Date of Hearing: June 28, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 987 (Portantino) – As Amended June 20, 2022

SENATE VOTE: 34-0

SUBJECT: California Cancer Care Equity Act.

SUMMARY: Requires a Medi-Cal managed care (MCMC) plan to make a good faith effort to include in its contracted provider network at least one National Cancer Institute-designated Comprehensive Cancer Center (NCI-designated CCC), a site affiliated with the NCI Community Oncology Research Program (NCORP) or a Qualifying Academic Cancer Center (a QACC is effectively defined as Cedars-Sinai Medical Center) located within the beneficiary's county of residence or, if none exists in that county, located within the nearest county that has an NCI-designated CCC, NCORP affiliated site or specialized cancer center. Requires a MCMC plan to allow an eligible enrollee diagnosed with a complex cancer diagnosis (as defined) to directly access oncology, hematology, or other relevant specialists through an NCI-designated CCC, NCORP-affiliated site, or QACC, as appropriate, for the enrollee's condition and identified needs. Requires each applicable MCMC plan to reimburse an NCI-designated CCC, NCORP affiliated site or QACC provider furnishing services to a Medi-Cal beneficiary with a complex cancer diagnosis enrolled in that plan, and each NCI-designated CCC, NCORP affiliated site or QACC to accept the payment amount for those services, the amount by the Department of Health Care Services (DHCS) upon consultation with the MCMC plans, the NCI-designated CCC, the NCORP affiliated site and QACC, if the MCMC plan and the NCI-designated CCC, NCORP affiliated site or QACC, do not otherwise have an agreed-upon contracted rate. Specifically, **this bill**:

1) Requires a MCMC plan, for benefits under its contract with DHCS, to do both of the following:

    a) Make a good-faith effort to include in its contracted provider network at least:
        i) One NCI-designated CCC;
        ii) A site affiliated with the NCORP; or
        iii) A QACC (as defined), located within the beneficiary's county of residence or, if none exists in that county, located within the nearest county that has an NCI-designated CCC, NCORP-affiliated site, or QACC.

    b) Ensure that any beneficiary diagnosed with a complex cancer diagnosis is referred to an NCI-designated CCC, NCORP-affiliated site, or QACC within 15 business days of the diagnosis, unless the beneficiary chooses a different cancer treatment provider.

2) Defines a "complex cancer diagnosis" as a diagnosis for hematological malignancies, acute leukemia, multiple myeloma, advanced, relapsed, refractory non-Hodgkin lymphoma, rare hematological malignancies including blastic plasmacytoid dendritic cell neoplasm (BPDCN) and T-cell leukemias and lymphomas, and solid tumors including pancreatic cancer, advanced-stage lung cancer, advanced-stage prostate cancer, advanced-stage breast cancer, sarcomas, liver, and biliary cancer, relapsed, refractory gastric cancer, advanced-stage

relapsed, refractory colorectal cancer, or any other condition as determined pursuant to 13) below. Defines "advanced stage" cancer to mean stage IV metastatic cancer.

3) Defines an "NCORP affiliated site" as a cancer center that has received an approved grant from NCI through NCORP that provides cancer clinical trials and care delivery studies.

4) Requires a MCMC plan to comply with all of the following:

   a) Make a good-faith effort to contract with at least one:
      i) NCI-designated CCC;
      ii) A site affiliated with the NCI NCORP; or,
      iii) A QACC, within its primary network for provision of services to any eligible enrollee diagnosed with a complex cancer diagnosis.

   b) Allow any eligible enrollee diagnosed with a complex cancer diagnosis to choose to receive services through an NCI-designated CCC, NCORP-affiliated site, or QACC;
   c) Allow an eligible enrollee diagnosed with a complex cancer diagnosis to directly access oncology, hematology, or other relevant specialists through an NCI-designated CCC, NCORP-affiliated site, or QACC, as appropriate, for the enrollee's condition and identified needs;
   d) Inform an enrollee within seven calendar days of the enrollee receiving a complex cancer diagnosis of the enrollee's eligibility to receive cancer care at an NCI-designated CCC, NCORP-affiliated site, or QACC, any restrictions on the enrollee's choice to receive that care, and grievance, appeal, and fair hearing procedures and timeframes should the enrollee's choice be denied;

   e) Ensure that the services of an NCI-designated CCC, NCORP-affiliated site, or QACC available to an eligible enrollee are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished; and,

   f) Refrain from arbitrarily denying or reducing the amount, duration, or scope of required services solely because of diagnosis, type of illness, or condition of the beneficiary.

5) Requires a MCMC to also inform the enrollee of their ability to access Medi-Cal covered nonmedical transportation services if needed to access their care.

6) Requires contracts between MCMC plans and applicable health care providers to require the treating provider who determines cancer stage or response to treatment to inform enrollees who receive a complex cancer diagnosis of the right to receive care through an NCI-designated CCC, NCORP-affiliated site, or QACC.

7) Requires a MCMC plan to provide written and verbal notice to all enrollees of their right to access care through an NCI-designated CCC, NCORP-affiliated site, or QACC, if they are diagnosed with a complex cancer diagnosis.

8) Requires DHCS, in consultation with representatives of NCI-designated CCCs, NCORP-affiliated sites, QACCs, patients or patient advocates, and MCMC plans, to develop a standard written notice and process for verbally notifying enrollees of their right to access cancer treatment care through an NCI-designated CCC, NCORP-affiliated site, or QACC.

9) Requires each applicable MCMC plan, beginning January 1, 2023, to reimburse an NCI-designated CCC, NCORP-affiliated site, or QACC provider furnishing services to a Medi-Cal beneficiary with a complex cancer diagnosis enrolled in that plan, and requires each NCI-designated CCC, NCORP-affiliated site, or QACC to accept the payment amount for those services, the amount set by DHCS upon consultation with the MCMC plans, NCI-designated CCCs, NCORP-affiliated sites, and QACCs, if the MCMC plan and the NCI-designated CCC, NCORP-affiliated site, or QACC do not otherwise have an agreed-upon contracted rate.

10) Requires, for contract periods during which 9) above is implemented, capitation rates paid by DHCS to a MCMC plan to be actuarially sound and to account for the payment levels described in 9) above.

11) Permits DHCS to require MCMC plans and NCI-designated CCC, NCORP-affiliated site, or QACC providers to submit information DHCS deems necessary to implement 9) above, at the times and in the form and manner specified by DHCS.

12) Requires DHCS, for contract periods during which 9) above is implemented, to develop and implement risk mitigation strategies, such as a risk corridor or supplemental capitation payment, and requires risk mitigation strategies to be developed in consultation with MCMC plans and NCI-designated CCCs, NCORP-affiliated sites, and QACCs.

13) Requires DHCS to develop a process for updating and further defining a "complex cancer diagnosis" on a periodic basis, and requires the process to include an advisory committee consisting of experts in the field of oncology and stakeholders, including, but not limited to, oncologists, representatives of NCI-designated CCCs, NCORP-affiliated sites, and QACCs, representatives of MCMC plans, and cancer patient advocacy groups.

14) Permits DHCS to implement, interpret, or make specific 4) through 13) above, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar guidance, without the adoption of regulations pursuant to the Administrative Procedures Act until any necessary regulations are adopted.

15) Requires DHCS to seek any federal approvals it deems necessary to implement 4) through 14) above, and implements these provisions only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

16) Adds, as an additional basis for an MCMC plan's expedited review process and expedited resolution of an appeal, when a request from the beneficiary or provider is for, or related to, treatment pursuant to a complex cancer diagnosis, as defined by this bill.

17) Requires a MCMC plan, for purposes of 16) above, to give a request for, or related to, treatment pursuant to a complex cancer diagnosis, as defined, an expedited authorization decision pursuant to a specified Medicaid managed care regulation.

18) Makes legislative findings that:

a) Effective treatment of complex cancers relies on the accuracy of initial diagnosis, timeliness of intervention, choice of therapy, collaboration among multiple experts, and access to appropriate clinical trials or emerging therapies;
b) NCI CCC are recognized for their scientific leadership, resources, and exceptional depth and breadth of transdisciplinary research that bridges the fields of prevention, cancer control, and population science;
c) The NCORP is a national network that brings cancer clinical trials and care delivery studies to patients in their own communities and contributes to improved patient outcomes and a reduction in cancer disparities for all people; and,
d) Varying levels of access to quality cancer care correlated with socioeconomic status lead to disparities in cancer outcomes, disfavoring the most vulnerable and disadvantaged patients.

19) States legislative intent that a MCMC beneficiary who has received a complex cancer diagnosis will be eligible to receive and able to access the services of an NCI-designated CCC, NCORP-affiliated site, or QACC.

20) Requires this bill to be known, and permits it be cited, as the California Cancer Care Equity Act.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by DHCS, under which low-income individuals are eligible for medical coverage.

2) Establishes the schedule of benefits for the Medi-Cal program, which includes, among other things, the coverage of physician, hospital, or clinic outpatient services, inpatient hospital services, and prescription drugs including any drug for cancer, opportunistic infections associated with cancer, or any drug or biologic used in an anticancer chemotherapeutic regimen that is approved by the federal Food and Drug Administration where the manufacturer has a contract with the Health Care Financing Administration.

3) Authorizes the Director of DHCS to contract, on a bid or nonbid basis, with any qualified individual, organization, or entity to provide services to, arrange for, or case manage the care of Medi-Cal beneficiaries.

4) Requires MCMC plans to maintain a network of providers within specified time and distance standards, with differing requirements by provider type and county.

5) Requires a MCMC plan, if a plan cannot meet the time and distance standards, to submit a request for alternative access standards.

6) Requires MCMC plans to comply with the appointment time standards in existing Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) regulation.

7) Sunsets the MCMC time and distance standards and appointment time standards on January 1, 2023.

8) Requires a MCMC plan to resolve an appeal no more than 30 calendar days from the day the MCMC plan receives the appeal.

9) Requires a MCMC plan to resolve an expedited appeal no longer than 72 hours after the plan receives the appeal. Requires a MCMC plan to establish and maintain an expedited review process for a beneficiary or the beneficiary's provider to request an expedited resolution of an appeal based on either of the following circumstances:

    a) If the plan determines, for a request from the beneficiary, or the provider indicates, in making the request on the beneficiary's behalf or supporting the beneficiary's request, that taking the time for a standard resolution under the 30 day timeframe could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, or regain, maximum function; or,
    b) When the beneficiary's condition is such that the beneficiary faces an imminent and serious threat to the beneficiary's health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the 30 day timeframe would be detrimental to the beneficiary's life or health or could jeopardize the beneficiary's ability to regain maximum function.

10) Requires, under federal Medicaid managed care regulations, for cases in which a provider indicates, or the plan determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the plan to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

11) Permits, under the federal Medicaid managed care regulation, the plan to extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the plan justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

FISCAL EFFECT: According to the Senate Appropriations Committee, estimates unknown, significant ongoing costs (possibly hundreds of thousands to million, General Fund/federal fund) for DHCS for state operations workload to: ensure any beneficiary diagnosed with a complex cancer diagnosis, as defined, is referred to an NCI-designated CCC within 15 business days; review existing MCMC plans and networks; develop a standardized notice to enrollees on their right to access cancer treatment care through an NCI-designated Cancer Center; develop and implement risk mitigation strategies; and convene the advisory committee of oncology experts and specified stakeholders. While cancer treatments are typically covered services under MCMC plans, to the extent an enrollee elects to get services at NCI-designated CCC, there may also be costs to DHCS to updating Medi-Cal rates and reimbursements. Staff notes, if referrals, under this bill are made in a manner than currently, there may be anticipated health offsets in other systems that would avoid treatment of later-stage cancers.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, sadly there are serious inequalities in access to care for cancer patients. The impact of these care disparities are greater for patients who are Medi-Cal beneficiaries, especially those who come from underserved communities.

Health insurance doesn't guarantee access to experts specializing in complex cancer types, promising clinical trials, and advances in personalized, precision cancer treatments. With advances in cancer science and more effective treatments, it's critical that we ensure all cancer patients have access to new science and technology that can improve health outcomes for patients and their families. The author concludes this bill provides a more equitable model of health care for cancer patients.

2) **BACKGROUND**. DHCS contracts with over 24 MCMC plans through six models of MCMC to provide all medically necessary health care services to Medi-Cal beneficiaries under a per member per month capitated rate, unless that service is "carved out" of the plan contract, such as outpatient prescription drugs (provided through Medi-Cal fee-for-service (FFS)) or the provision of specialty mental health services for persons with severe mental illness (provided by county mental health plans). MCMC plans negotiate payment rates with most providers and determine which health care providers are in their provider network. Under MCMC plans, Medi-Cal beneficiaries must use plan-contracted health care providers (except for emergency services and family planning services, described below). There are some exceptions to this process. For example, there has long been in federal Medicaid law a "freedom of choice" provision for family planning services. California also codified this practice in state through SB 743 (Hernandez), Chapter 572, Statutes of 2017, which prohibited a MCMC plan from restricting the choice of the qualified provider, from whom a Medi-Cal beneficiary enrolled in the plan may receive family planning services and requires a MCMC plan to reimburse an out-of-plan or out-of-network qualified provider at the applicable FFS rate. In addition, existing MCMC regulations, for the two-plan model of MCMC in twelve counties, requires the local initiative (the public plan in those counties) to agree to:

   a) Include in its health care delivery system under the contract any safety net provider (as defined) that is physically located and operating within the designated region that is willing to agree to provide services under the same terms and conditions that the plan requires of any other similar provider included in the health care delivery system under the contract; and,

   b) Establish participation standards for any provider of medical or hospital services, physically located and operating within the region, that will ensure the opportunity for substantial participation of traditional providers (as defined), in the health care delivery system under the contract.

   As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative as passed in a 2021-2022 health budget trailer bill, AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, DHCS sought to make Medi-Cal benefits uniform across the various MCMC plan delivery models. This included requiring all models of MCMC to cover organ donor and transplant surgeries as part of their contract with DHCS, effective January 1, 2022, rather than having those services carved out in most MCMC models. Previously, organ donor and transplant surgeries were only a MCMC plan benefit in the 22 county organized health system counties. In addition, until December 31, 2024, MCMC plans are required to reimburse a provider furnishing organ or bone marrow transplant surgeries, and requires each provider of organ or bone marrow transplant surgeries to accept, the payment amount the provider of organ or bone marrow transplant surgeries would be paid for those services in the Medi-Cal FFS delivery system, as defined by DHCS.

This bill follows a similar but not identical model for complex cancer treatment. Rather than have an MCMC plan negotiate a rate with the cancer providers designated by this bill as they can now, the MCMC plan would pay the cancer center DHCS' rate for the services, instead of the FFS rate, as is required for organ donor and transplant surgeries.

3) **CANCER PROVIDERS UNDER THIS BILL**. This bill requires MCMC plans to make a good faith effort to include in its contracted provider network at least one of three entities: an NCI-designated CCC, a site affiliated with a NCORP or a QACC.

   a) An "NCI-designated CCC" is a cancer center that meets ongoing standards for cancer prevention, clinical services, and research, as determined by regular reviews and evaluations by NCI. The NCI-designated CCC centers in California are as follows: University of California Irvine Comprehensive Cancer Center, Stanford Cancer Institute, City of Hope Comprehensive Cancer Center, UC Davis Comprehensive Cancer Center, UCLA Jonsson Comprehensive Cancer Center, UCSD Moores Comprehensive Cancer Center, Stalk Institute Cancer Center, UCSF Helen Diller Family Comprehensive Cancer Center, Sanford Burnham Preby Medical Discovery Institute, and the USC Norris Comprehensive Cancer Center.

   b) NCORP is a national network that brings cancer clinical trials and care delivery studies to patients. The NCORP network designs and conducts clinical trials in certain focus areas, including cancer prevention, screening, supportive care and symptom management, surveillance, health-related quality of life, and cancer care delivery. The NCORP network also participates in treatment and imaging clinical trials conducted by the NCI National Clinical Trials Network (NCTN). The NCORP network is the primary source of accrual to NCI cancer control symptom management trials and to health-related quality of life trials that are embedded into NCTN treatment trials. There are over nearly 60 NCROP provider locations in California, including over 45 Kaiser locations.

   c) QACC is defined in this bill as a research and clinical cancer center that meets seven criteria in this bill intended to describe Cedars Sinai Medical Center, a trauma hospital with 889 licensed beds in Los Angeles. A QACC is defined in this bill as an institution with:
      i) A medical oncology or hematology subspecialty expertise in each of the diagnoses included in this bill;
      ii) It has a portfolio of Phase 1, 2, and 3 clinical trials for each of the cancer types included in this bill;
      iii) It provides fellowship programs in medical oncology, hematology or hematological oncology, radiation oncology, or a surgical oncology specialty;
      iv) It provides inpatient and outpatient supportive care services;
      v) It covers clinical, anatomic, and molecular pathology with subspecialty expertise for each of the cancer types included in paragraph;
      vi) It provides a program accredited by the American College of Surgeons Commission on Cancer; and,
      vii) It has accreditation for the main campus by the Foundation for the Accreditation of Cellular Therapy.

4) **CANCER CARE.** Cancer is leading cause of mortality. Published studies have found cancer care provided to people of color is not in accordance with established guidelines, outcomes

of cancer treatment vary widely in relation to where patients receive their care, and lower survival rates based on insurance coverage. A 2016 study by UC Davis found that significant disparities in cancer survival and quality of care were found among persons having different sources of health insurance. The greatest number and largest disparities were found among persons insured by Medi-Cal, being dually eligible for both Medicare-Medi-Cal, or having no insurance. Conducted on Medi-Cal prior to the expansion of coverage under the federal Patient Protection Affordable Care Act, the study found those with Medi-Cal had little advantage over the uninsured. Medi-Cal patients having breast, colon and rectal cancer were more likely to be diagnosed at an advanced stage of disease and to have less favorable five-year survival rates than persons having other sources of health insurance. Medicare-Medi-Cal dual eligible patients were the least likely to receive recommended treatment for breast and colon cancer.

5) **SUPPORT**. This bill is jointly sponsored by the City of Hope and the American Cancer Society Cancer Action Network to remove barriers that disproportionately prevent Californians in underserved communities from accessing optimal cancer care. The sponsors and supporters argue that, for too long, too many patients—especially those historically underserved—have been denied the opportunity to equally benefit from the latest advancements in cancer care. Recognition of these disparities in access—and the connection between access and survival—is the first step on a path toward more equitable and more effective cancer care for all Californians. Supporters cite studies that Californians insured with Medi-Cal suffer much worse-than-average outcomes for several cancer diagnoses, including lung cancer and breast cancer, and that 34% of cancer deaths among all U.S. adults ages 25 to 74 could be prevented if socioeconomic disparities were eliminated, and that patients receiving care from designated specialists saw a 53% reduction in the odds of early mortality, but less than half of California cancer patients received care aligned with national guidelines between 2004 and 2016. Approximately 189,000 Californians are expected to be diagnosed with cancer each year, making the increase of access to the optimal treatment for a patient's diagnosis critical – and can save lives.

   The sponsors and supporters argue this bill would ensure that Medi-Cal enrollees who receive a complex cancer diagnosis have the choice to seek treatment at a NCI-designated CCC, increasing the pool of Californians able to benefit from emerging therapies, clinical trials, and cancer doctors specializing in a particular type of cancer. A population-based model developed using Medi-Cal and California cancer registry data shows that approximately 17,000 Medi-Cal members with complex cancers (as defined in this bill) would be eligible annually for treatment under the access model outlined in the legislation. Supporters argue this bill is built on the recognition that cancer care is different, and that the current one-size-fits-most system is preventing too many California cancer patients from accessing optimal care. Cancer care is evolving at a pace that has resulted in dramatic changes to the diagnosis and treatment of patients. Delivering the best outcomes for certain complex cancer diagnoses increasingly relies on precision genetic and genomic testing to enable cancer subspecialists to develop personalized courses of care for a patient's particular subtype of cancer. Too many patients are being hurt by a one-size-fits-most system that often results in wrong care and connects patients to care too late, shortening lives and ultimately increasing costs. Too many Californians realize that health insurance coverage does necessarily add up to access to the care they need. This bill is a critical step to improving cancer care equity in California.

Western Center on Law & Poverty (WCLP) writes in support, stating its legal aid advocates report difficulty having plans authorize services at NCI-designated CCCs, and often have to establish separate letters of agreements to access these centers. WCLP writes that, ideally, with DCHS' proposal to transform Medi-Cal through CalAIM, Medi-Cal plans would be providing the comprehensive wraparound services through their network. However, considering the current difficulty accessing these centers and lack of comprehensive wraparound services provided by Medi-Cal plans, it supports this bill.

6) **OPPOSITION**. The California Association of Health Plans (CAHP) writes in opposition that, while it appreciates the intent of the bill and agree that ensuring access to complex cancer treatment is critical, CAHP is concerned that this bill will unintentionally lead to significant disruptions in patient care and create significant administrative and compliance challenges for managed care plans and providers. First, CAHP writes it is concerned that this bill would require a MCMC plan to include designated cancer providers within its primary plan network without the ability to delegate this responsibility to its delegated provider networks. CAHP writes that delegated provider networks are often responsible for utilization management and authorization procedures on behalf the primary health plan. CAHP argues creating a new process for which to submit authorizations back to the primary plan would create a significant burden on health plans and may cause delays in approval that would jeopardize our ability to meet existing contractually required time frames for such approvals. CAHP notes that DHCS is currently working on rules that would subject subcontracted networks to the same requirements as primary plan networks later this year, and it is not clear how imposing a contracting requirement only on the primary managed care plan would impact the implementation of this bill.

   Second, CAHP objects to the provision of this bill that permits beneficiaries to initiate a pre-service authorization request directly to their MCMC plan. CAHP writes there is currently no existing process by which a beneficiary initiates a pre-service authorization request to the plan as the beneficiary's treating provider typically makes the authorization request to the plan for approval. CAHP writes that it is concerned that this provision disrupts existing processes that will lead to confusion and potentially disrupt patient care.

   Third, CAHP writes that it is concerned with the provisions of the bill that requires MCMC plans to inform beneficiaries of their treatment options and review any request for treatment under the expedited review timeframes. CAHP writes that its members strive to incorporate evidence-based care, they do not directly engage in the practice of medicine by facilitating treatment advice. If a beneficiary is seeking treatment for a complex cancer diagnosis, those decisions should be made by an oncologist or other treating clinical professional, and that physicians may request expedited review based on medical necessity criteria and their assessment of a particular patient's medical condition. CAHP writes that placing MCMC plans in the position of overriding medical urgency recommendations of physicians is contrary to the practice of allowing clinical judgment to determine the urgency of a situation.

7) **RELATED LEGISLATION**. SB 1080 (Pan) extends the existing time and distance and appointment availability standards for MCMC plans an additional three years, from January 1, 2023 to January 1, 2026, requires DHCS to seek input from stakeholders, including consumer advocates, MCMC plans, and providers prior to January 1, 2025, to determine what changes, if any, are needed to those standards. SB 1080 is scheduled for hearing in the Assembly Health Committee on June 28, 2022.

8) PREVIOUS LEGISLATION.

a) SCR 11 (Rubio), Chapter 120, Statutes of 2021, proclaimed specified principles as the Cancer Patients' Bill of Rights to make clear the Legislature supports the best cancer care for cancer patients in the state. Among these rights is the statement that cancer patients have a right to contracting NCI-designated CCCs and leading academic medical centers for the management of complex cancers that require multiple experts or high-risk or emerging therapies.

b) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, required MCMC plans to pay providers the Medi-Cal FFS rate until at least December, 31, 2024 for transplant surgeries performed on Medi-Cal MCMC plan enrollees.

c) SB 743 (Hernandez) Chapter 572, Statutes of 2017 prohibited a MCMC plan from restricting the choice of the qualified provider, from whom a Medi-Cal beneficiary enrolled in the plan may receive family planning services and requires a MCMC plan to reimburse an out-of-plan or out-of-network qualified provider at the applicable fee-for-service rate.

9) PROPOSED AMENDMENTS. Following discussion between the author, sponsor and one of the opponents to this measure, this bill will be amended to: a) expand the legislative findings to include language related to NCORPs; b) modify the ability of a beneficiary diagnosed with a complex cancer care to receives services from one of the designed cancer providers, to instead allow a beneficiary to request a referral from one of the designated cancer providers, and to require a denial of a referral to be based upon a determination by the treating provider that the request to receive services is not medically necessary or the services are not available or applicable; c) limit the request to referral to a "contracted" NCI-designated CCC; d) delete the proposed changes to the appeals language; and e) modify the definition of "complex cancer diagnosis" to require it be limited to a diagnosis for which there is no effective FDA-approved treatment or which highly effective therapy for metastatic cancer has failed.

REGISTERED SUPPORT / OPPOSITION:

Support

American Cancer Society Cancer Action Network (cosponsor)
City of Hope (cosponsor)
California Black Health Network (cosponsor)
California Chronic Care Coalition (cosponsor)
Association of Regional Center Agencies
Be the Match/National Marrow Donor Program
Biocom California
California Life Sciences
Lazarex Cancer Foundation
North Bay Cancer Alliance
San Gabriel Valley Economic Partnership
Susan G. Komen
The Latino Cancer Institute

The Leukemia & Lymphoma Society
Triage Cancer
Western Center on Law & Poverty, Inc.

Opposition

California Association of Health Plans
Local Health Plans of California

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