DEPARTMENT OF
Managed
Health Care

Health Care Service Plans' Provider Dispute Resolution Mechanisms

2024 Annual Report

April 11, 2025

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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 2024 Provider Dispute Resolution Mechanisms Report summarizes provider claim disputes by type of health plan, including full service and specialized health plans, from October 1, 2023 through September 30, 2024.

Key Findings

Full Service Health Plans

Full service health plans provide all of the basic health care services and mandated benefits required under the Knox-Keene Act. The 59 licensed full service health plans subject to the reporting requirements[1] reported the following:

- Approximately 178 million claims were processed in the reporting period. Approximately 1.2% of these claims resulted in disputes.
- Approximately 2.2 million provider disputes were received during the reporting period.

[1] There were 99 licensed full service health plans on September 30, 2024. However, 40 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), were in pre-operations, or had no enrollment in California.

- Approximately 94% of all provider disputes were resolved within 45 working days.

- Approximately 95% of provider disputes involved claims payment issues.

- Providers prevailed in 30% of all disputes and health plans upheld their original determinations in 61% of the disputes. Nine percent of the disputes were pending at the time the 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. The 36 licensed specialized health plans subject to the reporting requirements reported the following:

- Over 37 million claims were processed in the reporting period. Less than half of 1% (0.03%) of these claims were the subject of a payment dispute.

- The plans received 13,629 provider disputes during the reporting period.

- Approximately 44% of all provider disputes were resolved in favor of the provider, 55% were upheld by the plans, and 1% of disputes were pending as of September 30, 2024.

- Approximately 82% of provider disputes 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. The full service health plans reported the following data on 236 capitated providers:

- Capitated providers processed approximately 57 million claims and received 996,686 provider disputes in the reporting period.

- Approximately 95% of disputes involved claims payment.

- Approximately 29% 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, 2023 through September 30, 2024.

[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.

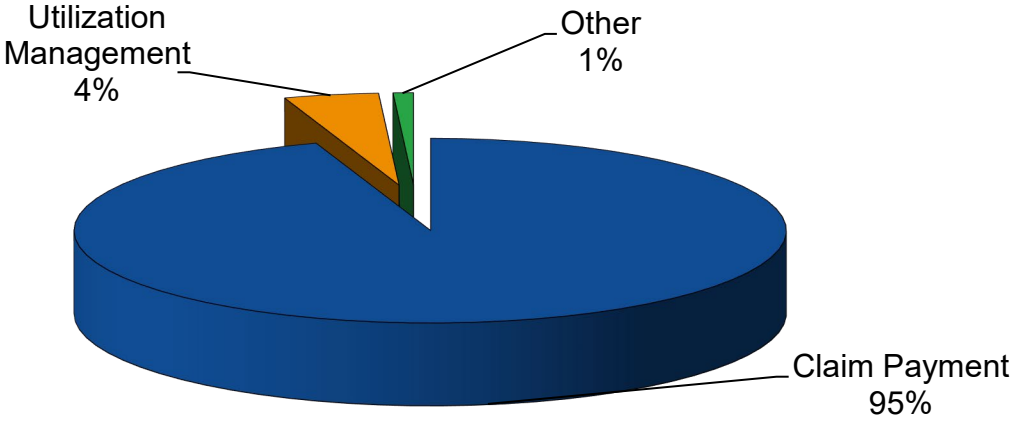
III. Full Service Health Plans

Of the 99 licensed full service health plans, data from 59 full service health plans are included in this report. Forty 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 had no enrollment in California.

The 59 full service health plans reported approximately 178 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 2,214,176 provider disputes during the 2024 reporting period. This represents a two percent increase in the total amount of claims processed, and a seven percent decrease in disputes compared to 2023.

Claim payment disputes, which primarily involve claims of inadequate reimbursement, comprised of 95% of the full service health plan provider disputes (See Chart 1).

Chart 1
Provider Disputes – Full Service Health Plans



Total Number of Claim Payment Disputes:	2,098,818
Total Number of Utilization Management Disputes:	94,967
Total Number of Other Disputes:	20,391

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 94% of all provider disputes were resolved within 45 working days.

Twelve 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 staffing issues, and an increased volume of provider disputes caused by the implementation of a new claim system or claims adjustment project. Health plans indicated that corrective action plans have been instituted to improve timeliness going forward. The corrective actions include adding additional staff to process disputes, implementing new processes for inventory management and contract configuration, forming dedicated work groups to optimize manual tasks, conducting routine monitoring to increase oversight for dispute processing, and educating claims processing staff. Health plans collectively improved in their provider dispute resolution timeliness percentages by three percentage points from 91% in 2023 to 94% in 2024.

Provider Disputes Compared to Claims

Approximately 81% of provider claims processed were paid or adjusted by the health plans, and 19% were contested or denied. Nearly all claims (approximately 97%) were processed within 45 working days.

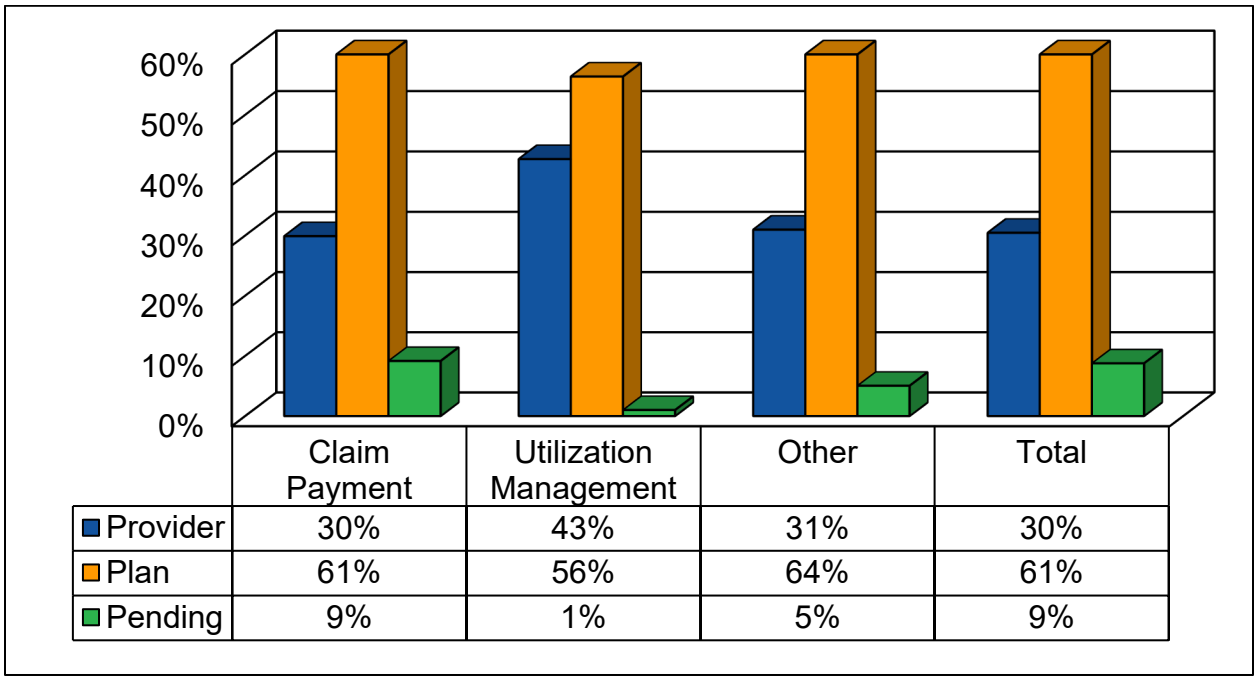
Approximately 178 million claims were processed during the reporting period. Over two million (2,214,176) of these claims were disputed by providers. This represents approximately 1.2% of all claims processed by full-service health plans.

Disposition of Full Service Health Plan Provider Disputes

For the 2024 reporting period, full service health plans reported that 30% of all disputes between providers and health plans were resolved in favor of the provider compared to 34% of provider disputes in 2023.

Of the 2,214,176 provider disputes submitted, 674,245 (30%) disputes resolved in favor of the provider, 1,345,908 (61%) in favor of the plan, and 194,023 (9%) were pending review as of September 30, 2024 (See Chart 2).

Chart 2
Resolution of Provider Disputes – Full Service Health Plans



	Claim Payment	Utilization Management	Other	Total
Provider	30%	43%	31%	30%
Plan	61%	56%	64%	61%
Pending	9%	1%	5%	9%

Seven Largest Full Service Health Plans

California's seven largest full service health plans[3] provide health care benefits to approximately 19 million enrollees, representing 62% of the over 29.8 million enrollees enrolled in health plans licensed by the DMHC. For the 2024 reporting period, approximately 73% of provider disputes were filed with these seven plans. Collectively, they processed approximately 123 million claims, accounting for roughly 69% 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 Plan, Inc., California Physicians' Service (Blue Shield of California), Health Net Community Solutions, Inc., Inland Empire Health Plan (IEHP), Kaiser Foundation Health Plan, Inc. (Kaiser Permanente), and Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan).

Table 1
Seven Largest Full Service Health Plans

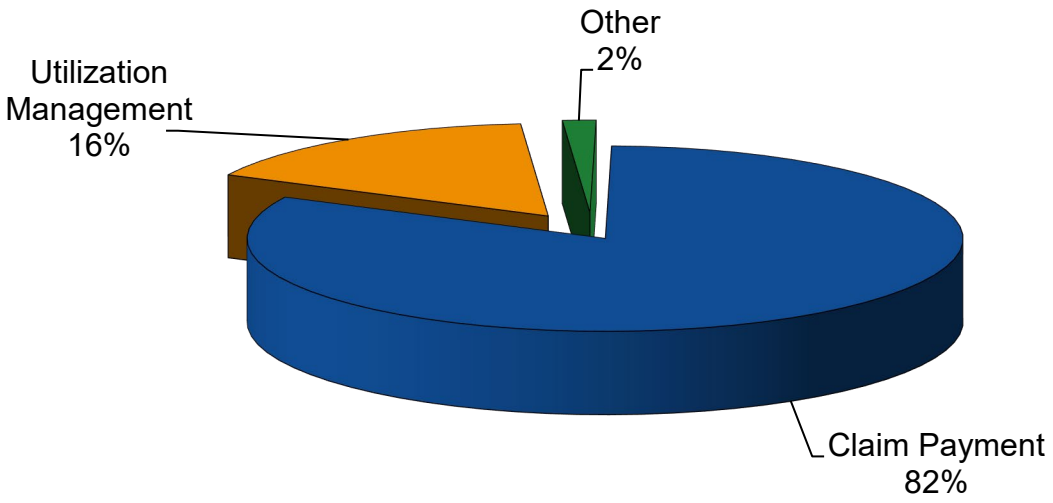
Health Plan	Enrollment as of 9/30/24	Number of Claims Processed	Number of Disputes Received	Resolved Disputes in Favor of the Provider	Resolved Disputes in Favor of the Health Plan	Disputes Pending	Percentage of Disputes Resolved Within 45 Working Days
Anthem Blue Cross	2,145,165	39,141,405	275,778	99,437 (36%)	176,341 (64%)	0 (0%)	84%
Blue Cross of California Partnership Plan, Inc.	791,429	5,535,126	93,856	43,761 (47%)	50,074 (52%)	21 (1%)	90%
Blue Shield of California	2,307,227	23,712,663	312,209	54,496 (17%)	245,886 (79%)	11,827 (4%)	96%
Health Net Community Solutions, Inc.	1,579,059	8,804,748	154,669	47,915 (31%)	104,162 (67%)	2,592 (2%)	99%
Inland Empire Health Plan	1,505,041	17,133,038	73,538	14,936 (20%)	50,924 (69%)	7,678 (11%)	99%
Kaiser Permanente	7,664,281	10,561,388	290,217	44,142 (15%)	185,794 (64%)	60,281 (21%)	91%
L.A. Care Health Plan	2,550,170	18,597,001	408,734	145,905 (36%)	179,544 (44%)	83,285 (20%)	98%
Total - Seven Largest Health Plan	**18,542,372**	**123,485,369**	**1,609,001**	**450,592 (28%)**	**992,725 (62%)**	**165,684 (10%)**	**94%**
All Other Full Service Health Plans	**11,586,158**	**55,006,190**	**605,175**	**223,653 (37%)**	**353,183 (58%)**	**28,339 (5%)**	**95%**
Total - All Full Service Health Plans	**30,128,530**	**178,491,559**	**2,214,176**	**678,245 (30%)**	**1,345,908 (61%)**	**194,023 (9%)**	**94%**

IV. Specialized Health Plans

There are 41 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 37 million provider claims and received 13,629 provider disputes. There was a 29% decrease in the number of disputes in the 2024 reporting period compared to 2023. Approximately 95% 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.

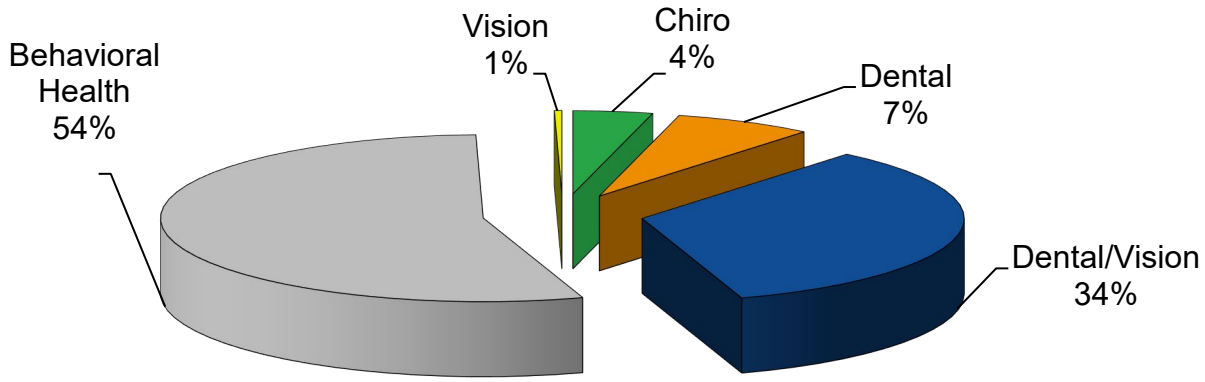
Chart 3
Provider Disputes – Specialized Health Plans



Total Number of Claim Payment Disputes:	11,187
Total Number of Utilization Management Disputes:	2,236
Total Number of Other Disputes:	206

Of the 13,629 provider disputes submitted to specialized health plans during the 2024 reporting period, behavioral health plans accounted for approximately 54% of the disputes, followed by dental plans (including dental/vision plans) with 41% of the disputes, chiropractic plans with 4%, and vision plans with 1%. (See Chart 4).

Chart 4
Provider Disputes by Type of Specialized Health Plans



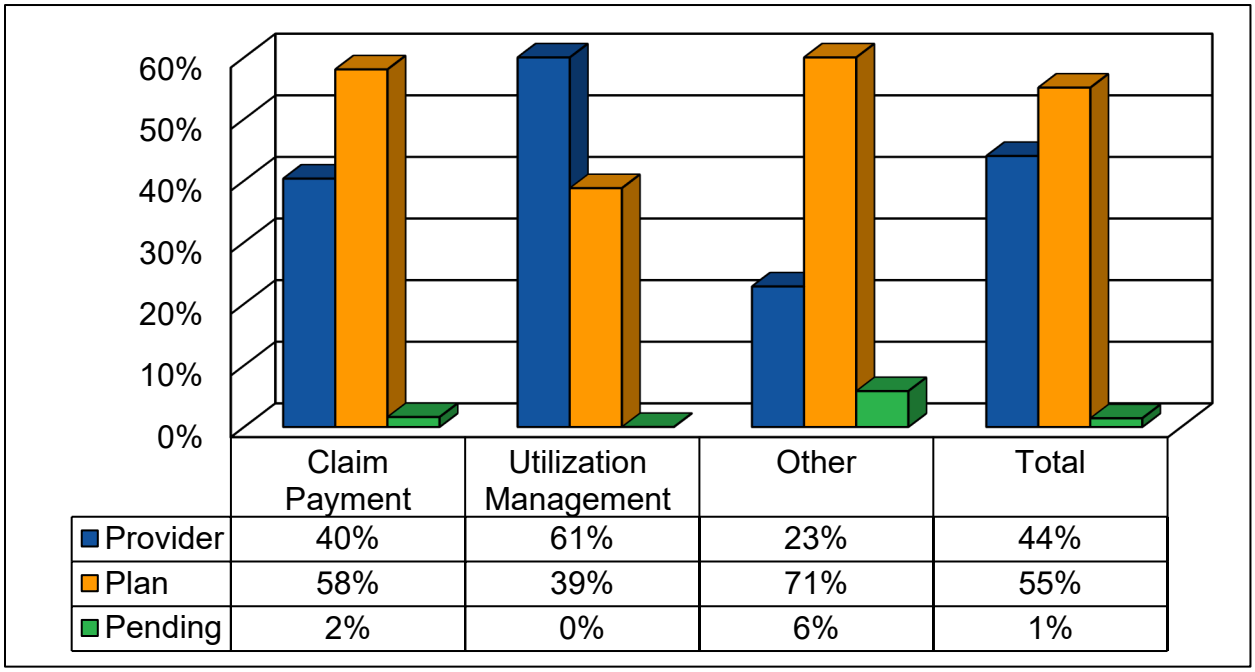
Total Disputes by Specialized Plan Type	2024
Dental/Vision	4,640
Behavioral Health	7,443
Dental	952
Chiropractic	543
Vision	51

Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported 44% of all provider disputes were resolved in favor of the provider, a one percent decrease from the prior year. Forty percent of disputes involving claims payment issues were resolved in favor of the provider while 58% of disputes were resolved in favor of the plan, and two percent were pending at year-end. Utilization management disputes were resolved in favor of providers 61% of the time, 39% were in favor of the plan, and 0% were pending at year-end. Other disputes were resolved in favor of providers 23% of the time 71% in favor of the plan, and 6% were pending at year-end (See Chart 5).

Chart 5

Resolution of Provider Disputes - Specialized Health Plans



	Claim Payment	Utilization Management	Other	Total
Provider	40%	61%	23%	44%
Plan	58%	39%	71%	55%
Pending	2%	0%	6%	1%

V. Capitated Providers

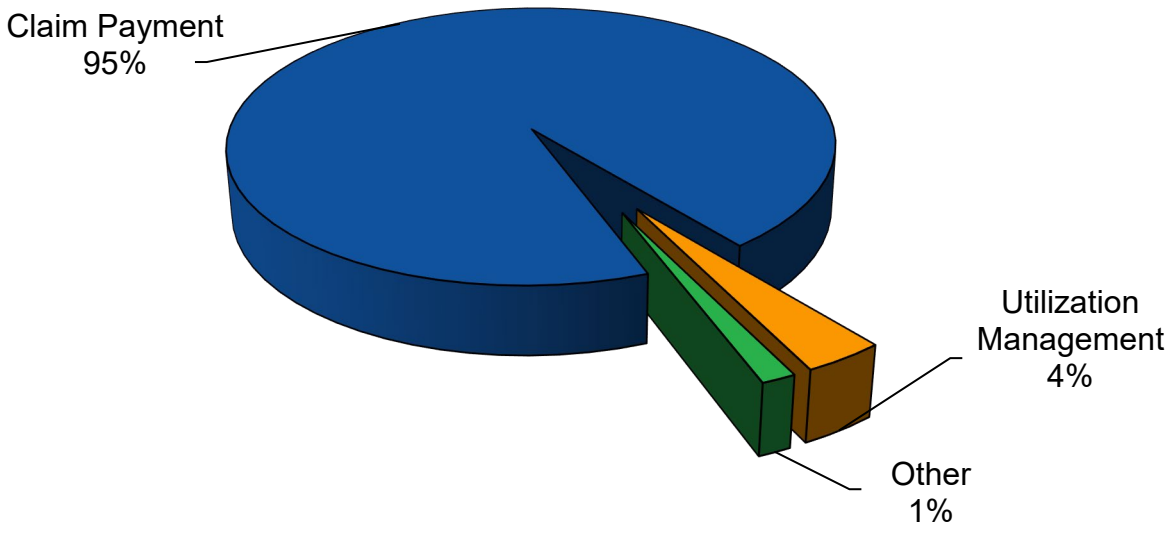
Capitated providers contract with health plans and are responsible for processing and paying claims. Generally, capitated providers fall within two main categories: (1) medical groups and Independent Practice Associations (IPAs); and (2) hospital systems that receive capitation from health plans, and 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 236 capitated providers that were contracted with full service health plans.

Health plans reported a total of 996,686 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 their contracting health plans. Capitated providers are required to follow the same reporting elements as full service and specialized health plans.

Capitated providers processed approximately 57 million claims in the 2024 reporting period. Ninety-five percent of provider disputes involved claim payment issues. Chart 6 reflects the breakdown of provider disputes.

Chart 6
Provider Disputes – Capitated Providers



Total Number of Claim Payment Disputes:	945,333
Total Number of Utilization Management Disputes:	36,064
Total Number of Other Disputes:	15,289

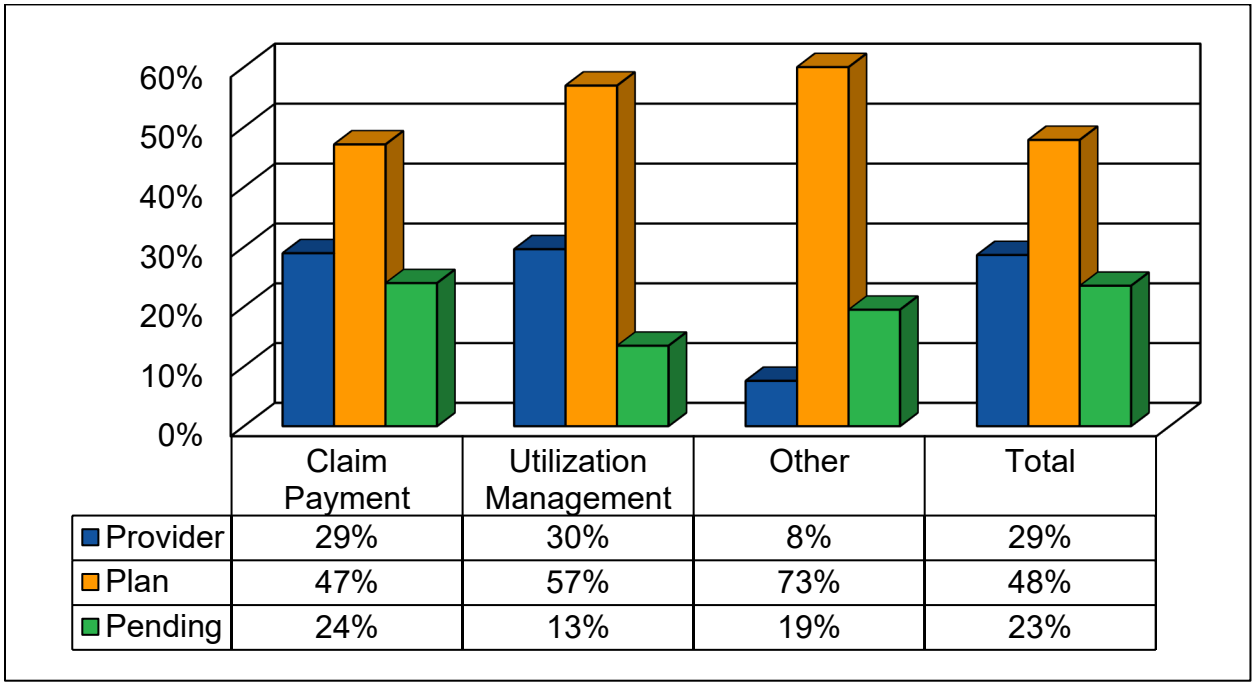
Approximately 84% of all claims processed were paid or adjusted and 16% of the claims processed were contested or denied. Capitated providers processed approximately 98% of claims within the 45-day statutory requirement. For provider disputes not resolved within the prescribed timeframes, the capitated 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 38% increase in the number of disputes in the 2024 reporting period compared to 2023. Of the 996,686 provider disputes submitted, 29% were resolved in favor of the provider, 48% were resolved in favor of the plan, and 23% were pending review as of September 30, 2024.

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



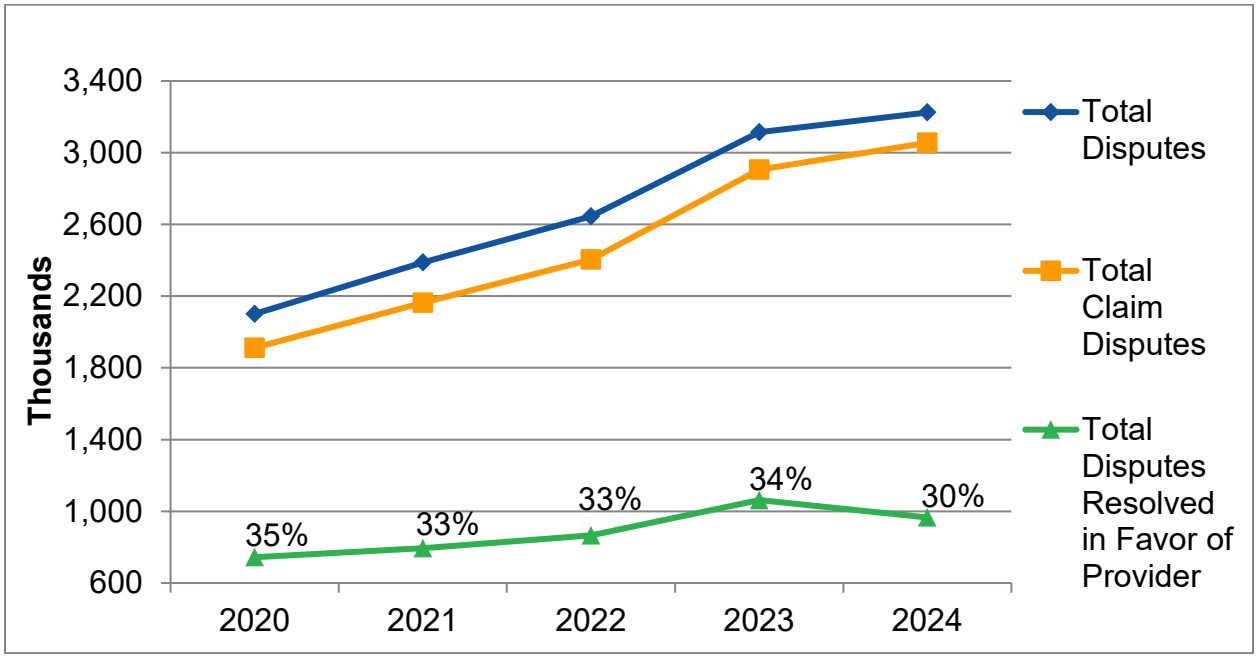
	Claim Payment	Utilization Management	Other	Total
Provider	29%	30%	8%	29%
Plan	47%	57%	73%	48%
Pending	24%	13%	19%	23%

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 2023 to 2024, provider disputes increased from 3.1 million to 3.2 million, representing a four percent increase. The number of disputes resolved in favor of the provider has fluctuated between 30% and 35% over the five-year period. For 2024, 30% 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 2024. Health plans reported resolving 94% of provider disputes within the required 45-day time frame, a three percent increase from the prior reporting period.

The percentage of provider disputes resolved by health plans in favor of the provider was 30% in the 2024 reporting period, a four percent decrease from the prior reporting period.

There was a 29% decrease in provider disputes received by specialized health plans. Forty-four percent of the provider disputes filed were resolved in favor of the provider.

Approximately 29% of provider disputes filed with capitated providers were resolved in favor of the provider with approximately 23% of these disputes pending as of September 30, 2024.

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.