Date of Hearing: August 20, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 530 (Richardson) – As Amended July 9, 2025

Policy Committee: Health Vote: 15 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill strengthens oversight and extends the sunset date of "time and distance" access standards for Medi-Cal managed care plans. Time and distance standards are used to judge whether a plan has an adequate and accessible network of health care providers.

Specifically, this bill:

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

2) Requires an MCP's network adequacy compliance reports to include reporting on each subcontractor network.

3) Codifies federal regulations that require, effective January 1, 2029, DHCS evaluate an MCP's 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 MCP, 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 clarifying that the use of telehealth providers to meet time or distance standards, including those imposed by contract, does not absolve the MCP 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 an MCP 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 MCPs. Requires DHCS to ensure that enhanced standards specified in an MCP contract are consistent across contracts for similar geographic classifications and requires DHCS publish all enhanced time and distance standards adopted by contract, with a rationale for the enhanced standards.

6) Restricts DHCS' existing authorization to allow alternative access standards unless the DHCS has determined the requesting plan is capable of delivering an appropriate level of

care and access, and has noted in the relevant record that the alternative access standards will not have a detrimental impact on the health of enrollees.

7) Requires DHCS publish and periodically update as necessary, after consultation with affected stakeholders, the standards and criteria for evaluating and authorizing alternative access standards described.

8) Requires an MCP with a previously approved alternative access standards request submit that request to DHCS for approval every three years and to (a) include steps taken to obtain providers to meet the applicable standard and (b) demonstrate that the alternative access standards will not have a detrimental impact on the health of enrollees. Requires the MCP explain why alternative provider recruitment strategies were not attempted if the steps taken do not differ from previous attempts to obtain providers.

9) Requires an MCP notify affected beneficiaries of their options to receive services when an MCP is subject to a corrective action plan for having an insufficient network. Requires MCPs 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 MCP to the provider type or for the service type for which an alternative access standard is being requested.

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 conduct analyses when developing or adjusting network adequacy standards, DHCS 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. Requires, by January 1, 2028, DHCS seek federal approval of evidence-based network adequacy standards developed in consultation with stakeholders.

14) Extends the sunset date for time and distance access standards an MCPs must meet, from January 1, 2026, to January 1, 2029.

FISCAL EFFECT:

Costs of an unknown amount, potentially in the high hundreds of thousands to low millions of dollars, for DHCS to engage in stronger oversight of MCPs by imposing stricter standards for provider network adequacy and convene stakeholders to develop evidence-based network adequacy standards, and for MCPs to improve provider networks and meet stricter criteria for network adequacy and demonstrate absence of harmful effects when adequacy standards are not met (General Fund, federal funds).

COMMENTS:

1) **Purpose.** This bill is sponsored by National Health Law Program and Western Center on Law and Poverty. According to the author:

> Access to covered services is a persistent problem for Medi-Cal recipients enrolled in managed care. Yet, there has been an increasing volume of Medi-Cal alternative access request and approvals. In 2023, DHCS received approximately 25,000 alternative access standard requests from health plans, and approximately 14,000 were approved. Approval of these requests means that Medi-Cal patients must travel farther or longer than state law requires just to access care. Research indicates that there is an association between increasing time or distance to healthcare and increasingly worse health outcomes. Barriers to such care can mean delayed routine preventative care, such as regular medical and dental checkups, disease screening tests, and delayed diagnosis and treatment for cancer. 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.** MCPs are paid on a capitated basis, meaning an agreed-upon amount per-member, per-month is paid to an MCP. MCPs negotiate payment rates with most health care 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.

   Accordingly, in 2016, the federal Centers for Medicare and Medicaid Services 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 health plans, which comprise the majority of full-service Medi-Cal MCPs. To implement the required changes, the Legislature, through AB 205 (Wood), Chapter 738, Statutes of 2018, established network adequacy requirements for Medi-Cal MCPs and other types of health plans. AB 205 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.

   DHCS may allow, upon request by an MCP, "alternative access standard" requests from the time and distance standards if the MCP has exhausted all other reasonable options to obtain providers to meet the applicable standard, or DHCS determines that the requesting plan has demonstrated that the plan's delivery structure is capable of delivering the appropriate level of care and access.

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