

Department of Managed Health Care Update

CADP Conference
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DMHC Mission Statement

The mission of the Department of Managed Health Care (DMHC) is to ensure health plan members have access to equitable, high-quality, timely, and affordable health care within a stable health care delivery system.

2024 Accomplishments



3.1 MILLION
HEALTH PLAN MEMBERS ASSISTED

The DMHC Help Center protects health plan member rights, resolves member complaints, and helps members navigate and understand their coverage ensuring access to health care services.



\$296.1 MILLION

dollars saved on Health Plan Premiums through the Rate Review Program since 2011



\$62.2 MILLION

dollars recovered from health plans on behalf of health plan members



30.2 MILLION

Californians' health care rights are protected by the DMHC

140

LICENSED
HEALTH PLANS



98 FULL SERVICE



42 SPECIALIZED



\$227.1
MILLION

dollars in payments recovered to physicians and hospitals

97%

of state-regulated commercial and public health plan enrollment is regulated by the DMHC



\$198.4 MILLION

dollars assessed against health plans that violated the law



Approximately
73%

of health plan member appeals (IMRs) to the DMHC resulted in the health plan member receiving the requested service or treatment from their health plan

December 31, 2024

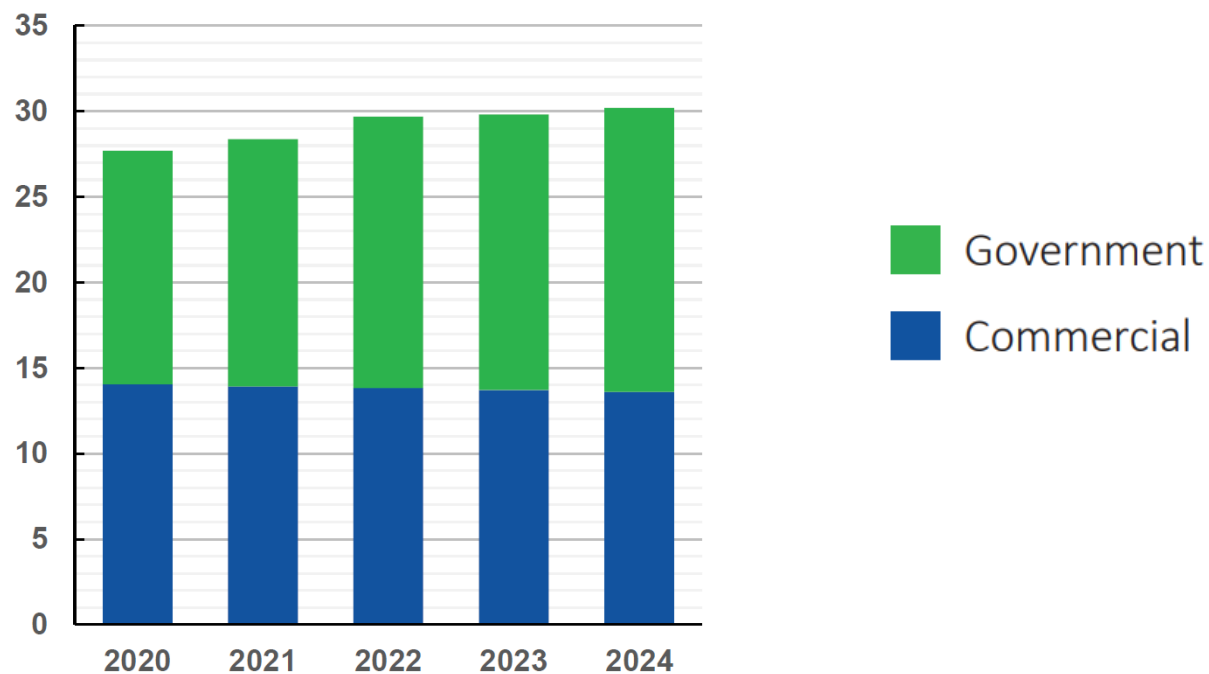
What is the DMHC?

Regulator of full service and specialized health plans

- All HMO and some PPO/EPO products
- Some large group and most small group & individual products
- Most Medi-Cal Managed Care plans
- Dental, vision, behavioral health, chiropractic and prescription drug plans
- Medicare Advantage (for financial solvency only)

DMHC Enrollment Over Time

Full Service Enrollment (In Millions)



How We Regulate Dental Plans

- License Products
- Dental Medical Loss Ratio Annual Review
- Annual Dental Rate Review
- DMHC Help Center
- Track Enrollee Complaints
- Enforce the Law

DMHC Priorities

1. Affordability and Federal Changes
2. Pharmacy Benefit Manager (PBM) Licensure
3. Menopause Proposal
4. Behavioral Health
5. Health Equity and Quality

Recently Adopted Regulations

- SB 137, Provider Directories
 - Rulemaking commenced on January 10, 2025
 - Rulemaking was approved on December 17, 2025
 - Regulation Effective Date: April 1, 2026

Regulations in Formal Rulemaking

- SB 17 – Prescription Drug Costs Reporting
 - Rulemaking Commenced on March 13, 2026
 - First Comment Period Closed on April 27, 2026
 - Second Comment Period Anticipated

Upcoming Regulations

- SB 368 – Deductible and Out-of- Pocket Maximum Accrual Balance Monitoring and Reporting
- Claims Settlement Practices/Dispute Resolution Process
- General Licensure/Risk Regulation Amendment
- Health Equity and Quality
- Legislation implementation

Office of Plan Monitoring

Division of Plan Surveys

Oksana Meyer, MPA, CHC
Assistant Deputy Director,
Division of Plan Surveys

Knox-Keene Act Survey Authority

- The Knox-Keene Act (**KKA or Act**) is California's foundational managed care law, administered by the DMHC (Health & Safety Code § 1340 et seq.)
- **Routine Survey-** The Department shall conduct periodically an onsite medical survey of health delivery systems of each plan (Section 1380)

Division of Plan Surveys

Survey Cycle and Process

Routine Medical Surveys (every three years)

- **Follow-Up Survey** *within* 18 months of issuance of the Final Report to determine and report on the status of the plan's efforts to correct deficiencies

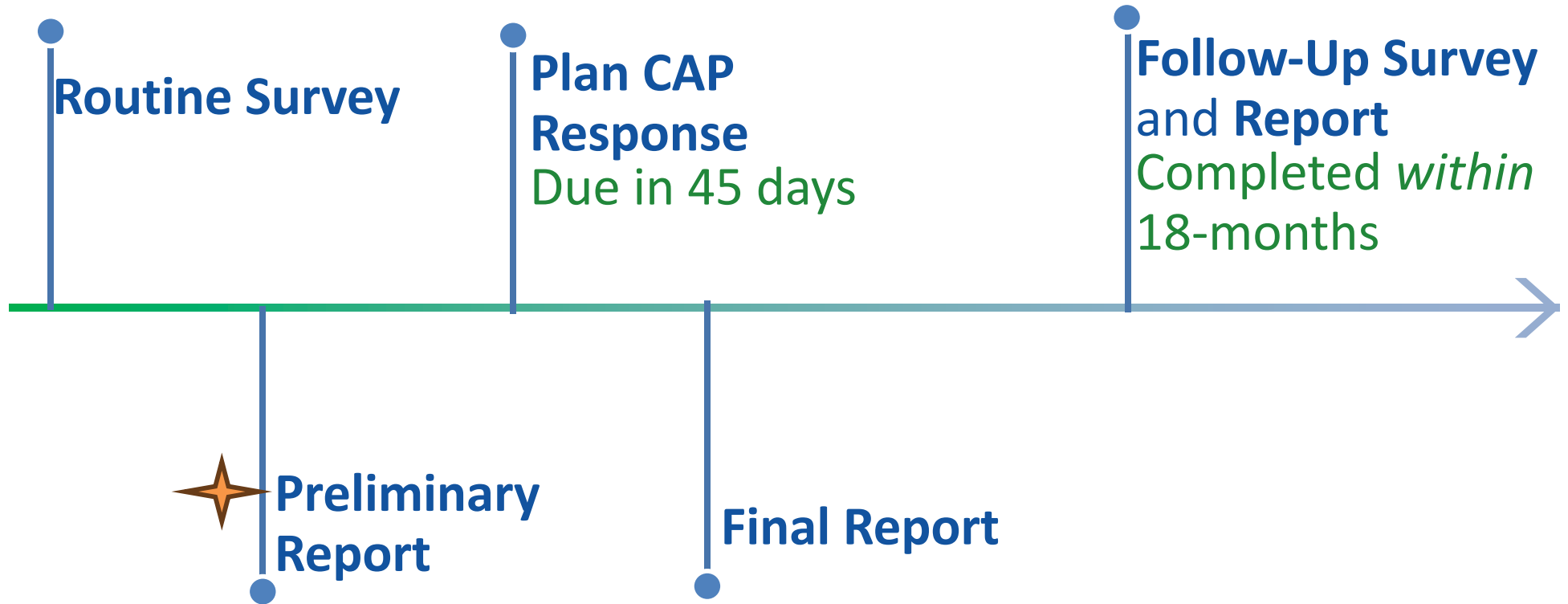
Survey Areas: **Dental Plans**

Quality Assurance
Utilization Management
Grievances and Appeals
Access and Availability

DMHC Survey Focus

- Review for **operational compliance**
- Statistical sampling methodology
- **Evidence of compliance:** case files, listen to calls, meeting minutes, job aids, work flows, internal monitoring and reporting/documentation, etc.

3-Year Cycle



Pre-Onsite

- Notify plans approximately 150 days prior to onsite date
- Plans submits documents and data through DMHC's Web Portal
- Conduct file review (QA, GA,UM, etc.)
- Team prepares for interviews with a focus on questions arising from pre-onsite document review

Onsite

- Interviews with plan team members
- Ask questions to clarify or confirm DMHC's understanding of plan practices
- System demonstrations
- DMHC may request additional documents or have additional questions after the onsite portion of the survey

Issuance of Preliminary Report

- DMHC issues Preliminary Report to plan **at least 90 days before public release** of the Final Report.
 - Deficiency-based report
- Plan's response to Preliminary Report and Corrective Action Plan (CAP) **due 45 days from receipt of report**

Preliminary Report: CAP

The plan has 45 days to submit a written statement identifying each deficiency, describing the action taken to correct each deficiency and the results

- Describe the actions taken to correct each deficiency (including submission of any supporting documents)
- Describe the results of the actions taken (including submission of any supporting documents or if actions will take longer)

Final Report

- DMHC reviews plan responses and CAP submission
- Assess compliance efforts, identify deficiencies that have been corrected, and describe remedial actions for deficiencies requiring longer periods to remedy
- DMHC issues the Final Report to the plan; the plan has 10 days to append a statement to the Final Report (optional)

Follow-Up Survey

- If outstanding deficiencies remain in the **Final Report**, a **Follow-Up Survey** is initiated, and a Follow-Up Report issued **within 18 months of the Final Report**
- Follow-Up Survey will determine and report on status of plan's efforts to correct deficiencies and identify any deficiencies that remain uncorrected

The cycle is now complete

CADP Topics of Interest

Timing of Surveys
Consistency in DMHC Review
DMHC Logs/Data Requests
Structured Feedback to Plans
Grievances and PQIs

Timing of Surveys: Review Periods

- As part of the 3-year survey cycle, DMHC must complete a Follow-Up review *within 18 months* of the Final Report
- If uncorrected deficiencies are identified during the Follow-Up, then during the “next” Routine survey, the Department **adjusts** the Routine survey lookback period for areas **where there are outstanding uncorrected deficiencies** to ensure no files previously found deficient are selected

Consistency in DMHC Review

- A Dental Consultant is part of every Dental survey
- Survey findings are fact-specific determinations
- All survey findings are reviewed by attorneys to ensure the relevant legal requirement(s) were applied correctly to the facts at issue

DMHC Logs/Data Requests

- The Department requests data points relevant to assessing the plan's compliance with specific KKA requirements
- The DMHC does not require plans use specific data formats, however:
- Plans are requested to submit data logs using Excel
 - If the plan is unable to report data in this format, please reach out upon receipt of the Department's Notice of Intent to conduct a survey

DMHC Logs/Data Requests continued

- If the plan does not track a requested data point or if that data point is not accessible in a reportable format, please submit a narrative to the DMHC stating as such
- The DMHC may ask follow up questions intended to help clarify where we might be able to review the requested information, if available

Example: HSC Section 1368 (a)(4)(B)

... (4)(B) Grievances received by telephone . . . that are not coverage disputes . . . and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The **plan shall maintain a log** of all these grievances. The log shall be periodically reviewed by the plan and **shall include the following information** for each complaint: (i) **The date of the call.** (ii) **The name of the complainant.** (iii) **The complainant's member identification number.** (iv) **The nature of the grievance . . .**

Example: GA-001 - Key Element 3

GA-001 - Key Element 3:

3. The Plan has established an effective mechanism for documenting and tracking grievances.

CA Health and Safety Code section 1368(a)(4)(B) and (c); 28 CCR 1300.68(b)(5), (d)(8), (e) and (f)(1).

3.6 For grievances exempt from acknowledgement requirements (grievances received over the phone, by facsimile, by e-mail, or online through the Plan's internet website, resolved the next day, and not coverage, medical necessity or experimental/investigational disputes) does the Plan **maintain a log** of such grievances?

3.7 For grievances exempt from acknowledgement requirements (grievances received over the phone, resolved the next day, and not coverage, medical necessity or experimental/investigational disputes) does the log include the date of the call, the **name and id number** of the complainant, the **nature** of the grievance, the **resolution**, and the **representative** who took the call and resolved the grievance?

Structured Feedback to Plans

The DMHC cannot provide advice to plans regarding (1) **what** remedial measures it **must** implement to correct the outstanding deficiencies and (2) whether a plan's proposed remedial measures **would** correct the outstanding deficiencies

- The DMHC **can clarify** the **basis** for deficiency findings
- If a plan believes DMHC misapplied legal requirements to facts at issue or missed evidence, include this in response to Preliminary Report
- If a plan has questions regarding survey findings after receipt of any survey report, you may request a meeting with the survey team

Grievances and Potential Quality Issues (PQIs)



Grievance Defined

“Grievance” means a written or oral **expression of dissatisfaction** regarding the plan and/or provider, including **quality of care concerns**, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee’s representative. Where the plan is **unable to distinguish** between a **grievance and an inquiry**, it shall be considered a **grievance** (Rule 1300.68(a)(1))

Grievance Simplified

- Written or oral expression of dissatisfaction
- Regarding the Plan and/or provider, and shall include:
 - Complaint
 - Dispute
 - Request for reconsideration or appeal
- Made by an enrollee or the enrollee's representative

DMHC's Grievance and Appeal Review

Customer Service Enrollee Contacts/Call
Inquiries

Exempt Grievances

Standard Grievances

Expedited Grievances

Grievances and PQIs

Grievances and Potential Quality Issues (PQIs) are **distinct concepts**

- A grievance can **contain** a PQI. However, **not** all grievances **are** PQIs

What is a PQI?

- The KKA does not define a “PQI” or prescribe specific procedures when handling PQIs
- PQI is a widely accepted term used to refer to a suspected deviation from established standards of care, performance, and/or service
- It is primarily used to refer to individual providers or specific facilities rather than more systemic quality issues

QA Program Requirements: PQI Identification and Remediation

The Act requires all plans maintain a **Quality Assurance (QA) Program** addressing all service elements, including accessibility, availability and quality of care

The QA program...must document that the quality of care provided is being **reviewed**, that problems are being **identified**, and that **effective action** is taken to improve care where deficiencies are identified and **follow-up** is **planned** where indicated

(Rule 1300.70(a)(1))

Meeting Requirements

- Plans have **broad discretion** to design an effective QA program
 - Rule 1300.70 specifically states it “is not intended to set forth a prescriptive approach to QA methodology” and “is intended to afford each plan flexibility” in meeting the Act’s quality assurance requirements
- A compliant process must demonstrate the plan: **identifies and reviews**, takes **effective action** to improve care and **follows-up** as necessary

PQI Identification

- Referral sources may include the Plan's UM system, provider complaints, facility site reviews, medical record reviews, etc.

Quality of care problems may also be identified through **grievances**

Assessing PQI Issues in Grievances

- DMHC primarily relies on the plan's QA policy and procedures, specifically the plan's definition of a PQI, to determine if the grievance met referral criteria
- DMHC applies a fact specific analysis based on the issues presented in the grievance
- Also consider whether or not the grievance includes allegations that the standard of care was not met requiring additional investigation by qualified health care professionals

Common PQI Deficiencies

- **Most common finding:** failure to identify PQIs in exempt grievances
 - These grievances tend to be processed and resolved by call center or member service staff who may lack training or clinical expertise to identify quality issues
- **By contrast:** most standard and expedited grievances are handled by staff within the plan's GA Department – these staff tend to receive more training on identification of PQIs and follow triage/referral steps

Common PQI Deficiencies continued

- **Other common findings relate to a plan's investigation and resolution of PQI**
 - Plans don't investigate all issue raised within the PQI
 - Remedial measures unlikely to correct the underlying quality issue

Available Survey Resource:
DENTAL TECHNICAL ASSISTANCE GUIDES
(TAG)

Dental Technical Assistance Guides

- [Utilization Management](#) - Last Update: 09/15/14
- [Access and Availability](#) - Last Update: 04/15/26
- [Grievances and Appeals](#) - Last Update: 02/26/25
- [Quality Assurance](#) - Last Update: 04/30/13

TAG Example: GA TAG Question

DOCUMENTS TO BE REVIEWED

- Policies and procedures that describe the grievance system and processes
- Sample of grievance and appeal template letters
- Documentation of translated Plan responses to grievances in languages other than English
- Sample of grievance/appeal files to be reviewed

GA-003 - Key Element 1:

1. The Plan acknowledges grievances and appeals in writing within five (5) calendar days of receipt.
28 CCR 1300.68(d)(1).

Assessment Question

- | | |
|-----|---|
| 1.1 | Does the Plan consistently acknowledge grievances and appeals in writing within five (5) calendar days of receipt (except as noted in 28 CCR 1300.68(d)(8))? |
|-----|---|

Other CADP Topics of Interest Shared with DMHC

Questions?

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