AB 55

Emergency medical services. This bill would set the Medi-Cal fee-for-service reimbursement rate for emergency medical transports at $350 per transport. Under the bill, the resulting fee-for-service payment schedule amounts would instead be equal to the sum of the Medi-Cal fee-for-service payment schedule amount, based on the $350 rate, and the add-on increase.

Under existing law, the increased payments under the add-on provisions are funded solely from a quality assurance fee (QAF), which emergency medical transport providers are required to pay based on a specified formula, and from federal reimbursement and any other related federal funds.

This bill would specify that the $350 reimbursement rate would not affect the calculation of the QAF rate, and that the calculation of the QAF rate would be based on the methodology and reimbursement rate in effect as of January 1, 2023.

Existing law authorizes the Director of Health Care Services to modify or make adjustments to any methodology or fee amount under these provisions to the extent necessary to meet federal requirements or to obtain federal approval.

If a modification or adjustment is needed to meet federal requirements or to obtain federal approval, this bill would require the director to recalculate and reduce the add-on amount as necessary, and would prohibit the director from reducing the $350 reimbursement rate.

AB 608

Medi-Cal: comprehensive perinatal services.

This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered. Status: vetoed by Governor.

AB 616

Medical Group Financial Transparency Act.
This bill, the Medical Group Financial Transparency Act, would authorize the disclosure of audited financial reports and comprehensive financial statements of providers and physician organizations collected by the Office of Health Care Affordability and financial and other records of risk-bearing organizations made available to the Department of Managed Health Care. The bill would also make related findings and declarations. Status: vetoed by Governor.

AB 620

Health care coverage for metabolic disorders.
This bill would require a health care service plan contract and disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after January 1, 2024, to provide coverage for the testing and treatment of other digestive and inherited metabolic disorders. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. Status: vetoed by Governor.

AB 632

Health care coverage: prostate cancer screening.
This bill would prohibit a health care service plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, from applying a deductible, copayment, or coinsurance to coverage for prostate cancer screening services for an enrollee or insured who is 55 years of age or older or who is 40 years of age or older and is high risk, as determined by the attending or treating health care provider. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. Status: vetoed by Governor.

AB 719

Medi-Cal benefits.
This bill would require the department to require managed care plans to contract with public transit operators for the purpose of establishing reimbursement rates for nonmedical and nonemergency medical transportation trips provided by a public transit operator. The bill would require the rates reimbursed by the managed care plan to the public transit operator to be based on the department’s fee-for-service rates for nonmedical and nonemergency medical transportation service. Status: vetoed by Governor.

AB 907

Coverage for PANDAS and PANS. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to provide coverage for treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) prescribed or ordered by a provider. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other similar benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for medically necessary treatment of PANDAS or PANS solely because the enrollee or insured previously received treatment for PANDAS or PANS or has been diagnosed with or received treatment for the condition under a different diagnostic name. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. Status: vetoed by Governor.

AB 931

Prior authorization: physical therapy. This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides coverage for physical therapy from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. Status: vetoed by Governor.

AB 1230

Medi-Cal and Medicare: dual eligible beneficiaries: special needs plans.
This bill would require the department, commencing no later than January 1, 2025, to offer contracts to health care service plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), as defined, to provide care to dual eligible beneficiaries.
The bill would require that a HIDE-SNP or FIDE-SNP contract authorize a beneficiary to select from a number of available options and to maintain their established or selected health care providers. The bill would also require a contracting plan to perform all applicable required care coordination and data-sharing functions, and to provide documentation demonstrating the care integration that dual eligible beneficiaries receive through a HIDE-SNP or FIDE-SNP contract.

AB 317

Pharmacist service coverage.
This bill would instead require a health care service plan and certain disability insurers that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist to pay or reimburse the cost of services performed by a pharmacist at an in-network pharmacy or by a pharmacist at an out-of-network pharmacy if the health care service plan or insurer has an out-of-network pharmacy benefit. Because a willful violation of the bill’s requirements

relative to health care service plans would be a crime, the bill would impose a state-mandated local program.