DMHC Update
2023 CAHP Conference

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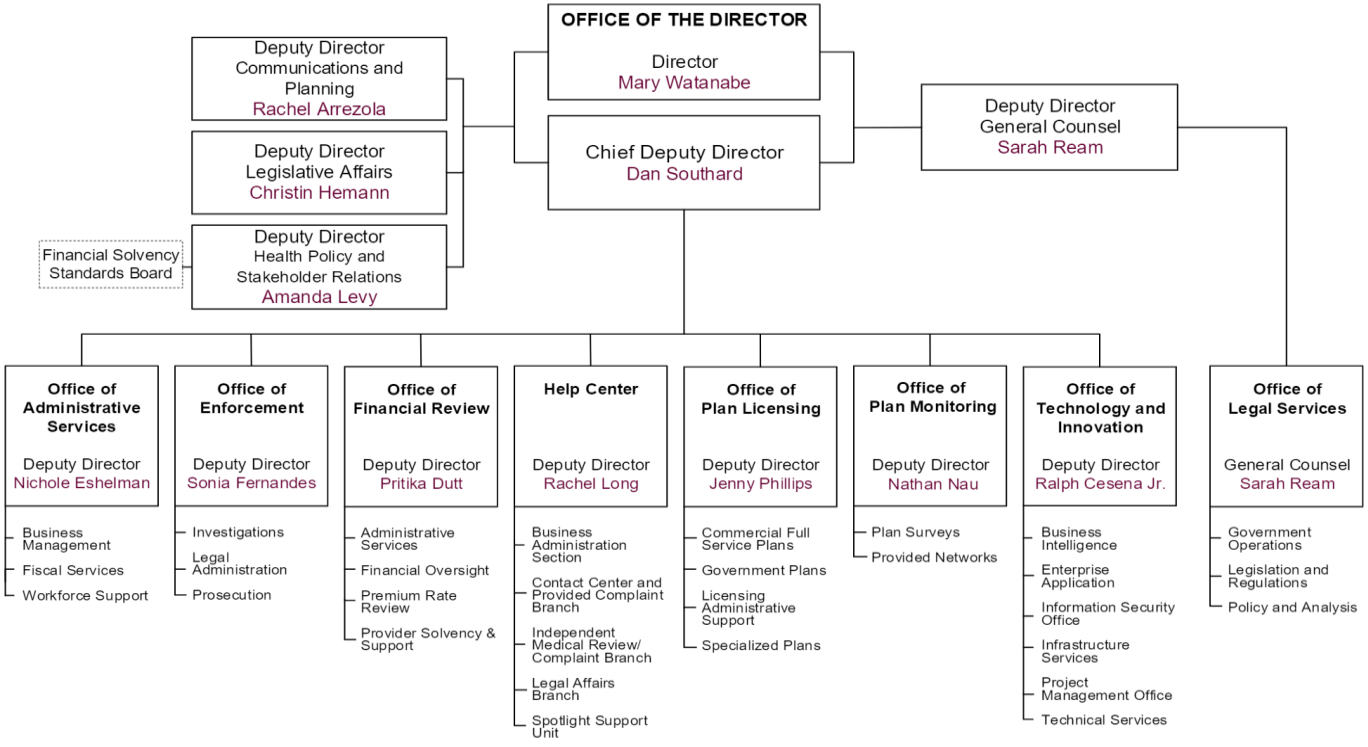
DMHC Mission Statement

The California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

DMHC Leadership Team



Our Accomplishments

2.8 MILLION CONSUMERS ASSISTED

The DMHC Help Center educates consumers about their rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and ensures access to health care services.

$126.1 MILLION

dollars assessed against health plans that violated the law

143 LICENSED HEALTH PLANS

97 FULL SERVICE

46 SPECIALIZED

$296.1 MILLION

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

29.7 MILLION CALIFORNIANS' HEALTH CARE RIGHTS ARE PROTECTED BY THE DMHC

96% of state-regulated commercial and public health plan enrollment is regulated by the DMHC

Approximately **68%** of consumer appeals (IMRs) to the DMHC resulted in the consumer receiving the requested service or treatment from their health plan

$43.8 MILLION

dollars recovered from health plans on behalf of consumers

$194.3 MILLION

dollars in payments recovered to physicians and hospitals

December 31, 2022

DMHC Priorities

- Behavioral Health
- Affordability
- Health Equity and Quality
- Transgender, Gender Diverse, or Intersex Working Group
- Legislation Implementation and Regulations

Behavioral Health

- Behavioral Health Investigations
- Children and Youth Behavioral Health Initiative (CYBHI)
- SB 855, Mental Health/Substance Use Disorder Coverage Requirements
- CARE Act
- AB 988, Mental Health: 988 Crisis Hotline
- Parity Between Commercial and Medi-Cal Coverage

Affordability

- 2024 Individual market rates ranged from -0.9% to 15% with a weighted average rate increase of 10.4%.
- 2024 Small Group market rates ranged from -6.5% to 13.4% with a weighted average rate increase of 8.4%.
- 2024 Large Group market rates ranged from 0% to 15.7% with a weighted average rate increase of 11.5%.

Health Equity and Quality Initiative

- The Health Equity and Quality Committee met nine times from February – September 2022.
- The Committee recommended 13 measures to be stratified by race and ethnicity.
- The DMHC released an All Plan Letter on December 21, 2022, adopting the 13 measures.
- The Committee recommended using the NCQA Quality Compass National Medicaid data for benchmarking but did not reach consensus on a percentile.

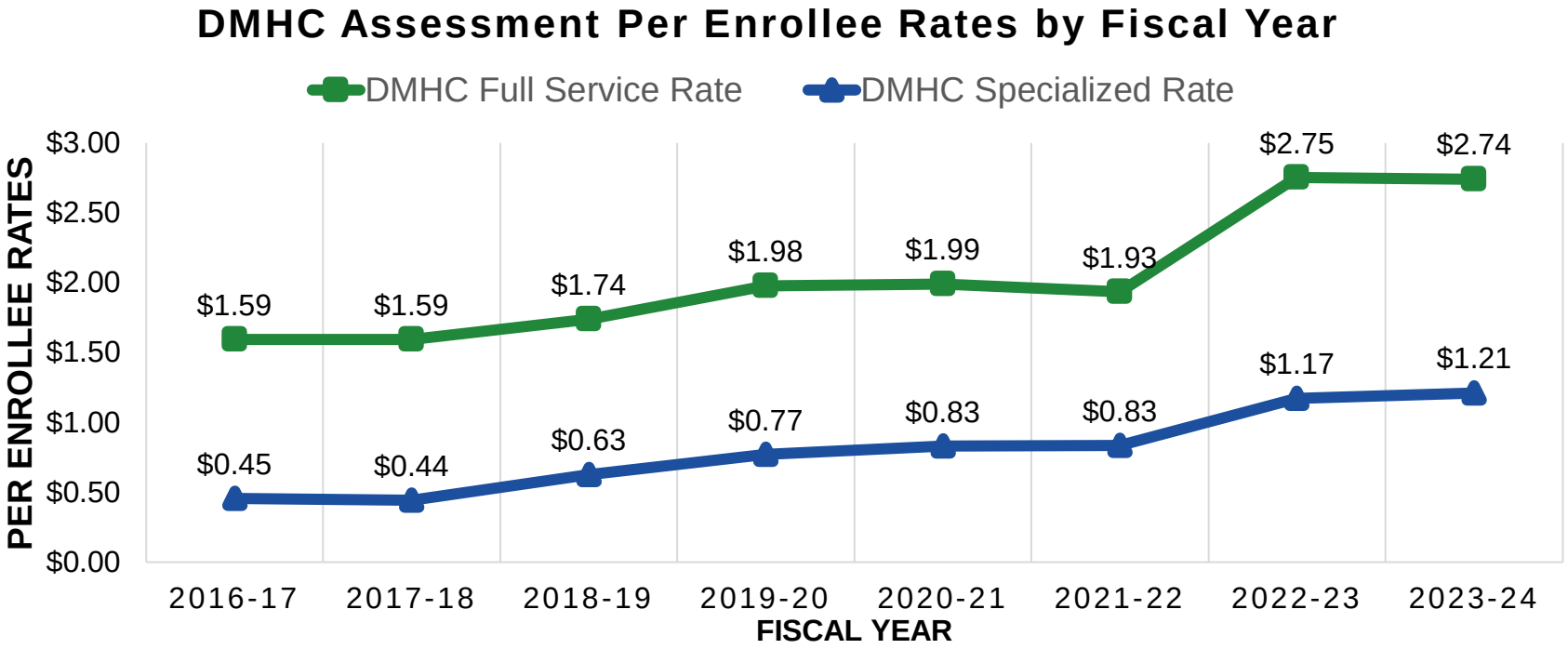
Key Dates

- Measurement Year 2023: Health plans begin collecting data on health equity and quality measures
- 2024: Health plans submit MY 2023 data to the DMHC
- 2025: First annual report published
- By January 1, 2027: The DMHC will promulgate a regulation codifying the measures and benchmarks. Once the regulations are promulgated, the DMHC may begin assessing administrative penalties for failure to meet the health equity and quality benchmarks.

DMHC Growth
(Dollars in millions)

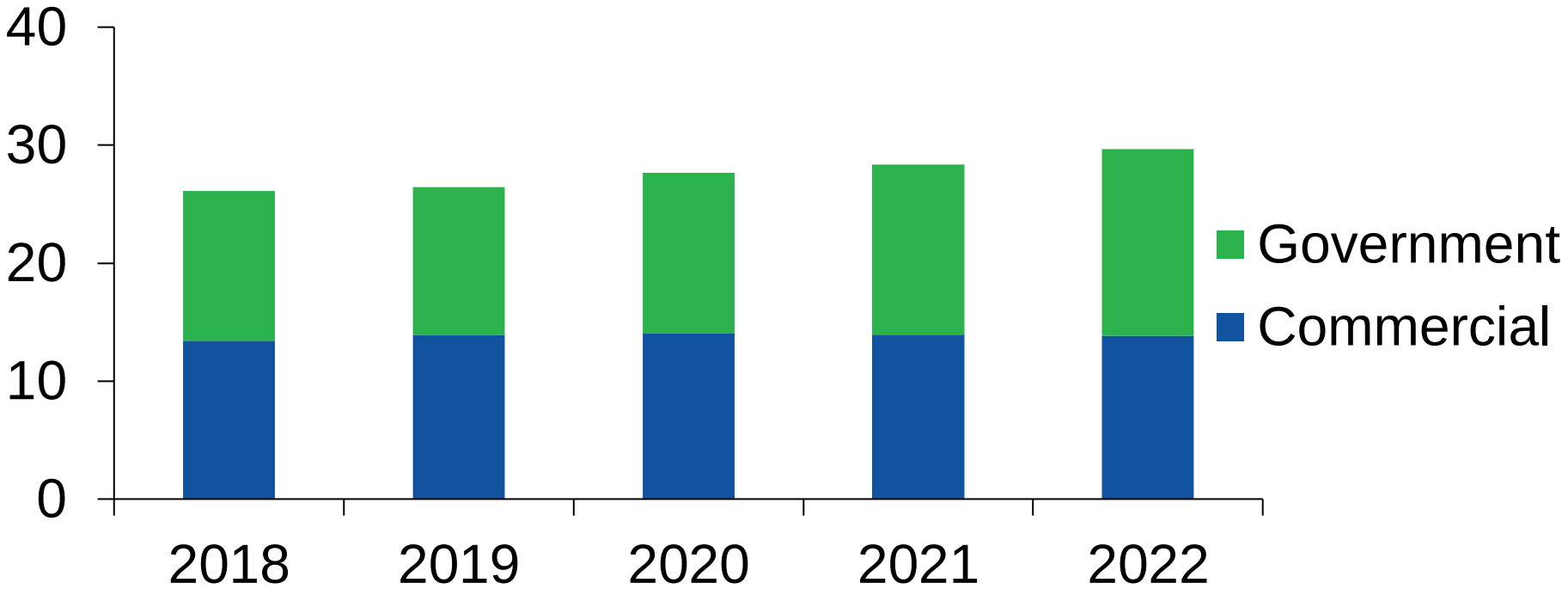
	2019-20	2020-21	2021-22	2022-23	2023-24
Funding	$91	$96	$103	$125.7	$161
Positions	482	505	516	610	707

DMHC Assessments



DMHC Enrollment Over Time

Full Service Enrollment (In Millions)



Regulations in Formal Rulemaking

- Update to AB 72, Surprise Balance Billing
  - Final regulation submitted to Office of Administrative Law (OAL) in September 2023
- SB 855, Mental Health/Substance Use Disorder Parity
  - Third comment period closed on October 3, 2023

Upcoming Regulations

- Iatrogenic Fertility Preservation
  - Rulemaking to commence in late 2023
- SB 137, Provider Directories
  - Rulemaking to commence in late 2023

Upcoming Regulations

- General licensure/risk regulation amendment
- Grievances and appeals
- Large group rate review
- Individual and small group aggregate rate reporting
- Regulations needed to implement recent legislation

Transgender, Gender Diverse, or Intersex (TGI) Working Group

- Senate Bill 923 (Wiener) required formation of the Transgender, Gender Diverse, or Intersex (TGI) Health Care Quality Standards and Training Curriculum Working Group.

TGI Working Group Purpose

- Develop a quality standard for patient experience to measure cultural competency related to the TGI community.
- Recommend a trans-inclusive training curriculum to be used by health care plan staff who are in direct contact with enrollees in the delivery of health care services.

TGI Working Group Meetings

- Monthly Meetings through early 2024
  - Convened in Spring 2023
- Statewide Listening Sessions: September/October 2023
  - Sacramento, Oakland, Los Angeles, Modesto
- Working Group recommendations due March 2024

Children and Youth Behavioral Health Initiative

- As part of the Children and Youth Behavioral Health Initiative, commercial and Medi-Cal plans are required to reimburse for certain behavioral health services in the Department of Health Care Services (DHCS) published Multi-Payer Fee Schedule.
- These services are available to individuals 25 years of age or younger provided or arranged by local educational agencies and public institutions of higher education.

Children and Youth Behavioral Health Initiative

- These services will be provided without utilization management and will not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.
- DMHC will issue guidance via an All Plan Letter by December 31, 2023, to address commercial plan coverage of school-linked Behavioral Health services.

Children and Youth Behavioral Health Initiative Updates

- DMHC and DHCS have met with stakeholders throughout 2023 to discuss policy and operational issues with health plans, education representatives, and consumer advocates.

Children and Youth Behavioral Health Initiative Implementation

- Phased Implementation
  - Phase One-Early Adopters: January 1, 2024
  - Phase Two-Select Expansion: July 1, 2024
  - Phase Three: Rolling opt-in beginning January 1, 2025
- Third Party Administrator

2023 Enacted Bill Summary

- AB 254 (Bauer-Kahan): Digital Application Medical Privacy
- AB 904 (Calderon): Doula Workshop
- AB 952 (Wood): Dental Coverage Disclosures
- AB 1048 (Wicks): Dental Services Rate Review
- SB 496 (Limon): Biomarker Testing
- SB 786 (Portantino): Pharmacy Benefit Manager Discrimination

Cost Sharing Related Bills

AB 659 (Aguiar-Curry): HPV Vaccine Coverage

- Requires a health plan to provide coverage without cost-sharing for the human papillomavirus (HVP) vaccine, as approved by the U.S. Food and Drug Administration (FDA).
- Currently, the Center for Disease Control's (CDC) Advisory Committee on Immunization Practices (ACIP) recommends administration of the HPV vaccines to individuals up to age 26. The FDA limits approved usage of the HPV vaccination at 45 years old.
- Effective date: January 1, 2024.

Cost Sharing Related Bills

AB 948 (Berman): $250/$500 Prescription Drug Cost-Share Limit

- Current law states that cost-sharing for prescription drugs shall not exceed $250 for up to a 30-day supply unless the health plan is equivalent to a bonze health plan, in which a maximum payment is $500.
- Eliminates the January 1, 2024, sunset date for a cost-sharing limit for prescription drugs.
- Defines health plan drug formulary tiers.

Cost Sharing Related Bills

SB 421 (Limon): $250 Oral Anti-Cancer Prescription Drug Cost-Share Limit

- Current law states that cost-sharing for prescription drugs shall not exceed $250 for up to a 30-day supply of an orally administered anticancer medication.
- Eliminates the January 1, 2024, sunset date for a cost-sharing limit on a prescription of a 30-day supply of a prescribed oral anticancer medication.

AB 317 (Weber): Pharmacist Reimbursement

- Requires a health plan that offers coverage for a service that is within the scope of practice of a licensed pharmacist to pay or reimburse the cost of services performed at an in-network pharmacy, or by a pharmacist at an out-of-network pharmacy if the health plan has an out-of-network pharmacy benefit.
- Effective date: January 1, 2024.

AB 716 (Boerner): Ground Ambulance Balance Billing Prohibition

- Requires the Emergency Medical Services Authority (EMSA) to develop and publish on its website an annual report showing the allowable maximum rates for ground ambulance services in each county.
- Limits an enrollee's financial responsibility to the in-network cost-sharing amount for ground ambulance services.

AB 716 (Boerner): Ground Ambulance Balance Billing Prohibition (cont.)

- Requires health plans to reimburse noncontracted ground ambulance providers the difference between the in-network cost-sharing amount and the established or approved rate by the relevant local government entity.
- Effective date: January 1, 2024.

SB 621 (Caballero): Biosimilar Drug Coverage

- Authorizes a health plan, or utilization review organization, to require an enrollee to try a biosimilar drug before providing for the equivalent branded prescription drug, if it does not prohibit or supersede a step therapy exception request.
- Clarifies that requirement to try biosimilar, generic, and interchangeable drugs does not prohibit or supersede a step therapy exception request.
- Effective date: January 1, 2024.

Questions