Date of Hearing: July 15, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 530 (Richardson) – As Amended July 9, 2025

SENATE VOTE: 28-7

SUBJECT: Medi-Cal: time and distance standards.

SUMMARY: This bill strengthens oversight of "time and distance" access standards for Medi-Cal managed care plans, which are used to judge whether a plan has an adequate and accessible network of health care providers. These standards establish a maximum wait time for appointments and a maximum time or distance from a beneficiary's place of residence, within which specified types of providers must be available. This bill also extends the sunset of these requirements, which would otherwise expire January 1, 2026, until January 1, 2029. Specifically, **this bill**:

Time and Distance Standards

1) Codifies Department of Health Care Services (DHCS) policy guidance that requires each Medi-Cal plan to ensure that each subcontractor network complies with the existing appointment time standards, unless already required to ensure compliance.

2) Requires Medi-Cal plans' network adequacy compliance reports to include reporting on each subcontractor network.

3) Codifies federal regulations that require, effective January 1, 2029, DHCS to evaluate Medi-Cal plans' compliance with standards through a direct testing method, such as a "secret shopper" method, for appointment time standards, and an examination of appointment time standards complaints data submitted to the plan, DHCS, or the Department of Managed Health Care (DMHC). Specifies failure to comply with the evaluations required by this paragraph may result in contract termination or the issuance of sanctions pursuant to existing DHCS authority.

4) Codifies DHCS policy guidance that clarifies that the use of telehealth providers to meet time or distance standards, including those imposed by contract, does not absolve the Medi-Cal plan of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. Specifies that DHCS's policy on how to consider telehealth services in determining compliance only applies to Medi-Cal plans that cover at least 85% of the population points in the ZIP code.

5) Authorizes DHCS to require enhanced time or distance standards that are more stringent than those set forth in law, in its contracts with Medi-Cal managed care plans. Requires DHCS to ensure that enhanced standards specified in Medi-Cal managed care plan contracts are consistent across contracts for similar geographic classifications. Requires DHCS to publish all enhanced time and distance standards adopted by contract, with a rationale for the enhanced standards.

Alternative Access Standards

6) Restricts DHCS from authorizing alternative access standards unless all of the following occur:

   a) A plan has exhausted all other reasonable options to obtain providers to meet the applicable standard;

   b) DHCS determines that the requesting plan has demonstrated it is capable of delivering an appropriate level of care and access that is consistent with professionally recognized standards of practice; and,

   c) The plan has determined and noted in the relevant record that the alternative access standards will not have a detrimental impact on the health of enrollees.

7) Exempts alternate health care service plans (this applies to plans offered by Kaiser Permanente Health Plan) from 6) a) above.

8) Requires Medi-Cal managed care plans requesting to extend or modify a previously approved alternative access standards request to include steps taken to obtain providers to meet the applicable standard and to demonstrate that the alternative access standards will not have a detrimental impact on the health of enrollees. Requires Medi-Cal plans to explain why alternative provider recruitment strategies were not attempted if the steps taken do not differ from previous attempts to obtain providers.

9) Requires Medi-Cal managed care plans to notify affected beneficiaries of their options to receive services when a Medi-Cal managed care plan is subject to a corrective action plan having an insufficient network. Requires Medi-Cal plans to notify beneficiaries of their option to use or not use telehealth, covered transportation services, or out-of-network providers for services located outside of the existing time and distance standards.

10) Codifies federal regulations that require, effective for contract periods commencing on or after January 1, 2027, as part of DHCS's evaluation of a request pursuant to this subdivision, DHCS to also consider the sufficiency of payment rates offered by the Medi-Cal managed care plan to the provider type or for the service type for which an alternative access standard is being requested.

Transparency and Public Input

11) Requires DHCS to publish and periodically update the standards and criteria used for evaluating and authorizing alternative access standards and to consult with affected stakeholders prior to publishing or updating the standards and criteria.

12) Requires, in alignment with federal regulation that requires DHCS to conduct analyses when developing or adjusting network adequacy standards, DHCS to publish these analyses and any related work plan on DHCS's website by January 1, 2027.

13) Requires, by January 1, 2027, DHCS to convene a stakeholder workgroup to assist in the development of evidence-based network adequacy standards. Requires DHCS to provide a

30-day public comment period before implementing any changes to network adequacy standards or guidance.

14) Requires, by January 1, 2028, DHCS to seek federal approval of evidence-based network adequacy standards developed in consultation with stakeholders as described in 13) above.

EXISTING LAW:

1) Requires a Medi-Cal managed care plan to maintain a network of providers that are located within specified time and distance standards for specified services. [Welfare and Institutions Code (WIC) § 14197 (b)]

2) Establishes time or distance standards for primary care (adult and pediatric), dental services, and obstetrics and gynecology, as 10 miles or 30 minutes from the beneficiary's place of residence; a standard for hospitals that is 15 miles or 30 minutes from the beneficiary's place of residence; and other standards for specialists (adult and pediatric), pharmacy services, outpatient mental health and substance use disorder services, and opioid treatment programs. [WIC § 14197(b)(1)]

3) Requires Medi-Cal managed care plans to comply with appointment availability standards developed under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and its regulations. [WIC § 14197(d)(1)(A)]

4) Allows, if a Medi-Cal managed care plan cannot meet the time and distance standards set forth in statute, the plan to submit to DHCS a request for alternative access standards, in the form and manner specified by DHCS. [WIC § 14197(f)(3)]

5) Allows DHCS, upon request of a Medi-Cal managed care plan, to authorize alternative access standards for the established time or distance standards if either of the following occur:

   a) The requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet the applicable standard; or,

   b) DHCS determines that the requesting Medi-Cal managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access. [WIC § 14197(f)(2)]

6) Allows DHCS to authorize a Medi-Cal managed care plan to use clinically appropriate synchronous video telehealth as a means of demonstrating compliance with time or distance standards. [WIC § 14197(e)]

7) Requires the plan to close out any corrective action plan deficiencies in a timely manner to ensure beneficiary access is adequate and to continually work to improve access in its provider network. [WIC § 14197(f)(3)(D)]

8) Requires measurement of compliance with time or distance and appointment time standards separately for adult and pediatric services for primary care, behavioral health, and core specialist services. [WIC § 14197(g)(1)]

9) Sunsets the time and distance and appointment availability standards on January 1, 2026. [WIC § 14197(l)]

10) Requires an external quality review of Medi-Cal managed care plans annually and a related report that compiles specified data, for the purpose of informing the status of implementation of the time, distance, and appointment time requirements. [WIC § 14197.05, Title 42 Code of Federal Regulations § 438.364]

11) Grants the Director of DHCS the power and authority to take one or more of the following actions against a Medi-Cal managed care plan for specified findings of noncompliance, including with time, distance, appointment time, provider network adequacy, and a number of related standards:

    a) Suspend enrollment and marketing activities;

    b) Impose a CAP;

    c) Require the contractor to suspend or terminate contractor personnel or subcontractors;

    d) Impose civil penalties in various amounts up to $100,000;

    e) Impose monetary sanctions of up to $25,000 for a first violation, $50,000 for a second violation, and up to $100,000 for each subsequent violation; or,

    f) Various other actions. [WIC § 14197.7 (d), (e), (f)]

12) Requires, by July 1, 2025, DHCS to adopt any regulations necessary to implement penalties and sanctions. [WIC § 14197.7 (r)(2)]

13) Requires, under federal regulations, a state that contracts with a managed care plan to deliver Medicaid services to develop and enforce network adequacy standards, as specified. Requires states to establish, and plans to comply with, specified appointment time standards as well as another quantitative network adequacy standard, other than appointment wait times, for specified provider types. Requires states to consider, at a minimum, nine specific factors in the development of a network adequacy standard. [Title 42, Code of Federal Regulations (CFR) § 438.68]

14) Requires, under federal regulations, by January 1, 2027, to the extent a state permits an exception to network standards, that the standard by which the exception will be evaluated and approved be specified in the managed care plan contract; be based, at a minimum, on the number of providers in that specialty practicing in the service area; and include consideration of the payment rates offered by the plan to the provider type or for the service type for which an exception is being requested. [*Ibid*.]

15) Requires, under federal regulations, by January 1, 2029, states to contract with an entity to conduct annual secret shopper surveys of each plans' compliance with provider directory requirements and appointment wait time requirements. [*Ibid*.]

FISCAL EFFECT: According to the Senate Committee on Appropriations:

1) Unknown ongoing costs, likely hundreds of thousands, for the DHCS for state administration (General Fund and federal funds).

2) Unknown, potential cost pressures to increase Medi-Cal plan payment rates for providers or services (General Fund and federal funds).

COMMENTS:

1) PURPOSE OF THIS BILL. This bill is intended to strengthen access standards for Medi-Cal managed care plans and extend the sunset on the section of code that establishes these standards. According to the author, access to covered services is a persistent problem for Medi-Cal recipients enrolled in managed care—and yet, there has been an increasing volume of requests for and approvals of Medi-Cal alternative access standards. In 2023, the author notes, DHCS received approximately 25,000 alternative access standard requests from health plans, and approximately 14,000 were approved. The author states that approval of these requests means that Medi-Cal patients must travel farther or longer than state law requires, just to access care. The author argues there is an association between increasing time or distance to healthcare and worse health outcomes, and that barriers to care can mean delayed routine preventative care, such as regular medical and dental checkups, disease screening tests, and delayed diagnosis and treatment for cancer. The author concludes that with over one third of Californians receiving health care coverage through Medi-Cal and roughly 94% of Medi-Cal recipients receiving their care through the managed care system, it is critical that we ensure timely access to care.

2) BACKGROUND.

a) Medicaid Managed Care. According to the Medicaid and Children's Health Insurance Program Payment and Access Commission (MACPAC), a federal entity that tracks and advises on Medicaid policy, many states have incorporated managed care into their Medicaid programs. Managed care plans are paid on a capitated basis (an agreed-upon amount that is paid to plans per-member, per-month), and plans negotiate payment rates with most providers. Because plans receive a monthly payment regardless of the services they provide in a given month, it is important for the state to closely monitor plans and hold them accountable to ensure plan members are able to access care. As the federal government has allowed states more flexibility to expand the role of managed care in their Medicaid programs, it has concurrently implemented more monitoring and accountability requirements.

b) Network Adequacy Standards. Accordingly, in 2016, the federal Centers for Medicare and Medicaid Services (CMS) adopted a major new regulation requiring states to develop and enforce network adequacy standards for managed care plans, including time and distance standards for different provider types. California already had standards in place for Knox-Keene Act-licensed plans, which comprise the majority of full-service Medi-Cal managed care plans. To implement the required changes, the Legislature established network adequacy requirements for Medi-Cal managed care plans (including Denti-Cal plans), county mental health plans that provide specialty mental health services, and county Drug Medi-Cal-Organized Delivery System (DMC-ODS) plans, through AB 205 (Wood), Chapter 738, Statutes of 2018.

AB 205 established maximum time and distance standards for specialists, based on the county population density. For example, plans have to maintain a network of specialists who are up to 15 miles or 30 minutes from the beneficiary's place of residence in nine major urban counties (such as Alameda, Los Angeles, and San Francisco), but can have a standard that is up to 60 miles or 90 minutes from the beneficiary's place of residence for 13 rural counties (such as Alpine, Colusa, and, Trinity), as shown in the chart below:

Time and Distance Standards in AB 205 for Specialists and Outpatient Mental Health

Category	Population Density	# of Counties	Counties	Standard
Rural	< 50 people per square mile	21	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra , Siskiyou, Tehama, Tuolumne, Trinity	60 miles/ 90 minutes
Small	51 to 200 people per square mile	19	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, Yuba	45 miles/ 75 minutes
Medium	201 to 600 people per square mile	9	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura	30 miles/ 60 minutes
Dense	≥ 600 people per square mile	9	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara	15 miles/ 30 minutes

AB 205 also required plans to make available appointments within specified timeframes for physicians, with different timeframes depending upon whether the visit is urgent and whether the visit is with a specialist, using the current Knox-Keene Act standards for physicians and mental health providers. Those standards are as follows:

Urgent Appointments	Time
For services that do not need prior approval	48 hours
For services that do need prior approval	96 hours

Non-urgent appointments	Wait Time
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a non-MD mental health provider	10 business days
Appointment for a services to diagnose/treat a health conditions	15 business days

Medi-Cal managed care plans, as well as private health plans licensed by the Knox-Keene Act, are also required to maintain minimum provider-to-enrollee ratios. For example, plan networks must include one primary care provider for every 2,000 beneficiaries.

c) Alternative Access Standard Requests. DHCS can allow, upon request by a Medi-Cal managed care plan, "alternative access standard" requests from the time and distance standards if:

i) The requesting plan has exhausted all other reasonable options to obtain providers to meet the applicable standard; or,

ii) DHCS determines that the requesting plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

Plan requests for alternative access standards are typically based on one or more of the following:

i) The lack of providers in an area (such as in rural parts of the state);

ii) Specialists providers for complex cases where beneficiaries would need to travel to because of the expertise of the particular provider (for example, children's hospitals, university teaching hospitals and cancer centers); or,

iii) Providers who are within a plan's area but who do not contract with Medi-Cal plans, typically because of plan rates paid to providers, plan contract terms, or an unwillingness to participate in Medi-Cal.

Pursuant to DHCS guidance in All-Plan Letter (APL) 23-001, before submitting such a request, plans must make good faith efforts to exhaust reasonable contracting options with additional providers within the time or distance standards. DHCS requires plans to submit the unsuccessful contracting efforts for closer providers as part of the request. DHCS indicates it will generally not accept contracting efforts with the same provider ongoing as a rationale for the request, in order to ensure that plans are actively outreaching to closer providers. DHCS indicates it may consider allowing some exceptions for plans operating in challenging geographical areas or for provider types that may be difficult to contract with. Alternative access standard requests for the plan's entire

network must be submitted every three years. In the intervals where the request is not required to be submitted, plans must submit an attestation.

If a plan is able to cover at least 85% of the members in a ZIP code and the plan can show that they have additional capacity through the use of telehealth providers to serve the remaining members, the plan would be deemed compliant with time or distance standards and an alternative access standard request is not required.

d) State Audits and DHCS Response. In March 2019, the Bureau of State Audits (auditor) released an audit titled "*Department of Health Care Services - Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services*," regarding DHCS' oversight of the delivery of preventive services to children in Medi-Cal. The auditor found, among other things, that many of the state's children do not have adequate access to Medi-Cal providers who can deliver the required pediatric preventive services, and issued a follow-up audit in 2022 noting some progress. In November 2023, the auditor issued a different audit related to children's access to behavioral health care in Medi-Cal, which found many Medi-Cal managed care plans are unable to provide children with timely access to behavioral health care. The report raised numerous issues and questions about the state's ability to accurately monitor and oversee compliance with time and distance and appointment time requirements, with negative results for beneficiaries who have difficulty getting timely access to care despite plans showing they meet standards "on paper." DHCS acknowledged and agreed with many of the recommendations and has ongoing work to improve measurement and compliance monitoring activities, consistent with recommendations from recent audits as well as new federal regulations.

e) 2024 Regulations. CMS updated its regulations on Medicaid managed care in 2024 through two rules called the "*Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule*" (dubbed the Managed Care Final Rule) and "*Ensuring Access to Medicaid Services Final Rule"* (Access Rule). According to CMS, these rules are intended to enhance access to care and quality of care, and will improve health outcomes for Medicaid beneficiaries. In issuing these rules, CMS notes its efforts to improve access to care and services has been limited by outdated regulations. The Managed Care Final Rule is intended to enhance and standardize rules related to access to care requirements and monitoring. Some of the relevant provisions of the regulations, as modified by the Managed Care Final Rule, are listed in 13) to 15) of Existing Law, above.

This bill codifies certain requirements included in the federal rules, including the requirement for a "secret shopper" approach for appointment time surveys and requirements related to the approval of alternative access standards.

f) June Trailer Bill Proposal to Extend Sunset Conflicts with This Bill. On June 17th, 2025, Department of Finance released proposed Budget Trailer Bill Language (TBL) related to implementation of new federal regulations, including the two rules listed above as well as an eligibility-related rule. The proposed TBL would also extend the sunset on the section of law that establishes time and distance standards. The TBL would extent the sunset for three years but would make no other changes to network adequacy provisions. This bill, in contrast, also includes a three-year sunset extension but makes numerous other changes, as described above.

In the Fact Sheet related to this TBL proposal, DHCS notes it relies on this existing section of law as the regulatory authority to hold plans accountable to network adequacy standards, maintain access to care for Medi-Cal members, and comply with federal regulations. DHCS notes it is necessary to extend the sunset date to provide DHCS sufficient time to continue to analyze the Managed Care Final Rule, engage with relevant stakeholders, and propose and implement a revised policy responding to additional network adequacy requirements as specified in the new Managed Care Final Rule. Further, DHCS notes federal regulations require DHCS to conduct analyses considering nine factors while developing or adjusting network adequacy standards.

No legislative action has been taken on the TBL at this time.

g) **Recent Amendments**. A number of provisions included in this bill are intended to codify requirements DHCS has already promulgated through guidance to managed care plans. Recent amendments have also attempted to align the bill with the timeline and process DHCS has laid out for implementing the federal Managed Care Final Rule. Finally, some of the bill's provisions strengthen access standards in a manner that goes beyond DHCS guidance and federal regulations, although a number of provisions that were in a prior version of the bill, including the addition of new provider categories and the measurement of compliance separately for new and returning patients, are no longer included in the July 9, 2025 version of this bill.

3) **SUPPORT**. Co-sponsors National Health Law Program and Western Center on Law and Poverty write that over recent years, DHCS has approved an increasing volume of approved alternative access requests, which have spanned across the entire state. In some cases, such as Alameda, Los Angeles, and San Bernardino, the approved alternative access standards nearly doubled the average time and distance Medi-Cal enrollees must travel to access health care services beyond the state standards. The co-sponsors conclude this bill is needed to ensure network adequacy standards translate into meaningful access.

4) **SUPPORT IF AMENDED**. The California Chapter of the American College of Emergency Physicians write requesting that emergency physicians be included among the enumerated specialists that plans must ensure timely access to. They cite a non-Medicaid federal rule as a model for imposing such a standard.

5) **RELATED LEGISLATION**. SB 32 (Weber Pierson) would require DHCS, along with DMHC and the California Department of Insurance to consult together and with stakeholders to develop and adopt time and distance standards for perinatal units, to ensure timely access for covered enrollees and insureds. SB 32 passed this Committee on July 1, 2025, on a 15-0 vote and is pending in the Assembly Appropriations Committee.

6) **PREVIOUS LEGISLATION**.

a) AB 2466 (Wendy Carrillo) of 2024 would have implemented a number of recommendations from a state audit related to improving monitoring and oversight of the accuracy of provider networks and timely access to care in Medi-Cal managed care. AB 2466 was held on the suspense file of the Assembly Appropriations Committee.

b) AB 1202 (Lackey) of 2023 would have required DHCS to prepare a public report including information on each Medi-Cal managed care plan's network adequacy of

pediatric primary care, data on beneficiaries, and reporting on DHCS' efforts to improve access. AB 1202 was vetoed by Governor Newsom, who cited concerns the reporting was duplicative with current and pending DHCS efforts.

c) SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, extends from January 1, 2023, to January 1, 2026, time, distance, and appointment time standards for specified services to ensure that Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner. Authorizes DHCS to allow a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction as a means of demonstrating compliance with the time or distance standards, and as part of an alternative access standard request, and authorizes DHCS to develop policies for granting credit, as specified. Makes changes to the frequency of alternative access standards request submissions made by Medi-Cal managed care plans when they cannot meet the time and distance standards, and requires the plan to close out any corrective action plan deficiencies in a timely manner to ensure beneficiary access is adequate and to continually work to improve access in its provider network.

d) AB 1642 (Wood), Chapter 465, Statues of 2019, increases the maximum civil penalty amounts in existing law for Medi-Cal managed care plans. Broadens the bases for the DHCS to levy sanctions against plans, and broadens DHCS authority to find noncompliance beyond medical audits. Includes county mental health plans and Drug Medi-Cal organized delivery system in the plan penalty provisions. Requires penalty revenue to be deposited into the General Fund for use, and upon appropriation by the Legislature, to address workforce issues in the Medi-Cal program and to improve access to care in the Medi-Cal program. Requires plans seeking exceptions from appointment travel time standards to include a description of how the plan intends to arrange for beneficiaries to access covered services if the health care provider is located outside of the time and distance standards. Requires DHCS to evaluate and determine whether the resulting time and distance is reasonable to expect a beneficiary to travel to receive care.

e) AB 205 (Wood), Chapter 738, Statutes of 2018 implements federal rules establishing network adequacy requirements for Medi-Cal managed care plans.

REGISTERED SUPPORT / OPPOSITION:

Support

National Health Law Program (co-sponsor)
Western Center on Law and Poverty (co-sponsor)
Alliance of Catholic Health Care, Inc.
Alzheimer's Association
Asian Americans Advancing Justice-southern California
Asian Resources, Inc.
California Dental Association
California Hospital Association
California LGBTQ Health and Human Services Network
California Pan - Ethnic Health Network
California Physicians Alliance
California Rural Legal Assistance Foundation, Inc.

California Senior Legislature
California Urgent Care Association
CANHR
Children Now
Courage California
Health Access California
Justice in Aging
Latino Coalition for a Healthy California
Private Essential Access Community Hospitals
Rady Children's Hospital
SEIU California
The Arc and United Cerebral Palsy California Collaboration
The Children's Partnership

Opposition

None on file

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