AMENDED IN SENATE MARCH 25, 2025

SENATE BILL No. 530

Introduced by Senator Richardson

February 20, 2025

An act to amend Section 14197 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 530, as amended, Richardson. Medi-Cal: time and distance standards.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Existing law establishes, until January 1, 2026, certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified.

This bill would extend the operation of those standards indefinitely. The bill would also require a managed care plan to ensure that each subcontractor network complies with certain appointment time standards unless already required to do so. The bill would set forth related reporting requirements with regard to subcontractor networks.

Existing law permits the department to authorize a managed care plan to use clinically appropriate video synchronous interaction, as defined,

as a means of demonstrating compliance with the time or distance standards.

Under this bill, the use of telehealth providers to meet time or distance standards would not absolve the managed care plan of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. The bill would set forth other related provisions with regard to the use of telehealth.

Existing law permits the department, upon request of a managed care plan, to authorize alternative access standards for the time or distance standards if either of the following occur: (1) the requesting plan has exhausted all other reasonable options to obtain providers to meet the applicable standard; or (2) the department determines that the requesting plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

This bill would recast those provisions and would specify, under both circumstances, that there be an appropriate level of care and access that is consistent with professionally recognized standards of practice, with a departmental determination that the alternative access standards will not have a detrimental impact on the health of enrollees. *The bill would require the department to consider the sufficiency of payment rates offered by the Medi-Cal managed care plan to the provider type or for the service type when evaluating requests for the utilization of alterative access standards. The bill would also require the department to publish, and periodically update as necessary, the criteria for evaluation and authorizing alternative access standards under the above-described provisions, as specified.* The bill would make other changes to the procedure for a managed care plan to submit a previously approved alternative access standard request.

Existing law requires the department to annually evaluate a managed care plan's compliance with the time or distance and appointment time ~~standards.~~ *standards and to annually publish a report of its findings, as specified.*

This bill would require that the evaluation be performed using a direct testing method and an examination of complaints data, as specified. *The bill would, effective for contract periods commencing on or after January 1, 2026, additionally require the report to include, for each of the preceding 3 years, the number and percentage of enrollees that are subject to an approved alternative access standard, and the number and percentage of alternative access standards requested, approved, and denied, as specified.*

Existing law defines "specialist" for purposes of these provisions, including with regard to a managed care plan's requirement to maintain a network of providers located within the time or distance standards.

This bill would expand the scope of the definition for "specialist" to include providers of immunology, urology, and sleep medicine, among other additional areas of medicine.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14197 of the Welfare and Institutions Code is amended to read:

14197. (a) It is the intent of the Legislature that the department implement and monitor compliance with the time or distance requirements set forth in Sections 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

(b) Commencing January 1, 2018, for covered benefits under its contract, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time or distance standards for the following services:

(1) For primary care, both adult and pediatric, 10 miles or 30 minutes from the beneficiary's place of residence.

(2) For hospitals, 15 miles or 30 minutes from the beneficiary's place of residence.

(3) For dental services provided by a Medi-Cal managed care plan, 10 miles or 30 minutes from the beneficiary's place of residence.

(4) For obstetrics and gynecology primary care, 10 miles or 30 minutes from the beneficiary's place of residence.

(c) Commencing July 1, 2018, for the covered benefits under its contracts, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time or distance standards for the following services:

(1) For specialists, as defined in subdivision (i), adult and pediatric, including obstetric and gynecology specialty care, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(2) For pharmacy services, 10 miles or 30 minutes from the beneficiary's place of residence.

(3) For outpatient mental health services, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(4) (A) For outpatient substance use disorder services other than opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

(B) For opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(iv) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(d) (1) (A) A Medi-Cal managed care plan shall comply with the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety Code, Section 1300.67.2.2 of Title 28 of the California Code of Regulations, subject to any authorized exceptions in Section 1300.67.2.2 of Title 28 of the

California Code of Regulations, and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

(B) Commencing July 1, 2018, subparagraph (A) applies to Medi-Cal managed care plans that are not, as of January 1, 2018, subject to the appointment time standards described in subparagraph (A).

(C) Commencing on January 1, 2026, a Medi-Cal managed care plan shall ensure that each subcontractor network complies with the appointment time standards described in subparagraph (A), unless already required to ensure compliance.

(2) A Medi-Cal managed care plan shall comply with the following availability standards for skilled nursing facility services and intermediate care facility services, as follows:

(A) Within five business days of the request for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Within seven business days of the request for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Within 14 calendar days of the request for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Within 14 calendar days of the request for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(3) A county Drug Medi-Cal organized delivery system shall provide an appointment within three business days to an opioid treatment program.

(4) A dental managed care plan shall provide an appointment within four weeks of a request for routine pediatric dental services and within 30 calendar days of a request for specialist pediatric dental services.

(e) The department may authorize a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5

of the Business and Professions Code, as a means of demonstrating compliance with the time or distance standards established pursuant to this section, as defined by the ~~department.~~ *department, or imposed under a contract.* The use of telehealth providers to meet time or distance standards does not absolve the Medi-Cal managed care plan of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers.

(f) (1) The department may develop policies for granting credit in the determination of compliance with time or distance standards established pursuant to this section *or imposed under a contract* when Medi-Cal managed care plans contract with specified providers to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions Code, and only for Medi-Cal managed care plans that cover at least 85 percent of the population points in the ZIP Code.

(2) *(A)* The department, upon request of a Medi-Cal managed care plan, may authorize alternative access standards for the time or distance standards established under this section *or imposed under a contract* if either of the following occur:

~~(A)~~

(i) The requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet the applicable standard, and the department determines that the requesting Medi-Cal managed care plan has demonstrated that it is capable of delivering an appropriate level of care and access that is consistent with professionally recognized standards of practice, and has determined and noted in the relevant record that the alternative access standards will not have a detrimental impact on the health of enrollees.

~~(B)~~

(ii) The department determines that the requesting Medi-Cal managed care plan, in the case of an alternate health care service plan as defined in Section 14197.11, has demonstrated that its delivery structure is capable of delivering an appropriate level of care and access that is consistent with professionally recognized standards of practice, and has determined and noted in the relevant record that the alternative access standards will not have a detrimental impact on the health of enrollees.

(B) The department shall publish, and periodically update as necessary, the standards and criteria for evaluating and authorizing alternative access standards described in subparagraph (A). The department shall consult with affected stakeholders prior to publishing or updating the standards and criteria required by subparagraph (A).

(3) (A) If a Medi-Cal managed care plan cannot meet the time or distance standards set forth in this ~~section,~~ *section or imposed under a contract,* the Medi-Cal managed care plan shall submit a request for alternative access standards to the department, in the form and manner specified by the department.

(B) An alternative access standard request may be submitted at the same time as the Medi-Cal managed care plan submits its annual demonstration of compliance with time or distance standards, if known at that time and at any time the Medi-Cal managed care plan is unable to meet time or distance standards.

(C) A Medi-Cal managed care plan is required to submit a previously approved alternative access standard request to the department for review and approval on an annual basis. For Medi-Cal managed care plans that have a previously approved alternative access standard request and are requesting an extension or modification of alternative access standards, the extension or modification request shall include steps taken to obtain providers to meet the applicable standard and shall demonstrate that the alternative access standards will not have a detrimental impact on the health of enrollees. If steps taken do not differ from previous attempts to obtain providers, the Medi-Cal managed care plan shall explain why alternative provider recruitment strategies were not attempted.

(D) A Medi-Cal managed care plan shall close out any corrective action plan deficiencies in a timely manner to ensure that beneficiary access is adequate, including notifying affected beneficiaries of their options to receive services for which the network is inadequate, and shall continually work to improve access in its provider network.

(4) A request for alternative access standards shall be approved or denied on a ZIP Code and provider type, including specialty type, basis by the department within 90 days of submission of the request. The Medi-Cal managed care plan shall also include a description of the reasons justifying the alternative access standards

based on those facts and circumstances. Effective no sooner than contract periods commencing on or after July 1, 2020, the Medi-Cal managed care plan shall include a description on how the Medi-Cal managed care plan intends to arrange for beneficiaries to access covered services if the health care provider is located outside of the time or distance standards specified in subdivision (c). Effective no sooner than contract periods commencing on or after ~~July~~ *January* 1, 2026, the Medi-Cal managed care plan shall notify beneficiaries of their option to use or not use telehealth, covered transportation services, or out-of-network providers to access covered services if the health care provider is located outside of the time or distance standards specified in subdivision (c). The department may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Medi-Cal managed care plan requesting the alternative access standards. Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume at the same point in time it was previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information. If the department rejects the Medi-Cal managed care plan's proposal, the department shall inform the Medi-Cal managed care plan of the department's reason for rejecting the proposal. The department shall post any approved alternative access standards on its internet website.

(5) *(A)* As part of the department's evaluation of a request submitted by a Medi-Cal managed care plan to utilize an alternative access standard pursuant to this subdivision, the department shall evaluate and determine whether the resulting time or distance is reasonable to expect a beneficiary to travel to receive care, and whether it is consistent with professionally recognized standards of practice, and shall determine and note in the relevant record whether the alternative access standards will not have a detrimental impact on the health of enrollees.

(B) Effective for contract periods commencing on or after January 1, 2026, as part of the department's evaluation of a request pursuant to this subdivision, the department shall 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.

(6) The department may authorize a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions Code, as part of an alternative access standard request.

(g) (1) (A) Effective for contract periods commencing on or after July 1, 2018, a Medi-Cal managed care plan shall, on an annual basis and when requested by the department, demonstrate to the department the Medi-Cal managed care plan's compliance with the time or distance and appointment time standards developed pursuant to this ~~section.~~ *section or imposed under a contract.* The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, core specialist services, and each subcontractor network.

(B) Effective for contract periods commencing on or after ~~July~~ *January* 1, 2026, the report described in this paragraph shall measure compliance separately for new and returning patients.

(C) Failure to comply with this paragraph may result in contract termination or the issuance of sanctions pursuant to Section 14197.7.

(2) Effective for contract periods commencing on or after July 1, 2020, the Medi-Cal managed care plan shall demonstrate, on an annual basis, and when requested by the department, to the department how the Medi-Cal managed care plan arranged for the delivery of Medi-Cal covered services to Medi-Cal enrollees, such as through the use of either Medi-Cal covered transportation or clinically appropriate video synchronous interaction, as specified in paragraph (6) of subdivision (f), if the enrollees of a Medi-Cal managed care plan needed to obtain health care services from a health care provider or a facility located outside of the time or distance standards, as specified in subdivision (c).

The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, core specialist services, and each subcontractor network.

(3) (A) Effective for contract periods commencing on or after July 1, 2018, the department shall evaluate on an annual basis a Medi-Cal managed care plan's compliance with the time or distance and appointment time standards implemented pursuant

to this ~~section.~~ *section or imposed under a contract.* This evaluation may include, but need not be limited to, annual and random surveys, investigation of complaints, grievances, or other indicia of noncompliance. Nothing in this subdivision shall be construed to limit the appeal rights of a Medi-Cal managed care plan under its contracts with the department.

(B) Effective for contract periods commencing on or after ~~July~~ *January* 1, 2026, the evaluation by the department as described in this paragraph shall be performed using the following two methods:

(i) A direct testing method, which shall include, but need not be limited to, a "secret shopper" method. The direct testing shall be used to evaluate compliance with the appointment time standards set forth in subdivision (d) for appointments. To determine compliance with the urgent care standard, the evaluation shall measure the network's ability to provide urgent care within 48 hours pursuant to Section 1367.03 of the Health and Safety Code and Section 1300.67.2.2(c)(5)(A) of Title 28 of the California Code of Regulations. The evaluation shall also utilize a method for accounting for and reporting the number of providers who are unavailable or unreachable for purposes of the evaluation.

(ii) An examination of appointment time standards complaints data submitted to the plan, the Department of Managed Health Care if the plan is licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the department.

(C) Failure to comply with this paragraph may result in contract termination or the issuance of sanctions pursuant to Section 14197.7.

(4) *(A)* The department shall publish annually on its internet website a report that details the department's findings in evaluating a Medi-Cal managed care plan's compliance under paragraph (2). At a minimum, the department shall specify in this report those Medi-Cal managed care plans, if any, that were subject to a corrective action plan due to noncompliance with the time or distance and appointment time standards implemented pursuant to this section *or imposed under a contract* during the applicable year and the basis for the department's finding of noncompliance. The report shall include a Medi-Cal managed care plan's response to the corrective plan, if available.

(B) Effective for contract periods commencing on or after January 1, 2026, the report required pursuant to this paragraph shall also specify, for each year for the three preceding years, both of the following:

(i) The number and percentage of enrollees in each ZIP Code in each Medi-Cal managed care plan that are subject to an approved alternative access standard, by service category or specialty, as applicable.

(ii) The number and percentage of alternative access standards for Medi-Cal managed care plans that were requested, approved, and denied, by region, service category, or specialty, as applicable.

(h) The department shall consult with Medi-Cal managed care plans, including dental managed care plans, mental health plans, and Drug Medi-Cal Organized Delivery System programs, health care providers, consumers, providers and consumers of long-term services and supports, and organizations representing Medi-Cal beneficiaries in the implementation of the requirements of this section.

(i) For purposes of this section, the following definitions apply:

(1) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.9 (commencing with Section 14088).

(F) Article 2.91 (commencing with Section 14089).

(G) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(H) Chapter 8.9 (commencing with Section 14700).

(I) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(2) "Specialist" means a provider specializing in any of the following areas of medicine:

(A) Cardiology/interventional cardiology.
(B) Nephrology.
(C) Dermatology.
(D) Neurology/neurosurgery.
(E) Endocrinology.
(F) Ophthalmology.
(G) Ear, nose, and throat/otolaryngology.
(H) Orthopedics/orthopedic surgery.
(I) Gastroenterology.
(J) Physical medicine and rehabilitation.
(K) General surgery, including the following subspecialties:
(i) Gender-affirming surgery.
(ii) Colorectal surgery.
(iii) Plastic surgery.
(L) Psychiatry.
(M) Hematology.
(N) Oncology/surgical oncology.
(O) Pulmonology.
(P) HIV/AIDS specialists/infectious diseases.
(Q) Rheumatology.
(R) Urology.
(S) Immunology/allergy.
(T) Podiatry.
(U) Sleep medicine.

(3) "Subcontractor network" means a provider network of a subcontractor or downstream subcontractor, wherein the subcontractor or downstream subcontractor is delegated risk and is responsible for arranging for the provision of, and paying for, covered services as stated in their subcontractor or downstream subcontractor agreement.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

(k) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals

are obtained and federal financial participation is available and is not otherwise jeopardized.

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