



**Health Care Service Plans'
Provider Dispute Resolution Mechanisms
2023 Annual Report**

April 3, 2024

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I. Executive Summary

The California Department of Managed Health Care (DMHC) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the DMHC licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975. The DMHC regulates the vast majority of commercial health plans and products in the large group, small group, and individual markets, including most of the health plans that participate in Covered California. The DMHC also regulates Medi-Cal managed care plans, Medicare Advantage plans, and specialized health plans, including dental and vision plans.

State law requires health plans to pay health care providers accurately and in a timely manner for services provided and to maintain a fast, fair, and cost-effective system for processing and resolving provider claim disputes (Health and Safety Code section 1367(h).) Health plans are required to annually report the number, type, and summaries of provider claim payment disputes, describe the resolutions including terms and timeliness, and explain how health plans are addressing trends or patterns in disputes. The report includes provider dispute data from health plans' capitated providers such as hospital systems and medical groups.

As required by Health and Safety Code section 1375.7(f), the DMHC annually summarizes the health plans' self-reported provider dispute data in a report to the Governor and the Legislature. The 2023 Provider Dispute Resolution Mechanisms Report summarizes provider claim disputes by type of health plan, including full service and specialized health plans, from October 1, 2022 through September 30, 2023.

Key Findings

Full Service Health Plans

Full service health plans are health plans that provide all of the basic health care services and mandated benefits required under the Knox-Keene Act.

- There are 59 licensed full service health plans in California subject to the reporting requirements of section 1375.7(f).¹
- Full service health plans processed approximately 175 million claims in the reporting period. Approximately 1.5% of these claims resulted in disputes.
- Full service health plans received approximately 2.4 million provider disputes for the reporting period.

¹ There were 98 licensed full service health plans on September 30, 2023. However, 39 licensed full service health plans are excluded from the report because they are licensed only for Medicare products, are operating as a county organized health system, exempt from Health and Safety Code section 1367(h), or had no enrollment in California.

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- Approximately 91% of all provider disputes processed by full service health plans were reported as being resolved within 45 working days.
 - Approximately 93% of provider disputes filed with full service health plans involved claims payment issues.
 - Providers prevailed in 34% of all disputes and health plans upheld their original determinations in 56% of the disputes. Ten percent of the disputes were pending at the time the full service health plans reported this data to the DMHC.

Specialized Health Plans

Specialized health plans are health plans that provide coverage in a specialized area of care such as vision, dental, behavioral health, and chiropractic health plans.

- There are 36 licensed specialized health plans subject to the provider dispute reporting requirements of section 1375.7(f).
- Specialized health plans processed over 34 million claims in the reporting period. Less than half of 1% (0.04%) of these claims were the subject of a payment dispute.
- Specialized health plans received 19,277 provider disputes for the reporting period.
- Specialized health plans reported 45% of all provider disputes were resolved in favor of the provider, 51% were upheld by the plans, and 4% of disputes were pending as of September 30, 2023.
- Approximately 78% of provider disputes with specialized health plans involved claims payment issues.

Capitated Providers

Capitated providers are providers such as hospitals, risk bearing organizations, or provider groups that contract with a full service health plan to assume the financial risk and pay claims for the provision of health care services to the enrollees.

- Full service health plans reported data on 243 capitated providers.
- Capitated providers processed approximately 50 million claims and received 724,058 provider disputes in the reporting period.
- 96% of disputes involved claims payment.
- 33% of all reported provider disputes with capitated providers were resolved in favor of the provider.

II. Introduction

In 2003, the DMHC issued regulations regarding the timely and accurate payment of provider claims and required health plans to establish a fast, fair and cost-effective dispute resolution process. These regulations, known as the Claims Settlement Practice and Dispute Resolution Mechanism Regulations, require all health plans, and their capitated providers that pay claims, to fully implement specific standards and safeguards for payment of provider claims for services rendered on or after January 1, 2004.²

In addition to defining the basic concepts relevant to all dispute resolution mechanisms, the regulations require health plans to submit to the DMHC the Annual Plan Dispute Resolution Mechanism Report, which is public information, and contains the following:

- (1) Information on the number and types of providers utilizing the dispute resolution mechanism;
- (2) A summary of the disposition of all provider disputes, including an informative description of the type, term, and resolution;
- (3) The timeliness of dispute resolution determinations;
- (4) A detailed information statement disclosing any emerging or established patterns of provider disputes, and how that information has been used to improve administrative capacity, plan/provider relations, claims payment procedures, quality assurance systems, and the quality of patient care, as well as dispute results.

Health plans are required to summarize their provider dispute results in three categories:

- Claim Payment Disputes - Provider complaints relating to the health plan's failure to reimburse complete claims with the correct payment, including the automatic payment of all interest and penalties.
- Utilization Management Disputes - Provider complaints relating to medical necessity and authorization determinations.
- Other Disputes - Provider complaints relating to non-monetary issues, such as enrollee eligibility and assignment matters, and provider credentialing and certification.

This report reflects information reported by health plans for October 1, 2022 through September 30, 2023.

² See California Code of Regulations, Title 28, sections 1300.71 and 1300.71.38.

The DMHC conducts regular onsite auditing activities, and reviews quarterly and annual claims payment and dispute resolution reports to monitor the industry's compliance with claims payment standards required by Health and Safety Code section 1371 and California Code of Regulations, Title 28, section 1300.71. The DMHC implements appropriate corrective actions for any identified claims payment deficiencies and monitors them accordingly.

Providers who are not satisfied with the resolution of their disputes may contact the DMHC Provider Complaint Section. Additional information regarding the provider complaint process can be found in the [DMHC's Provider Complaint Section](#).

The claim and provider dispute examination results are located in the [DMHC's Financial Examination Reports Section](#).

III. Full Service Health Plans

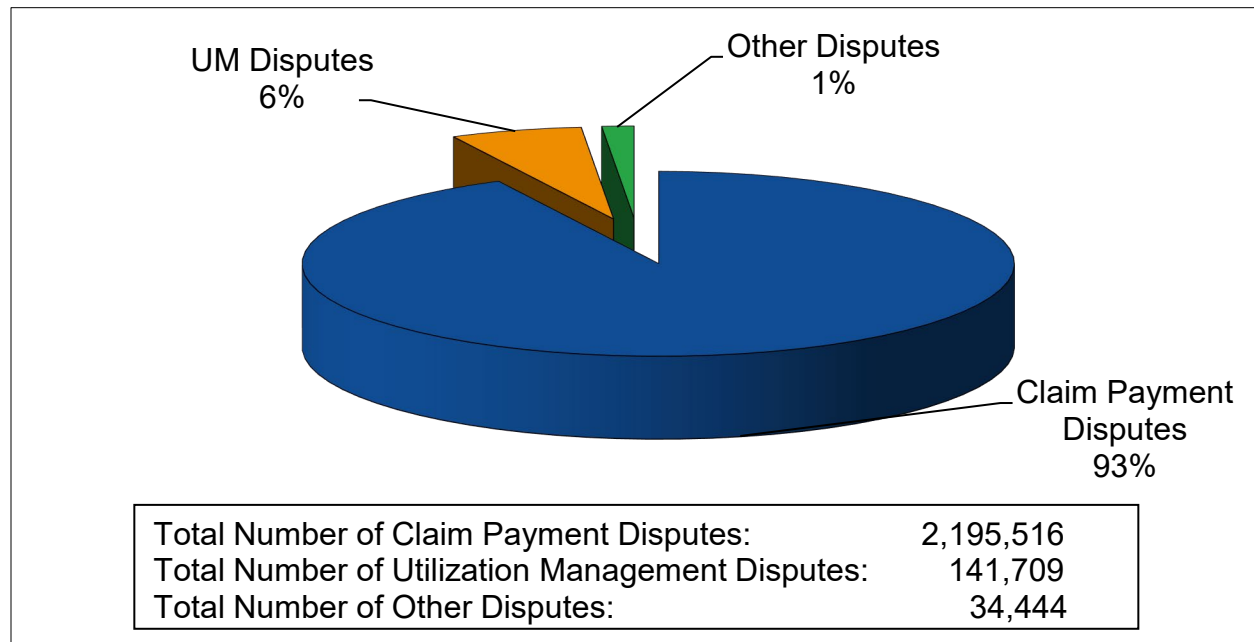
This report reflects information reported by health plans for October 1, 2022 through September 30, 2023.

Of the 98 licensed full service health plans, data from 59 full service health plans are included in this report. Thirty-nine licensed full service health plans are excluded from the report because they met one or more of the following criteria: licensed only for Medicare products, operate as a county organized health system, exempt from Health and Safety Code section 1367(h), were in pre-operations, or have no enrollment in California.

The 59 full service health plans reported approximately 175 million claims processed during the reporting period. A claim is considered processed when the health plan adjudicates and classifies the claim as paid, adjusted, contested, or denied. The reporting full service health plans received 2,371,669 provider disputes during the 2023 reporting period. This represents a 4% percent decrease in the total amount of claims processed, and a 24% increase in disputes since 2022.

Claim payment disputes, which primarily involve claims of inadequate reimbursement, comprised of 93% of the full service health plan provider disputes (See Chart 1).

Chart 1
Provider Disputes – Full Service Health Plans



Regulations require the health plans to resolve 95% of all completed provider disputes within 45 working days. Collectively, the full service health plans reported that 91% of all provider disputes were resolved within 45 working days.

Ten health plans reported noncompliance with the 45 working day requirement to resolve disputes. Health plans that fall below the 95% compliance requirement are required to file and implement a corrective action plan that is monitored by the DMHC quarterly and reviewed as part of the health plan's routine financial examination. Deficient health plans reported that timeliness standards were not met due to a variety of factors. These factors include incorrect system configurations, staffing issues, and an increased volume of provider disputes. Health plans indicated that corrective action plans have been instituted to improve timeliness going forward. The corrective actions include adding staff to process disputes, conducting routine audits to identify deficiencies, systematic enhancements to the claims processing system, increasing auto-adjudication, and educating providers and/or claims processing staff. Health plans collectively declined in their provider dispute resolution timeliness percentages by two percentage point from 93% in 2022 to 91% in 2023.

Provider Disputes Compared to Claims

Approximately 78% of provider claims processed were paid or adjusted by the health plans, and 22% were contested or denied. Nearly all claims (approximately 98%) were processed within 45 working days.

Approximately 175 million claims were processed during the reporting period. Over two million (2,371,669) of these claims were disputed by providers. This represents approximately 1.5% of all claims processed by full service health plans.

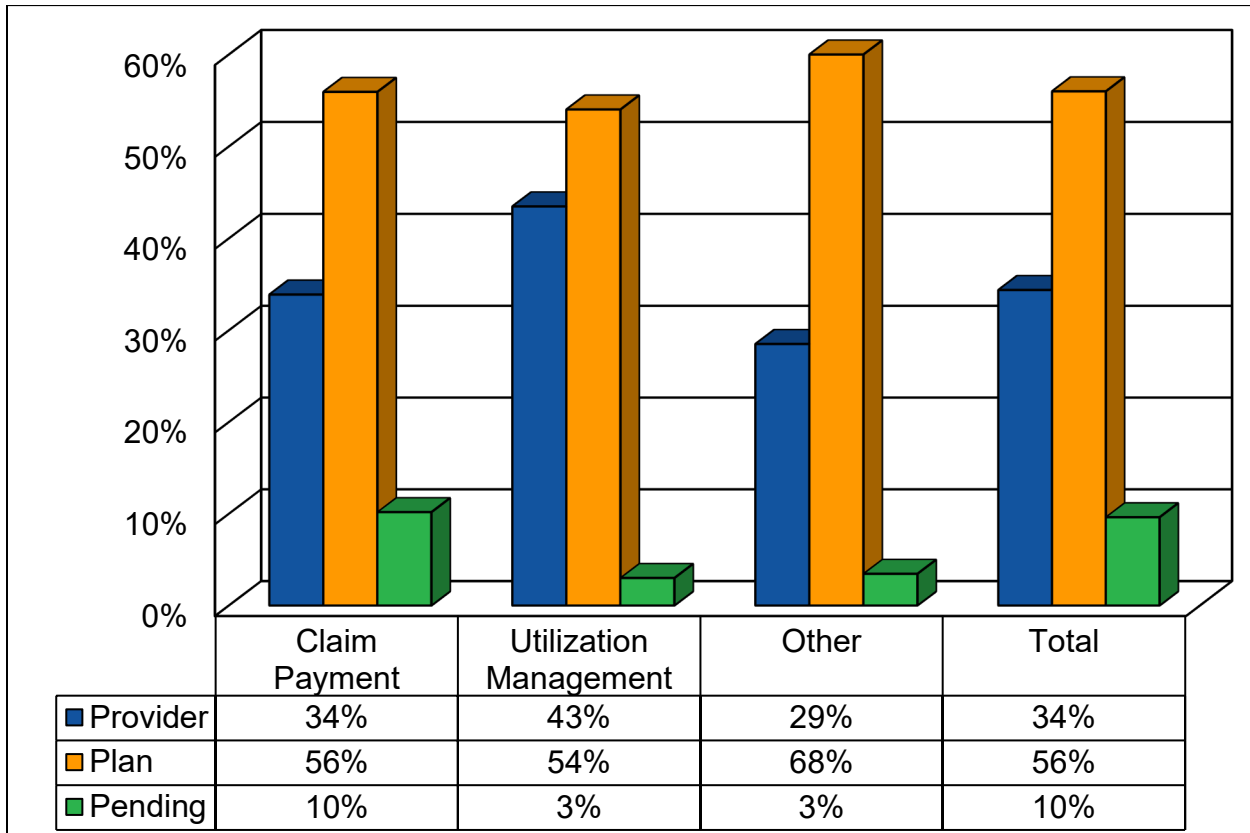
Disposition of Full Service Health Plan Provider Disputes

For the 2023 reporting period, full service health plans reported that 34% of all disputes between providers and health plans were resolved in favor of the provider compared to 31% of provider disputes in 2022.

Of the 2,371,669 provider disputes submitted, 815,444 (34%) disputes resolved in favor of the provider, 1,328,028 (56%) in favor of the plan, and 228,197 (10%) were pending review as of September 30, 2023 (See Chart 2).

Chart 2

Resolution of Provider Disputes – Full Service Health Plans



Seven Largest Full Service Health Plans

California's seven largest full service health plans³ provide health care benefits to approximately 19 million enrollees, representing 64% of the over 29.7 million enrollees enrolled in health plans licensed by the DMHC. For the 2023 reporting period, approximately 75% of provider disputes were filed with these seven plans. Collectively, they processed approximately 126 million claims, accounting for roughly 72% of all claims processed by full service health plans in California (See Table 1).

³ California's seven largest full service health plans are Blue Cross of California (Anthem Blue Cross), Blue Cross of California Partnership, California Physicians' Service (Blue Shield of California), Health Net Community Solutions, Inc., Inland Empire Health Plan (IEHP), Kaiser Foundation Health Plan (Kaiser Permanente), and Local Initiative Health Authority of L.A. County (L.A. Care Health Plan).

Table 1
Seven Largest Full Service Health Plans

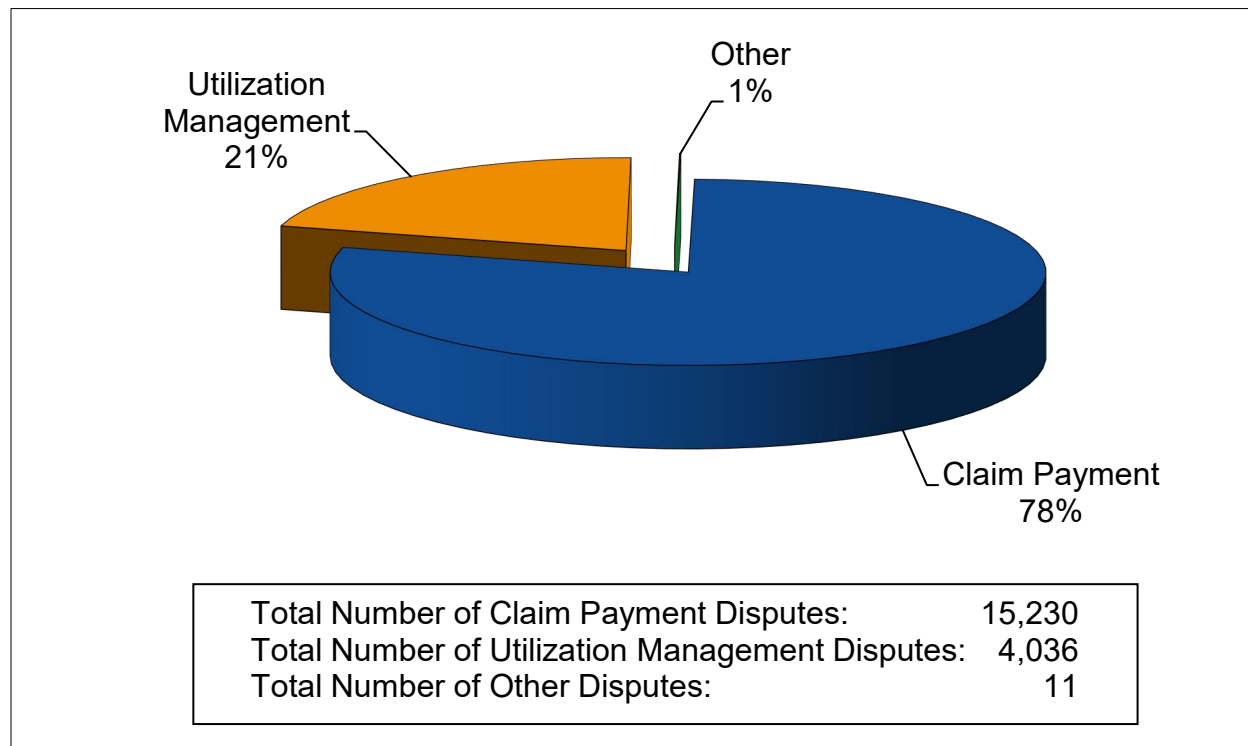
Health Plan	Enrollment as of 9/30/23	Number of Claims Processed	Number of Disputes Received	Resolved Disputes in Favor of the Provider	Resolved Disputes in Favor of the Health Plan	Disputes Pending	Percentage of Disputes Resolved Within 45 Working Days
Anthem Blue Cross	2,178,598	50,606,314	275,563	100,011 (36%)	175,519 (63%)	33 (1%)	94%
Blue Cross of California Partnership	1,065,020	6,467,938	273,375	99,465 (36%)	173,877 (63%)	33 (1%)	94%
Blue Shield of California	2,367,511	20,201,021	251,585	71,131 (28%)	156,165 (62%)	24,289 (10%)	81%
Health Net Community Solutions, Inc.	1,749,449	9,892,708	139,683	52,570 (38%)	84,024 (60%)	3,089 (2%)	96%
Inland Empire Health Plan	1,662,914	14,704,404	59,447	11,650 (20%)	42,351 (71%)	5,446 (9%)	100%
Kaiser Permanente	7,031,615	10,853,183	303,345	38,554 (13%)	187,135 (62%)	77,656 (25%)	83%
L.A. Care Health Plan	2,839,647	13,420,044	486,806	239,313 (49%)	165,857 (34%)	81,636 (17%)	90%
Total - Seven Largest Health Plan	18,894,754	126,145,612	1,789,804	612,694 (34%)	984,928 (55%)	192,182 (11%)	90%
All Other Full Service Health Plans	11,512,685	48,661,454	581,865	202,750 (35%)	343,100 (59%)	36,015 (6%)	96%
Total - All Full Service Health Plans	30,407,439	174,807,066	2,371,669	815,444 (34%)	1,328,028 (56%)	228,197 (10%)	91%

IV. Specialized Health Plans

There are 42 licensed specialized health plans and data from 36 specialized health plans are included in this report. Specialized health plans licensed only for Medicare products or that have no enrollment in California are excluded from the report.

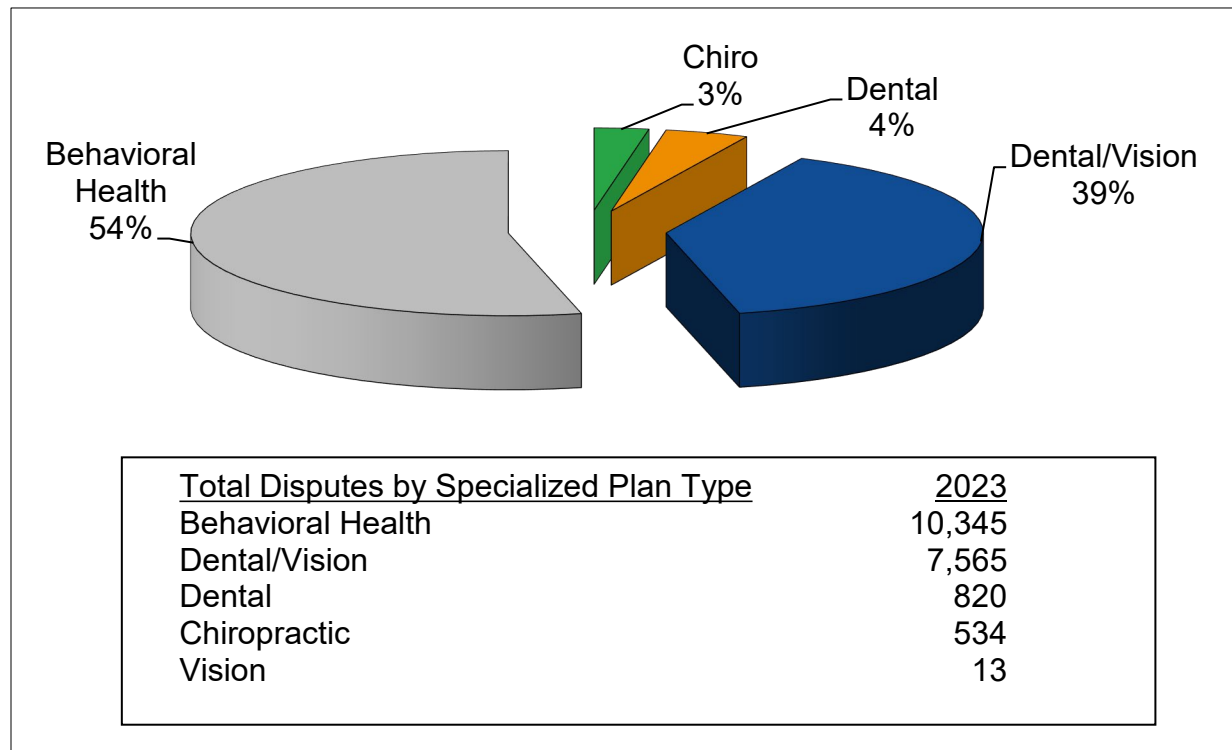
The 36 specialized health plans processed approximately 34 million provider claims and received 19,277 provider disputes. There was a 2% increase in the number of disputes in the 2023 reporting period compared to 2022. Approximately 93% of the provider disputes were resolved within 45 working days and a majority of provider disputes submitted to specialized health plans involved claim payment disputes. Chart 3 shows the breakdown of provider disputes.

Chart 3
Provider Disputes – Specialized Health Plans



Of the 19,277 provider disputes submitted to specialized health plans during the 2023 reporting period, behavioral health plans accounted for approximately 54% of the disputes, followed by dental plans (including dental/vision plans) with 43% of the disputes, and chiropractic plans with 3% (See Chart 4). Dental plans accounted for approximately 43% of total enrollment for specialized health plans required to report.

Chart 4
Provider Disputes by Type of Specialized Health Plans

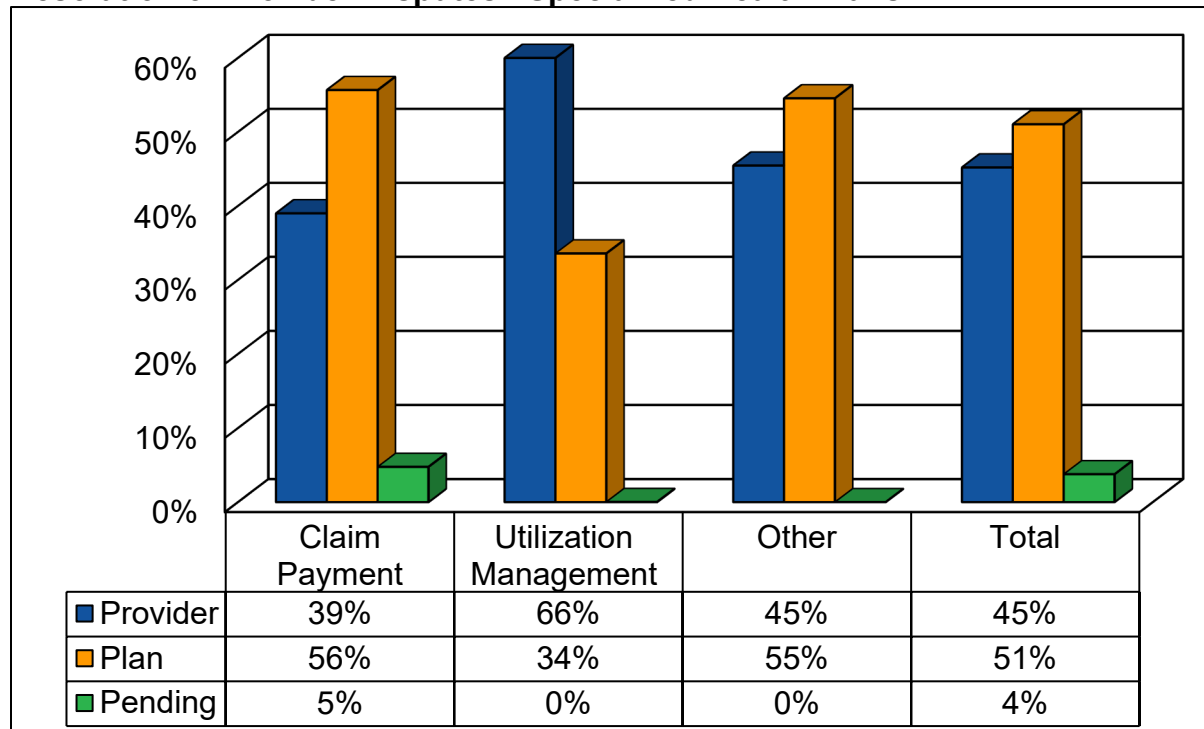


Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported 45% of all provider disputes were resolved in favor of the provider, an 8% decrease from the prior year. Thirty-nine percent of disputes involving claims payment issues were resolved in favor of the provider while 56% of disputes were resolved in favor of the plan, and 5% were pending at year-end. Utilization management disputes were resolved in favor of providers 66% of the time, 34% were in favor of the plan, and 0% were pending at year-end. Other disputes were resolved in favor of providers 45% of the time 55% in favor of the plan, and 0% were pending at year-end (See Chart 5).

Chart 5

Resolution of Provider Disputes - Specialized Health Plans



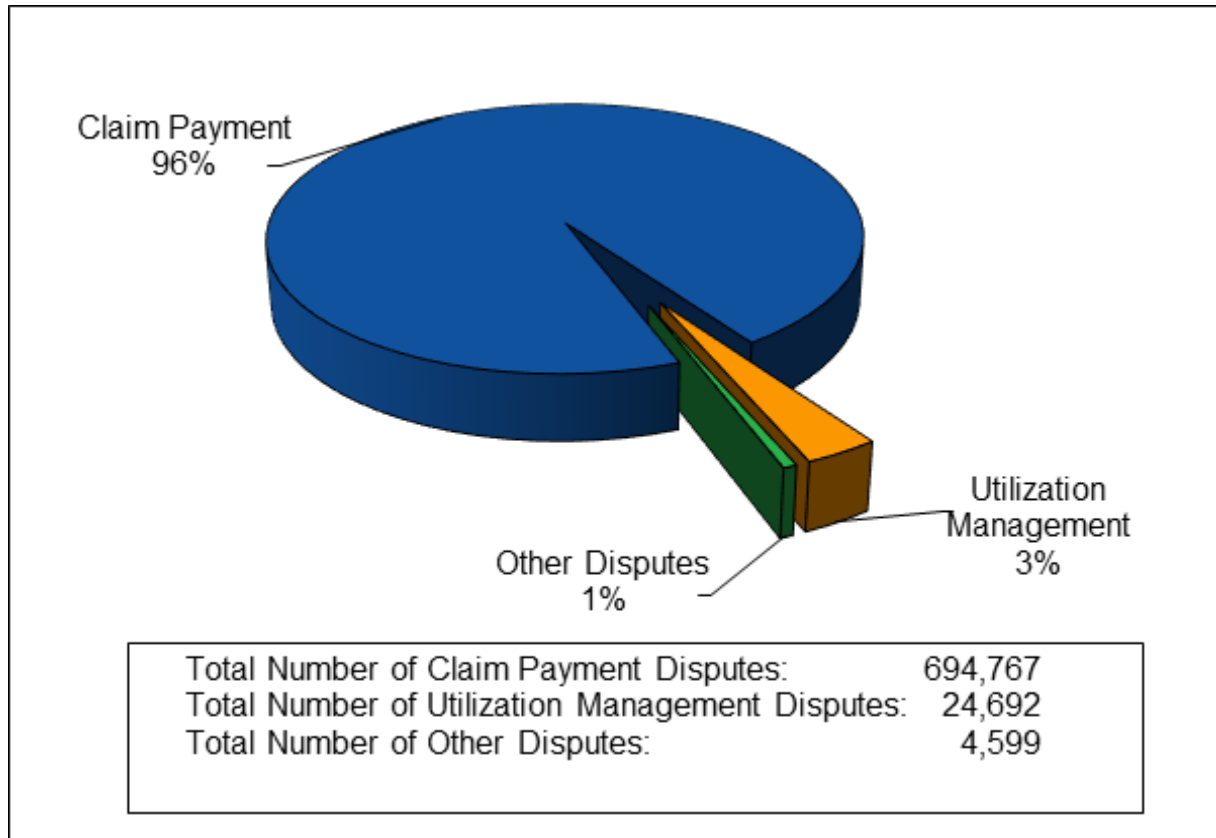
V. Capitated Providers

Capitated providers contract with health plans and are responsible for processing and paying claims. Generally, capitated providers fall within two main categories: (1) medical groups and Independent Practice Associations (IPAs); and (2) hospital systems that receive capitation from health plans, and in turn pay provider claims for health care services rendered to the plan's enrollees. Capitation is a prepaid amount received or paid out, based on the number of enrollees assigned to an organization. This arrangement is usually expressed in units or per member per month (PMPM) payments.

All health plans are required to compile and provide a dispute resolution report for each capitated provider or provider group. Based upon the number of filings received, the DMHC has identified 243 capitated providers that were contracted with full service health plans.

Health plans reported a total of 724,058 provider disputes filed with capitated providers during the reporting period. Any capitated provider that is non-compliant with Health and Safety Code section 1371 and California Code of Regulations, Title 28, section 1300.71 criteria must report to the health plan on a quarterly basis. Capitated providers must also file an annual provider dispute report with each of its contracting health plans. Capitated providers are required to follow the same reporting elements as full service and specialized health plans.

Capitated providers processed approximately 50 million claims in the 2023 reporting period. Ninety-six percent of provider disputes involved claims payment issues. Chart 6 reflects the breakdown of provider disputes.

Chart 6**Provider Disputes – Capitated Providers**

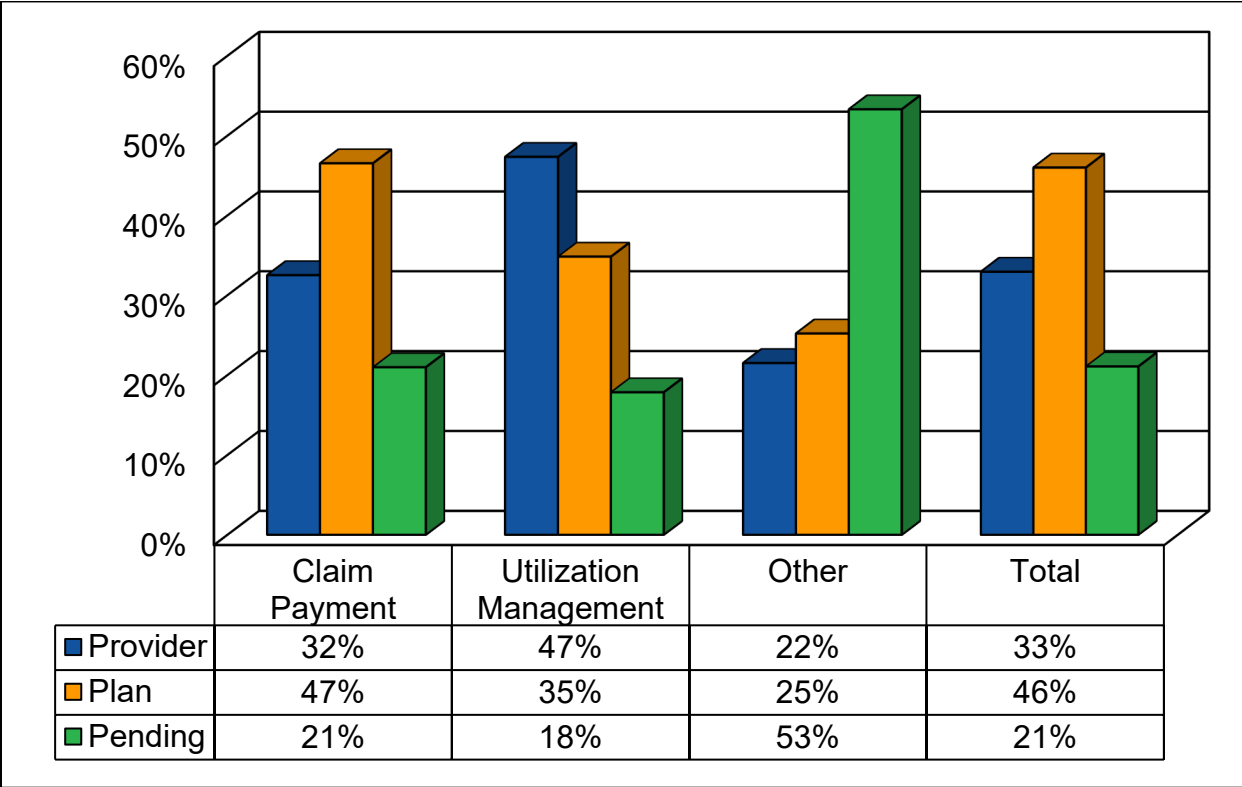
Approximately 84% of all claims processed were paid or adjusted and 16% of the claims processed were contested or denied. Capitated providers processed approximately 99% of claims within the 45-day statutory requirement. For provider disputes not resolved within the prescribed timeframes, the capitated providers self-initiate corrective action plans. These corrective action plans are monitored by the health plans to ensure compliance within the required timeframes.

Disposition of Capitated Providers’ Provider Disputes

The capitated providers had an approximately 1.5% increase in the number of disputes in the 2023 reporting period compared to 2022. Of the 724,058 provider disputes submitted, 33% were resolved in favor of the provider, 46% were resolved in favor of the plan, and 21% were pending review as of September 30, 2023.

Chart 7 illustrates the breakdown by percentages for each category of dispute compared to the total number of disputes.

Chart 7
Resolution of Provider Disputes – Capitated Providers

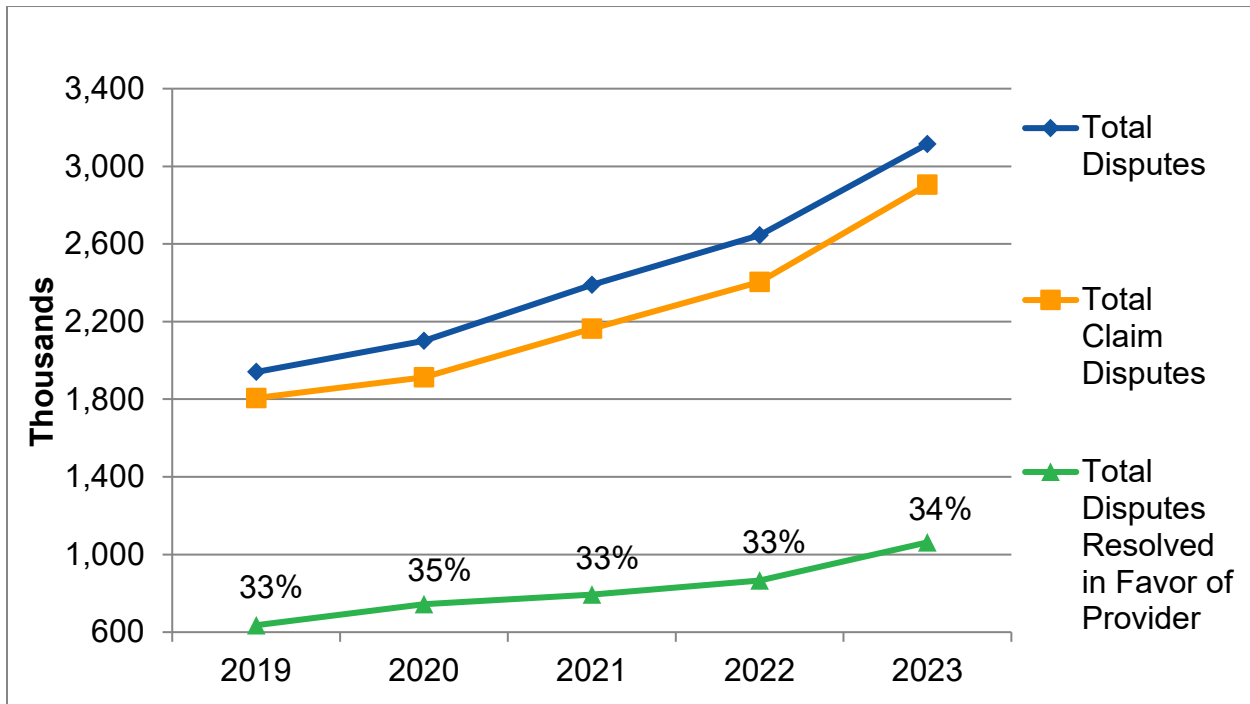


VI. Provider Dispute Trends

Chart 8 displays the trend for the volume of disputes reported by full service health plans, specialized health plans, and capitated providers over a five year period. The blue line represents the total number of disputes reported, the orange line represents total claim disputes reported and the green line represents the total number of disputes in favor of the provider.

From 2022 to 2023, provider disputes increased from 2.6 million to 3.1 million, representing an 18% increase. The number of disputes resolved in favor of the provider has fluctuated between 33% and 35% over the five-year period. For 2023, 34% of provider disputes were resolved in favor of the provider.

Chart 8
Five Year Provider Dispute Information



VII. Summary

The number of provider disputes represents roughly one percent of the total amount of claims processed for 2023. Health plans reported resolving 91% of provider disputes within the required 45-day time frame, a 2% decrease from the prior reporting period.

The percentage of provider disputes resolved by health plans in favor of the provider was 34% in the 2023 reporting period, a 3% increase from the prior reporting period.

There was a 2% increase in provider disputes received by specialized health plans. 45% of the provider disputes filed were resolved in favor of the provider.

Approximately 33% of provider disputes filed with capitated providers were resolved in favor of the provider with approximately 21% of these disputes pending as of September 30, 2023.

The provider dispute resolution data summarized in this report is self-reported by health plans and capitated providers. There may be substantive differences in the way health plans and capitated providers identify, quantify, and track provider disputes. The DMHC will continue to work with the health plans to ensure consistent reporting with the updated instructions for the claims and provider dispute reporting by health plans and capitated providers.