AB-1450 California Children's Services Program: providers. (2025-2026)

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CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

ASSEMBLY BILL NO. 1450

Introduced by Assembly Member Hoover

February 21, 2025

~~An act to amend Section 1371.55 of the Health and Safety Code, and to amend Section 10126.65 of the Insurance Code, relating to air ambulance services.~~ *An act to amend Section 123929 of, and to add Section 123928 to, the Health and Safety Code, relating to health.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1450, as amended, Hoover. ~~Air ambulance services.~~ *California Children's Services Program: providers.*

Existing law, the California Children's Services (CCS) Program, is a statewide program providing medically necessary services required by physically handicapped children whose parents are unable to pay for those services. Existing law requires the State Department of Health Care Services to administer the program. Existing law requires the board of supervisors of each county to designate the county department of public health or the county department of social welfare as the designated agency to administer the program. Existing law prohibits denying eligibility or aid under the program because an otherwise eligible person is receiving treatment services under specified teaching programs provided that treatment services are under the general supervision of a CCS Program panel physician and surgeon. Existing law requires those panel members to be board certified and have expertise in the care of children. Existing law requires prior authorization for CCS services provided pursuant to these provisions, contingent on the determination by the department or its designee of specified criteria, including that the provider of the services is approved in accordance with the standards of the program.

This bill would authorize the department to approve an advanced practice provider's, defined as a nurse practitioner, physician assistant, or certified registered nurse that meet specified qualifications, request to be CCS paneled. The bill would require eligible applicants to submit an application through the CCS internet website. The bill would require the department to acknowledge receipt of the application within 5 business days and would require the department to approve, deny, or return the application for additional information within 10 business days of submission.

The bill would require the advanced practice provider to be paneled prior to providing care, and once paneled, would authorize the advanced practice provider to perform initial or continuing care without the need of a cosignature for specified professional

services. The bill would also authorize those paneled providers enrolled as Medi-Cal ordering, referring, and prescribing only providers to bill Medi-Cal directly for independent office and inpatient visits.
The bill would also expand the meaning of a provider to include physician certified by their respective specialty board, except when in the opinion of the specialist, treatment may be delegated or shared with a family physician and advanced practice providers, as defined, who meet specified criteria.

~~Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service plan contracts and health insurance policies provide coverage for certain services and treatments, including emergency medical transportation services. Existing law requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2020, to provide, among other things, that if an enrollee, insured, or subscriber receives covered services from a noncontracting air ambulance provider, the individual will pay no more than the same cost sharing that the individual would pay for the same covered services received from a contracting air ambulance provider, referred to as the in-network cost-sharing amount.~~

~~This bill would make a technical, nonsubstantive change to those provisions.~~
Vote: majority Appropriation: no Fiscal Committee: ~~no~~*yes* Local Program: no

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. *Section 123928 is added to the Health and Safety Code, to read:*

123928. *(a) For the purposes of this article, "advanced practice provider" means a nurse practitioner, physician assistant, or certified registered nurse anesthetist recognized as a core team member and working collaboratively with a CCS-paneled physician team.*

(b) The department may approve an advanced practice provider's request to be CCS paneled and shall require eligible applicants to submit an application through the CCS internet website. The department shall acknowledge receipt of the application within 5 business days and shall approve, deny, or return the application for additional information within 10 business days of submission of the application.

(c) Advanced practice providers shall be CCS paneled prior to providing care to CCS participants.

(d) Once paneled, an advanced practice provider may perform initial or continuing care without the need for a cosignature for professional services, including progress notes, diagnostic orders, prescriptions, including those for durable medical equipment, specialty consults, rehabilitation services, or nutrition.

(e) CCS-paneled advanced practice providers who are enrolled as Medi-Cal ordering, referring, and prescribing only providers may bill Medi-Cal directly for independent office and inpatient visits.

SEC. 2. *Section 123929 of the Health and Safety Code is amended to read:*

123929. (a) Except as otherwise provided in this section and Section 14133.05 of the Welfare and Institutions Code, California Children's Services Program services provided pursuant to this article require prior authorization by the department or its designee. Prior authorization is contingent on determination by the department or its designee of all of the following:

(1) The child receiving the services is confirmed to be medically eligible for the CCS program.

(2) The provider of the services is approved in accordance with the standards of the CCS program. *For the purposes of this section, a provider may be either of the following:*

(A) A physician certified by their respective specialty board, except when in the opinion of a specialist treatment may be delegated or shared with a family physician.

(B) An advanced practice provider who meets all of the following:

(i) Is currently licensed and in good standing with the applicable regulatory body in the state.

(ii) Has been board certified by the applicable certifying body.

(iii) Has expertise in the care of physically handicapped children. For the purposes of this clause, "expertise" is defined as a minimum of two years post-training experience providing direct pediatric care or anesthesia services, with at least one year providing services to infants, children, or adolescents with CCS-eligible medical conditions.

(3) The services authorized are medically necessary to treat the child's CCS-eligible medical condition.

(b) The department or its designee may approve a request for a treatment authorization that is otherwise in conformance with subdivision (a) for services for a child participating in the Medi-Cal program pursuant to Section 14005.26 of the Welfare and Institutions Code or the Medi-Cal Access Program pursuant to Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code, received by the department or its designee after the requested treatment has been provided to the child.

(c) If a provider of services who meets the requirements of paragraph (2) of subdivision (a) incurs costs for services described in paragraph (3) of subdivision (a) to treat a child described in subdivision (b) who is subsequently determined to be medically eligible for the CCS program, as determined by the department or its designee, the department may reimburse the provider for those costs. Reimbursement under this section shall conform to the requirements of Section 14105.18 of the Welfare and Institutions Code.

(d) (1) By July 1, 2016, or a subsequent date determined by the department, requests for authorization of services, excluding requests for authorization of services submitted by dental providers enrolled in the Medi-Cal Dental program, shall be submitted in an electronic format determined by the department and shall be submitted via the department's ~~Internet Web site~~ *internet website* or other electronic means designated by the department. The department may implement this requirement in phases.

(2) The department shall designate an alternate format for submitting requests for authorization of services when the department's ~~Internet Web site~~ *internet website* or other electronic means designated in paragraph (1) are unavailable due to a system disruption.

(3) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may, without taking regulatory action, implement, interpret, or make specific this subdivision and any applicable waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions. Thereafter, the department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The department shall consult with interested parties and appropriate stakeholders in implementing this subdivision.

~~SECTION 1.Section 1371.55 of the Health and Safety Code is amended to read:~~

~~1371.55.(a)(1)A health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall provide that if an enrollee receives covered services from a noncontracting air ambulance provider, the enrollee shall pay no more than the same cost sharing amount that the enrollee would pay for the same covered services received from a contracting air ambulance provider. This amount shall be referred to as the "in-network cost sharing amount."~~

~~(2)An enrollee shall not owe the noncontracting provider more than the in-network cost sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting provider, the plan shall inform the enrollee and the noncontracting provider of the in network cost sharing amount owed by the enrollee.~~

~~(b)The following shall apply for purposes of this section:~~

~~(1)Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out of pocket expenses established under Section 1367.006.~~

~~(2)Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.~~

~~(3)The cost sharing paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the health service.~~

~~(c)A noncontracting provider may advance to collections only the in network cost sharing amount, as determined by the plan pursuant to subdivision (a), that the enrollee failed to pay.~~

~~(d)A health care service plan or a provider may seek relief in any court for the purpose of resolving a payment dispute. A provider is not prohibited from using a health care service plan's existing dispute resolution processes.~~

~~(e)Air ambulance service providers remain subject to the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.~~

~~SEC. 2.Section 10126.65 of the Insurance Code is amended to read:~~

~~10126.65.(a)(1)A health insurance policy issued, amended, or renewed on or after January 1, 2020, shall provide that if an insured or subscriber receives covered services from a noncontracting air ambulance provider, the insured or subscriber shall pay no more than the same cost sharing that the insured or subscriber would pay for the same covered services received from a~~

~~contracting air ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."~~

~~(2)A subscriber or insured shall not owe the noncontracting provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting provider, the insurer shall inform the insured or subscriber and the noncontracting provider of the in-network cost-sharing amount owed by the insured or subscriber.~~

~~(b)The following shall apply for purposes of this section:~~

~~(1)Any cost sharing paid by the insured or subscriber for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.~~

~~(2)Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.~~

~~(3)The cost sharing paid by the insured or subscriber pursuant to this section shall satisfy the insured's or subscriber's obligation to pay cost sharing for the health service.~~

~~(c)A noncontracting provider may advance to collections only the in-network cost-sharing amount, as determined by the insurer pursuant to subdivision (a), that the insured or subscriber failed to pay.~~

~~(d)A health insurer or a provider may seek relief in any court for the purpose of resolving a payment dispute. A provider is not prohibited from using a health insurer's existing dispute resolution processes.~~