late. Cases that do not require reporting to DHCS are internal errors and patient requests. To date, 100% of the HIPAA incidents reported did not result in any reportable breach.

In January, CCHP received an Excel worksheet from a contracted provider which included 81 records containing non-CCHP members' PHI, along with CCHP claims data. CCHP alerted the provider (Covered Entity) and provided HIPAA education.

In March, part of the 19 members impacted was a result of a clerical error in which a provider received an Explanation of Benefits (EOB) document meant for another provider. The incident was mitigated timely and no breach occurred.

The chart below summarizes the HIPAA investigation trends in CY 2025 vs CY 2026.



Month	01	02	03	04	05	06	07	08	09	10	11	12	Total
2025 Incident Count	8	5	3	1	6	2	4	1	1	3	4	5	43
2025 Member Impacted	8	5	3	12	256	6	5	1	1	3	4	5	309
2026 Incident Count	4	3	6	8									21
2026 Member Impacted	4	3	6	8									21

The tables below summarize the HIPAA investigation monitoring activities between January 2026 and April 2026.

Table 4: DHCS Regulatory Reporting of HIPAA Incidents in Calendar Year 2026

Report within 24 Hours	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV	DEC	Total
Not Timely	0	1	1	0									2
Timely	0	0	1	6									1
Not Reported	4	2	4	2									10
Grand Total	**4**	**3**	**6**	**8**									**13**

Table 5: Internal Reporting Delays between Breach Date and Compliance Receipt Date in Calendar Year 2026

Internal Reporting Delays	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV	DEC	Total
Not Timely	0	1	2	0									2
Timely	4	2	4	8									10
Grand Total	**4**	**3**	**6**	**8**									**13**

Table 6: HIPAA Incident by Breach or No Breach Categories in Calendar Year 2026

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Breach	0	0	0	0									0
No Breach	4	3	6	8									13
Members Impacted	4	3	19	21									25

V. Internal Audits and Investigations

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

VI. Policies and Culture of Compliance

A. Policy Review

We are developing and implementing a Policy Management Program (PMP). We are establishing a Policy Management Committee (PMC) between Q1 2026 and Q3 2026 as part of the CPIW effort. The first PMC meeting is scheduled for May 28, 2026. And it will focus on introducing the concept of Policy Management Program and rules of engagement for a formal CCHP policy lifecycle. This is so that going forward, all CCHP policies are tightly managed in preparation for audit readiness.

Before PMC, the Compliance Committee was reviewing and approving new and revised policies. Listed below are policies that were approved at the Compliance Committee meeting on May 8, 2026.

Department	Number	Policy	Type	Description
Appeals & Grievances	AGD 20.111	Submission of cases for IRE review policy	Modified	DSNP policy and attachments regarding submission of cases for IRE review.
Behavioral Health	BHD 18.001	Access to Mental Health	Modified	Revised per DMHC APL25-020: add language on autism diagnosis; cannot require new evaluation if ASD diagnosis already exists.

Department	Number	Policy	Type	Description
Behavioral Health	BHD 18.001	Access to Mental Health	Modified	Complies with DHCS APL 26-002 on approved Youth Trauma Screening Tools.
Behavioral Health	BHD 18.002	ABA	Modified	Revised per DMHC APL25-020: prohibition of re-diagnosis before service; may not delay/suspend/cancel service pending re-diagnosis; adds definitions for qualified autism providers/professionals/paras
Behavioral Health	BHD 18.002	ABA	Modified	Complies with DMHC APL 25-020 (SB402) defining BHT service providers per Business and Professions Code 4999.200-202
Behavioral Health	BHD 18.004	No Wrong Door	Modified	Revised per DMHC APL25-020: any outside request for records involving gender-affirming care must be escalated to Plan's Privacy Officer and Legal Counsel before providing. (Even though No Wrong Door is specifically a CalAIM/Medi-Cal feature, the language of the statute specifies applies to all plans.)
Behavioral Health	BHD 18.004	No Wrong Door	Modified	Complies with DHCS APL 26-002 on approved Youth Trauma Screening Tools.
Behavioral Health	BHD 18.007	Data Sharing	Modified	Revised per DMHC APL25-020: may not disclose medical or MH info relating to gender-affirming care in response to inquiries, subpoenas, etc. from other states. Plan, contractors and delegates shall not cooperate with out-of-state investigations or inquires.
CalAIM	CalAIM5.045	Community Support Overview, Eligibility, Restrictions and Limitations	Modified	Updated MTM/MSF eligibility, defined "At Risk for LTC" for the CS ALF transitions and personal care and homemaker services, further defined what "dependent for the majority of ADLs" meant for Respite Services.

Department	Number	Policy	Type	Description
Case Management	CM 16.403	Interdisciplinary Care Team for D-SNP Enrollees	Modified	Some minor edits to timing/frequency of ICT meeting to align with the full policy and other related policies.
Case Management	CM 16.400	Care Management Program Description for D-SNP Enrollees	Modified	Revised to explicitly include NCQA and CMS compliance/language to ensure alignment with accreditation standards and regulatory requirements.
Clinical Operations	CLIN 13.002	Reproductive Care	Modified	Updated to include legislative updates for IVF pursuant to DMHC APL 25-020 and SB 729.
Clinical Operations	CLIN 13.003	Street Medicine	Modified	Changing the name from “street Medicine” to “Field Medicine” updating minor changes.
Clinical Quality	CQA 10.007	Reporting Provider Preventable Conditions	Modified	Updated to include notification of provider responsibility to report PPCs to DHCS and provide a copy of the report to CCHP.
Member Services	MS8.055	Member Authorized Representative	New	Policy to establish procedure for authorized representative.
Quality and Health equity	QM 14.707	Health Information Form Screening and Health Risk Assessment	Modified	Minor edit to compliance with APL 26-001.
Quality and Health equity	QM14.701	Initial Health Appointment	Modified	Minor edit to compliance with APL 26-001.
Quality and Health equity	QM14.801	Cultural & Linguistic Services	Modified	Minor edit to meet requirements for APL 25-016 Alternative Format selection for members.
Utilization Management	UM15.018	Timeliness of the Utilization Review Decision and Communication	Modified	Removed language regarding date of receipt for requests received on weekends or holidays as next business day.
Utilization Management	UM15.102	Utilization Review Criteria and Guidelines	Modified	Updated to include Apollo guidelines.

Department	Number	Policy	Type	Description
Utilization Management	UM15.113	Transgender Services	Modified	Updated from MCG to Medicare guidelines.

B. Development of Compliance Awareness Training Materials

To foster and strengthen a culture of compliance at CCHP, the Compliance Department developed several training materials. These trainings meet applicable regulatory requirements. The topics covered are the following:

1. Elder Abuse
2. Fraud, Waste and Abuse
3. General Compliance & Code of Conduct
4. HIPAA Privacy and Security
5. General Compliance, FWA and Code of Conduct – Provider Focused

The Compliance Department also issued a survey to the CCHP leadership team for feedback on compliance awareness training needs. The top five topics that were requested are listed below:

1. Delegation and Vendor Oversight
2. Documentation Best Practices
3. Real Examples of FWA Cases
4. Lessons Learned from Audits
5. How and When to Report a HIPAA Incident

We will create training materials on the top five requested topics.

VII. Regulatory Audits

A. 2026 DMHC Financial Audit

During the reporting period, DMHC started their “pre-onsite” engagement with the Plan. During the “pre-onsite” period, we submitted approximately 4,475 supporting documents to the auditors as of April 16, 2026. More document requests will come from each interview session questions and answers (Q and A) section. During the “pre-onsite” period, Plan staff completed the following:

1. Prepared and submitted 107 documents, including several universe file extracts, before sample files were selected.

2. Prepared and submitted 3,583 supporting documents for 250 samples selected by the auditors.

3. Prepared and submitted additional 785 supporting documents during the interviews as of April 16, 2026.

The first mock audit was conducted on February 5, 2026. The mock audit focused on claims processing. More mock audits were conducted in March. The team held several huddles and discussions to ensure we were prepared for the actual audit.

The actual interview sessions were conducted virtually on April 6, 2026. We started with Claims topics, which included the examination of the following:

1. Paid Claims

2. Late Claims

3. Denied Claims

4. High Dollar Claims

5. Provider Dispute Resolutions

The DMHC auditors finished their final interview on May 12,2026. We expect the exit conference to take place at the end of May.

B. 2026 CMS Triennial Network Adequacy Review

CMS notified CCHP on January 6, 2026, for a "formal" Triennial Provider Network Adequacy Review. This is a requirement from Title 42 Chapter IV Subchapter B Part 422 Subpart C Section 422.116 here: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116. This requirement is also described in CMS's Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance here: https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance-12-09-2024.pdf. The notice states that we will receive instructions on how to start the formal review. We can upload the entire network for this contract into CMS's Network Management Module (NMM) for an Automated Criteria Check (ACC). We expect to get more instructions on submitting exception requests after the ACC is completed.

Since the last “informal” network adequacy review in January, the Provider Contracting Team continued to work on bridging the network adequacy gaps. As of April 1, 2026, the overall network adequacy is 93.1%. This is up by 4% compared to the prior reporting period. During this reporting period, network gaps in psychiatry, clinical psychology, surgical services and speech therapy were closed. Other gaps are all currently under active contract negotiations. The Provider Contracting Team is monitoring them.

The Plan has not received any formal notification on the formal review that is expected to start in June 2026. We are preparing while we wait for instructions from CMS to start the review process.

C. 2026 DMHC Medical Loss Ratio (MLR) Audit on CY2024 Commercial Line Submission

This audit is on track as of May 13,2026. All requested documentation has been submitted to the DMHC auditor. The auditor is reviewing the Plan's data. The audit is expected to be completed in spring of 2027.

D. 2026 DHCS Medical Loss Ratio (MLR) Audit on CY2024 on Medi-Cal Line Submission

This audit is on track as of May 13, 2026. All requested documentation has been submitted to DHCS. The auditor is currently reviewing the Plan's data. The audit is expected to be completed in summer 2026.

E. 2026 DMHC Follow-Up Survey

On May 4, 2026, DMHC issued a notice to conduct a Follow-Up Review of the Plan. The review or survey is on the outstanding deficiencies that were identified in March 13, 2025’s Final Report of the Routine Survey of Contra Costa County Medical Services. The final report came from the 2022 Full Scope Medical Survey that DMHC also conducted.

DMHC expects to conduct virtual or telephone interviews with key Plan staff starting at 9:00 a.m. on August 31, 2026. DMHC may choose to conduct the survey onsite instead if they tell us 60 days before their visit. The key dates for this Survey are outlined below:

1. **May 4, 2026:** CCHP received a formal notice from DMHC for a Follow-Up Survey on the Corrective Actions Plans (CAP) that we submitted on March 13, 2025.

2. **May 5 to May 18, 2026:** Prepare and submit two questionnaires and 13 log files to DMHC.

3. **May 19 to June 3, 2026:** Prepare and submit updated supporting documents reviewed during the 2022 audits.

4. **May 18 to May 22, 2026 (projected):** Receive sample case files from DMHC.

5. **May 26 to June 12, 2026 (projected):** Prepare and submit additional supporting documents for the selected samples. We are estimating 20 samples for each of the 13 categories of topics.

6. **August 2026:** Conduct internal mock audits.

7. **August 31 to September 11, 2026:** Virtual or telephone interviews with DMHC.

The Compliance Department is taking the lead to mobilize all impacted business leads to prepare for the pre-onsite requests. The impacted business units include the following:

- Culture and Linguistics
- Claims
- Compliance or Project Management Office (PMO)
- Appeals and Grievances
- IT
- Member Services
- Pharmacy
- Clinical Quality Assurance
- Mental Health and Substance Use Disorder (MH/SUD)
- Provider Network Operations
- Quality and Health Equity
- Utilization Management (UM)

The deficiencies identified from the 2022 Medical Survey are listed below:

#	Category	Deficiency Statement	Status
01	Quality Assurance	The Plan failed to demonstrate that the governing body approved the Quality Assurance program during the survey review period. Rule 1300.70(b)(2)(B).	Not Corrected
02	Quality Assurance	The Plan's governing body did not oversee the Quality Assurance program. Section 1370; Rule 1300.70(b)(2)(C).	Not Corrected
03	Grievances & Appeals	For grievances involving a denial based on medical necessity, the Plan's written responses to enrollees failed to consistently	Not Corrected

#	Category	Deficiency Statement	Status
		include the criteria, clinical guidelines or medical policies used and clinical reasons for the Plan's decision. Section 1368(a)(5).	
04	Access & Availability	The Plan's online provider directory did not indicate which providers are federally qualified providers, health centers or primary clinics. Section 1367.27(c)(2) and (h)(8)(c),(D).	Corrected
05	UM	The Plan's utilization management denial letters based in whole or in part on medical necessity did not consistently include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the Plan's decision. Section 1367.01(h)(4).	Not Corrected
06	UM	The Plan's utilization management denial and modification letters to providers did not consistently include the direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification decision. Section 1367.01(h)(4).	Not Corrected
07	UM	The Plan did not ensure its utilization management delegate, Kaiser, consistently provided written notifications to enrollees regarding denial, delay, or modification of requested health care services based on medical necessity that included a clinical reason for the decision. Section 1367.01(a); Section 1367.01(h)(4); Section 1367.01(j); Rule 1300.70(b)(2)(B) and (G)(3).	Not Corrected
08	UM	The Plan did not ensure its utilization management delegate, Kaiser, consistently included the accurately formatted statement required by Section 1368.02(b) in written notices regarding a delay, denial, or modification of requested healthcare services. Section 1368.02(b); Rule 1300.70(b)(2)(B) and (G)(3).	Not Corrected
09	UM	The Plan did not demonstrate it has the required processes in place for the denial of experimental health care services to terminally ill patients. Section 1368.1(a).	Corrected
10	UM	The Plan failed to demonstrate it complied with post stabilization care requirements. Section 1262.8(d)(1)(A) and (B); Section 1262.8(d)(2); Section 1371.4(a), (d) and (j)(1).	Not Corrected
11	ED Services	The Plan did not provide all noncontracting hospitals in the state with Plan contact information needed to request authorization of post-stabilization care. Section 1262.8(j).	Not Corrected
12	ED Services	The Plan failed to consistently process retrospective emergency room claims within 45 working days after the date the claim was received. Section 1371(a)(1).	Not Corrected
13	Drug Coverage	The Plan's formulary exception request denial and modification communications did not include a description of the process for requesting an external exception review. Section 1367.24(b) and (k); 45 C.F.R. part 156.122.	Not Corrected

#	Category	Deficiency Statement	Status
14	Language Assistance	The Plan's commercial evidence of coverage did not notify enrollees that the Plan does not discriminate based on ancestry, religion, marital status, gender, gender identity or sexual orientation. Section 1367.042(a)(3) and (b)(1).	Corrected
15	Behavioral Health	The Plan did not demonstrate that all staff who review claims, conduct utilization review and/or make medical necessity determinations received formal Nonprofit Association training for each Nonprofit Association training criteria. Section 1374.721(a), (b) and (e)(1).	Not Corrected
16	Behavioral Health	The Plan did not demonstrate that its Interrater Reliability testing scenarios cover all utilization management aspects, including concurrent inpatient or residential treatment cases. Section 1374.721(e)(5), (f)(3)(A) and (B).	Corrected

VIII. Risk Assessment and CAP Tracking

A. 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 deficiency, "2.6 ECM assessment is not comprehensive," is still in remediation with our ECM providers. This remediation process is long and challenging because ECM providers lack managed care knowledge and have limited resources. Below is an update for this reporting period:

1. Corrective Action Plans proposed for the deficiencies were partially accepted by DHCS.

2. Follow-up requests were focused on audits of ECM providers.

    a. Two ECM providers have successfully closed their CAPs, with remediation validated through clinical chart audits.

    b. Four ECM providers have completed CAP documentation revisions, including policies, workflows and supporting materials. These are pending clinical validation through chart audits.

    c. Nine ECM providers remain actively engaged in CAP implementation and ongoing remediation efforts.

    d. Two providers are no longer delivering ECM services within CCHP.

3. At this time, we received no additional follow-up requests from DHCS.

To mitigate, the Compliance Department and business units are closely monitoring each ECM provider. We are making sure that the ECM providers provide monthly progress updates and submit supporting documentation to us timely, until there is no longer a deficiency. Since this CAP has been open for a long time, we are analyzing alternative options to mitigate this regulatory risk.

B. 2025 DHCS Medical Survey

On March 16, 2026, DHCS issued its final audit report for the Plan's State Supported Services (SSS) Hyde Contract for abortion services and the 2025 DHCS Medical Survey Audit. The audit period covered activities between August 1, 2024, and July 31, 2025.

No deficiencies were identified for SSS in the audit. This indicates full compliance with the requirements for abortion services under the Hyde Contract.

The Medical Survey Audit resulted in nine findings. The Plan met the CAP submission deadline on April 20, 2026.

Remediation efforts began immediately after the Exit Conference in September 2025 and when we received the preliminary audit report. As a result, substantial progress had already been made by the time the final report was issued in March 2026.

DHCS responded to our submission and requested additional documentation based on the responses we submitted in April. DHCS expects the Plan to provide additional information to support our remediation effort by May 28, 2026.

As of May 11, 2026, here are the findings and statuses, or DHCS's review results, of our remediation efforts in the table below:

ID	Category	Finding Summary	Status (5/11/26)
1.2.1	Utilization Management Program	The Plan's concurrent NOA letters did not explicitly state how the member's condition did not meet the clinical criteria or guidelines.	• 5 Accepted • 1 Partially accepted
1.2.2	Utilization Management Program	The Plan incorrectly applied PA requirements to cancer biomarker testing and home hospice services.	• 2 Accepted • 4 Partially accepted
3.6.1	Network and Access to Care	The Plan improperly denied emergency services claims that involved CCS eligible diagnoses.	• 2 Accepted • 4 Partially accepted

ID	Category	Finding Summary	Status (5/11/26)
4.1.1	Grievances, Appeals, and Member Rights	The Plan did not send complete Ukrainian and Russian taglines in the Notice of Availability attached to grievance acknowledgement and resolution letters.	• 1 Accepted • 3 Partially accepted • 2 Pending Deliverable
4.1.3	Grievances, Appeals, and Member Rights	The Plan did not send translated acknowledgement letters within the required 5-calendar day timeframe or translated resolution letters within the 30-calendar day timeframe.	• 3 Accepted • 5 Partially accepted • 2 Pending Deliverable • 2 Not Accepted
4.12.1	Grievances, Appeals, and Member Rights	The Plan did not notify DHCS within 24 hours of suspected security incidents.	• 3 Accepted • 3 Partially accepted
5.13.1	Quality Improvement and Health Equity Transformation Program	The Plan did not conduct oversight to ensure that its delegated entities conduct new provider training.	• 2 Partially accepted • 4 Pending Deliverable
6.13.1	Plan Administration and Organization	The Plan did not complete an investigation of all reported or suspected FWA activities.	• 5 Accepted • 4 Partially accepted
6.13.2	Plan Administration and Organization	The Plan did not report all suspected fraud cases to the DHCS within ten working days	• 3 Accepted • 3 Partially accepted

Compliance Department will continue to monitor the remediation progress. We will submit monthly updates to DHCS until all remediation efforts are completed and accepted.

IX. Enforcement Matters

A. DMHC Enforcement Matter 24-143

On March 13, 2026, the Plan received an Investigative Interrogatory on the CAP we submitted to address deficiencies identified in the DMHC's 2021 investigation of the Plan's MH/SUD services. An Investigative Interrogatory is commonly referred to as a CAP Audit. They are formal enforcement actions and are not routine audit questions. This issuance means that this has escalated beyond standard oversight. And that it may carry regulatory or legal exposure. The Plan is required to respond separately, fully, in writing and under oath to each CAP identified in the request within 30 days of receipt.

During the 2021 MH/SUD investigative audit, the DMHC investigation team interviewed Plan staff and the Pharmacy Benefit Manager (PBM) from November 8 to 9 in 2021. DMHC issued

its preliminary investigation report on May 23, 2023. In response, the Plan submitted a set of CAPs addressing each deficiency on May 23, 2023. The final investigation report was issued on August 31, 2023. The current Investigative Interrogatory specifically concerns the CAP submitted by the Plan on May 23, 2023.

In the final report issued on August 31, 2023, the Plan was cited for eight deficiencies. Of the eight deficiencies, DMHC is performing additional inquiries on the following four findings:

Deficiency #2: The Plan failed to ensure the waiting time for enrollees to speak by telephone with a plan customer service representative did not exceed ten minutes.

Deficiency #3: The Plan failed to consistently notify the requesting provider of authorization decisions within 24 hours of making the decision.

Deficiency #6: Failure of customer service to identify all grievances.

Deficiency #8: The Plan failed to timely pay claims.

DMHC's Interrogatory Investigation demanded that the Plan submit evidence of compliance for the CAPs submitted in May 2023, specifically for the four deficiencies listed above. The Plan submitted all required supporting documentation on time. The Plan is waiting for DMHC to review, and we are prepared to provide more information if asked.

X. CPIW Update

Starting with the November 2025 JCC Staff Report, the Plan provided progress updates on the CPIW initiative. We continue to use the **7 Elements of an Effective Compliance Program** as our guide to establish an effective compliance program. This enables an organization-wide culture of compliance and audit readiness.

The updates primarily focus on current initiatives and ongoing projects. More updates will be included in future reports as we take on more initiatives or projects. In summary, the table below outlines the overall status of current initiatives and ongoing projects.

Initiative/Project	Timeline	Status*
PIW I.0 Implement Effective Organizational Structure & Staffing level	Q1/26 – Q4/26	67% Complete
PIW III.01 Implement Effective Compliance Program for All LOBs including III.02 Compliance Leadership & Governance	Q3/25 – Q4/26	75% Complete
PIW III.01 Implement a Policy Management Program (PMP)	Q1/26 – Q3/26	54% Complete
PIW III.03 Develop & Conduct Effective Compliance Training & Education	Q1/26 – Q2/27	29% Complete
PIW III.05 Develop & Implement an Effective Lines of Communication	Q4/25 – Q4/26	40% Complete
PIW II.0 Implement Technology Solutions	Q3/25 – Q4/27	50% Complete

Initiative/Project	Timeline	Status*
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.

Two out of three new full-time employees (FTEs) requested to support Audit & Oversight Program were approved by the Board in April. Therefore, we are back on track for this reporting period. We will start our recruitment effort to meet the timeline specified in the workplan.

For PIW II.0 Implement Technology Solutions, we may not meet one of the technology solution's original launch date because of the delay in executing the contract. The contract was executed in late April and we are implementing the solution now.

XI. Regulatory and Contract Updates Issued in Q1 2026:

A. All Plan Letters issued by Department of Health Care Services (DHCS)

1. Title: Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP). DHCS issued APL 26-006 on March 30, 2026. Click the link here to see the APL. The following is the executive summary:

    - Managed care plans must make directed payments to eligible SNFs for the WQIP based on per diem amounts and exhibits provided by DHCS.
    - Plans must withhold WQIP payments from facilities with Class AA or A citations issued by the California Department of Public Health and recoup payments if citations are discovered after the fact.
    - MCPs must report qualifying bed day data, publish payment information on a public website and establish processes for provider communication, data sharing and grievance resolution related to the WQIP program.
    - MCPs must review and, if necessary, amend their Policies and Procedures to comply with this APL, submitting updated P&Ps or an attestation to the MCOD-MCP Submission Portal.

2. Title: Maternity Services for Pregnant and Postpartum Medi-Cal Members. DHCS issued APL 26-005 on March 25, 2026. Click the link here to see the APL. The following is the executive summary:

This letter details your plan's payment and data sharing requirements for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for rating periods through December 31, 2025.

- Managed care plans must make directed payments to eligible Skilled Nursing Facilities for the Workforce and Quality Incentive Program based on per diem amounts and exhibits provided by DHCS.
- Plans must withhold WQIP payments from facilities with Class AA or A citations issued by the California Department of Public Health and recoup payments if citations are discovered after the fact.
- MCPs must report qualifying bed day data, publish payment information on a public website, and establish processes for provider communication, data sharing, and grievance resolution related to the WQIP program.
- MCPs must review and, if necessary, amend their Policies and Procedures to comply with this APL, submitting updated P&Ps or an attestation to the MCOD-MCP Submission Portal.

3. Title: Medi-Cal Managed Care Plan Responsibilities for Behavioral Health Data-Sharing. DHCS issued APL 26-004 on March 16, 2026. Click the link here to see the APL. The following is the executive summary:

   This letter details your plan's payment and data sharing requirements for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for rating periods through December 31, 2025.

   - Managed care plans must make directed payments to eligible Skilled Nursing Facilities for the Workforce and Quality Incentive Program based on per diem amounts and exhibits provided by DHCS.
   - Plans must withhold WQIP payments from facilities with Class AA or A citations issued by the California Department of Public Health and recoup payments if citations are discovered after the fact.
   - MCPs must report qualifying bed day data, publish payment information on a public website, and establish processes for provider communication, data sharing, and grievance resolution related to the WQIP program.
   - MCPs must review and, if necessary, amend their Policies and Procedures to comply with this APL, submitting updated P&Ps or an attestation to the MCOD-MCP Submission Portal.

4. Title: Quality Measures for Encounter Data Update: Quality Measures for Encounter Data 2.0. DHCS issued APL 26-003 on March 13, 2026. Click the link here to see the APL. The following is the executive summary:

   DHCS is updating the Quality Measures for Encounter Data (QMED) to version 2.0, impacting how Medi-Cal managed care plans' encounter data quality is measured starting January 1, 2026.

   - For managed care encounters submitted on or after January 1, 2026, the quality of encounter data will be measured quarterly as "Pass" or "Fail" according to the new QMED 2.0 requirements.
   - MCPs must review their policies and procedures (P&Ps) and submit either updated P&Ps or an attestation of no changes to the Managed Care Operations Division Submission Portal.
   - MCPs are responsible for ensuring that their subcontractors, downstream subcontractors, and network providers comply with all applicable laws, regulations, and DHCS guidance, including this APL.

5. Title: Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services. DHCS issued APL 26-002 on February 2, 2026. Click the link here to see the APL. The following is the executive summary:

   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.
   - 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.

6. Title: Initial Health Appointment. DHCS issued APL 26-001 on January 7, 2026. Click the link here to see the APL. The following is the executive summary:

   Medi-Cal managed care plans must adhere to updated requirements for the Initial Health Appointment (IHA), which streamlines the initial member screening process and removes previous assessment components.

   - Managed care plans must review their policies and procedures for compliance with this letter and submit any updates, or an attestation of no changes, to the DHCS submission portal.
   - Plans must ensure an Initial Health Appointment is completed for all members, noting that an Individual Health Education Behavioral Assessment (IHEBA) or Staying Healthy Assessment (SHA) is no longer required.
   - Plans are responsible for ensuring their subcontractors and network providers comply with all IHA requirements and must communicate these requirements to them.

B. All Plan Letters Issued by Department of Managed Health Care (DMHC)

1. Title: APL 26-006 – AB 118: Part 2 - Compliance with Individual and Small Group Standardized Evidence of Coverage/Disclosure Form. DMHC issued APL 26-006 – AB 118: Part 2 on April 8, 2026. Click the link here to see the APL. The following is the executive summary:

   APL 26-006 (Part 2) implements requirements from AB 118 to ensure standardization, transparency and consumer clarity in health plan Evidence of Coverage (EOC) documents and disclosure forms for individual and small group markets in California.

   - Standardized EOC/Disclosure Templates: Plans must use state-mandated standardized formats. Applies to Individual market products and small group products. Limits plan-specific variation in language, structure and benefit presentation.
   - Required Content Elements: Plans must ensure EOCs clearly and consistently describe: 1) Covered benefits and exclusions; 2) Cost-sharing (copays, coinsurance, deductibles); 3) Limitations and prior authorization requirements; and 4) Member rights and responsibilities.
   - Regulatory Review and Approval: EOCs and disclosure forms must be submitted to regulators for review and approval. The materials must also be updated to reflect standardized requirements before use.
   - Consistency Across Products: Benefit descriptions must align across EOC, Summary of Benefits and Coverage (SBC) and Marketing materials.

2. Title: Compliance with Assembly Bill 904, Maternal and Infant Health Equity Program. DMHC issued APL 26-005 on March 20, 2026. Click the link here to see the APL. The following is the executive summary:

   New filing requirements for health plans to demonstrate compliance with Assembly Bill 904, which mandates developing a maternal and infant health equity program using doulas.

   - Health plans covering maternity services must develop and implement a maternal and infant health equity program to address racial health disparities using doulas.
   - Plans must submit a compliance filing to the DMHC, which includes a summary of e-filing information, a completed AB 904 Implementation Form and any supporting documentation like new or amended contracts or policies.
   - Medi-Cal managed care plans are considered compliant as long as doula services remain a covered Medi-Cal benefit.

3. Title: APL 26-004 - Plan Year 2027 QHP, QDP, and Off-Exchange Filing Requirements. DMHC issued APL 26-004 on January 30, 2026. Click the link here to see the APL. This APL was issued January 30, 2026. The following is the executive summary:

   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.

4. Title: APL 26-003 - Large Group Renewal Notice Requirements. DMHC issued APL 26-003 on January 29, 2026. Click the link here to see the APL. The following is the executive summary:

   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.

5. Title: APL 26-002 – Delegation of risk for COVID-19 testing or immunizations. Applicability of SB 510 (Pan, 2021) to Medi-Cal Managed Care plans. DMHC issued APL 26-002 on January 15, 2026. Click the link here to see the APL. The following is the executive summary:

   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).

6. Title: APL 26-001 – National Committee for Quality Assurance Accreditation Compliance Filing. DMHC issued APL 26-001 on January 2, 2026. Click the link here to see the APL. The following is the executive summary:

   Health plans must submit documentation proving NCQA accreditation to the DMHC by February 2, 2026, to comply with state law. The APL 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.

CONSEQUENCE OF NEGATIVE ACTION

If this action is not accepted, the Board will not receive a required update on CCHP's overall compliance status, program activities and risk status. It could also lead to noncompliance under the federal and state regulations.