SENATE THIRD READING
SB 530 (Richardson)
As Amended July 9, 2025
Majority vote

SUMMARY

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.

COMMENTS

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.

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).

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.

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.

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

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

2) 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 a lack of providers, providers unwilling to contract, and/or lack of providers with expertise in complex specialty care.

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.

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.

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. 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.

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

According to the Author
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. 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. The author states that approval of thousands of 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 health care and worse health outcomes. 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.

Arguments in 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.

Arguments in Opposition
None.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations, 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 Medi-Cal managed care plans (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).

VOTES

SENATE FLOOR: 28-7-5
YES: Allen, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Cortese, Durazo, Gonzalez, Grayson, Hurtado, Laird, McGuire, McNerney, Menjivar, Padilla, Pérez, Richardson, Rubio, Smallwood-Cuevas, Stern, Umberg, Wahab, Weber Pierson, Wiener
NO: Choi, Dahle, Jones, Niello, Ochoa Bogh, Seyarto, Strickland
ABS, ABST OR NV: Alvarado-Gil, Grove, Limón, Reyes, Valladares

ASM HEALTH: 15-0-1
YES: Bonta, Chen, Addis, Aguiar-Curry, Caloza, Carrillo, Mark González, Krell, Patel, Patterson, Celeste Rodriguez, Sanchez, Schiavo, Sharp-Collins, Stefani
ABS, ABST OR NV: Flora

ASM APPROPRIATIONS: 14-0-1

YES: Wicks, Sanchez, Arambula, Calderon, Caloza, Dixon, Elhawary, Fong, Mark González, Ahrens, Pacheco, Pellerin, Solache, Ta
ABS, ABST OR NV: Tangipa

UPDATED

VERSION: July 9, 2025

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