

File No. 210574

Committee Item No. _____

Board Item No. 37

COMMITTEE/BOARD OF SUPERVISORS

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Prepared by: Jocelyn Wong

Date: May 21, 2021

Prepared by: _____

Date: _____

1 [Urging Passage of California State Senate Bill No. 221 (Wiener) - Health Care Coverage:
2 Timely Access to Care]

2

3 **Resolution urging passage of California State Senate Bill No. 221, authored by State**
4 **Senator Scott Wiener, to establish clear timely access standards for mental health care**
5 **follow-up appointments needed by patients in ongoing, medically necessary treatment**
6 **for mental health and substance use disorders.**

7

8 WHEREAS, In 2020, the California State Legislature passed Senate Bill No. 855 (SB
9 855), which strengthened the California Mental Health Parity Act by expanding coverage for
10 mental health and substance use disorder (MH/SUD) treatment and establishing a standard of
11 no more than 10 days for access to MH/SUD appointments needed by patients; and

12 WHEREAS, SB 855 did not establish similarly clear standards for offering needed
13 follow-up MH/SUD treatment appointments; and

14 WHEREAS, In the absence of clear timely access standards for follow-up
15 appointments with non-physician MH/SUD providers - like social workers and therapists -
16 large numbers of Californians requiring ongoing courses of treatment for mental health and
17 substance use disorders have been unable to access care within the timeframes that are
18 clinically appropriate for their diagnoses; and

19 WHEREAS, According to a December 2020 survey conducted by the National Union of
20 Healthcare Workers, 88% of the mental health therapists at California's largest HMO reported
21 that weekly individual psychotherapy treatment is unavailable for patients who need it, and
22 51% of therapists reported that their patients have to wait more than 4 weeks, on average, for
23 a follow-up appointment; and

24

25

1 WHEREAS, According to the California Health Care Foundation's 2020 survey on the
2 health care priorities and experiences of California residents, 52% of those who tried to make
3 an appointment believe they waited longer than was reasonable to get one; and

4 WHEREAS, According to a 2019 survey by the California Health Care Foundation,
5 Californians ranked access to mental health treatment as the state's top health care priority;
6 and

7 WHEREAS, This problem has been exacerbated by the significant increase in demand
8 for mental health and substance use disorder services driven by the COVID-19 pandemic,
9 with national survey data published in JAMA, an international peer-reviewed general medical
10 journal, showing that the rate of anxiety and depression has more than tripled over the last
11 year, and a recent Center for Disease Control study conducted between April 2020 and March
12 2021 finding that one in four people age 18 to 24 have seriously considered suicide in the past
13 30 days; and

14 WHEREAS, Recent studies indicate that without timely access to follow-up mental
15 health treatment, patients can suffer longer recovery times and worse outcomes including a
16 more chronic course of their disorders; and

17 WHEREAS, Delays in accessing appropriate treatment can lead to increased morbidity
18 and mortality rates, increased time away from work, increased strain on families, increased
19 risk of decompensation, and accelerating crises requiring more costly and intensive care; and

20 WHEREAS, Current law and regulations have been interpreted to require HMOs under
21 the jurisdiction of the Department of Managed Health Care and health insurers under the
22 jurisdiction of the California Department of Insurance to offer enrollees initial appointments
23 with non-physician MH/SUD providers within ten business days, but not to establish similarly
24 clear standards for offering needed follow-up care from these same providers; and

25

1 WHEREAS, SB 221 will close the loophole in existing law by detailing an appropriate
2 timely access standard for follow-up appointments with non-physician MH/SUD providers,
3 while giving the treating clinician an option to create alternative timeframes for follow-up
4 appointments when that is warranted; now, therefore, be it

5 RESOLVED, That the Board of Supervisors of the City and County of San Francisco
6 urges the passage of SB 221 to establish clear timely access standards for mental health care
7 follow-up appointments needed by patients in ongoing, medically necessary treatment for
8 mental health and substance use disorders; and, be it

9 FURTHER RESOLVED, That the Board of Supervisors of the City and County of San
10 Francisco further directs the Clerk of the Board to transmit copies of this Resolution to the
11 State Legislature and City Lobbyist upon passage.

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AMENDED IN SENATE MARCH 22, 2021

AMENDED IN SENATE MARCH 9, 2021

SENATE BILL

No. 221

Introduced by Senator Wiener

(Coauthors: Senators Leyva, Kamlager, and Newman)

(Coauthors: Assembly Members ~~Arambula, Kamlager,~~ *Arambula* and
Waldron)

January 13, 2021

An act to amend Sections 1367.03 and 1367.031 of the Health and Safety Code, and to amend Section 10133.53 of, and to add Section 10133.54 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 221, as amended, Wiener. Health care coverage: timely access to care.

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 each department to develop and adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner. Under existing law, a Medi-Cal managed care plan is required to comply with timely access standards developed by the department.

Existing regulations require a health care service plan or an insurer to ensure that their contracted provider networks have adequate capacity and availability of licensed health care providers to offer enrollees and insureds appointments that meet specified timeframes. Existing regulations require a health care service plan or an insurer to ensure

that for an enrollee requesting a nonurgent appointment with a nonphysician mental health care provider, or an insured requesting a nonurgent appointment with a nonphysician mental health care or substance use disorder provider, appointments are offered within 10 business days of the request for an appointment. Existing regulations also authorize appointments for preventive care services and periodic followup care, including periodic office visits to monitor and treat mental health or substance use disorder conditions, as specified, to be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the provider's scope of practice. These regulations of the Department of Managed *Health* Care are limited in application to mental health care providers, while those regulations of the Department of Insurance are applicable to both mental health care and substance use disorder providers.

This bill would codify the regulations adopted by the Department of Managed Health Care and the Department of Insurance to provide timely access standards for health care service plans and insurers for nonemergency health care services. The bill would require both a health care service plan and a health insurer, including a Medi-Cal Managed Care Plan, to ensure that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements. The bill would additionally require a health care service plan and a health insurer, including a Medi-Cal Managed Care Plan, to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health or substance use disorder condition is able to get a followup appointment with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment. *The bill would require that a referral to a specialist by another provider meet the timely access standards.* If a health care service plan is operating in a service area that has a shortage of providers and the plan is not able to meet the geographic and timely access standards for providing mental health or substance use disorder services with an in-network provider, the bill would require the plan, including a Medi-Cal Managed Care Plan, to arrange coverage outside the plan's contracted network. By imposing new requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:

3 (a) It is the intent of the Legislature to ensure that all enrollees
4 of health care service plans and health insurers who require ongoing
5 courses of medically necessary treatment for mental health and
6 substance use disorders are able to obtain followup appointments
7 with nonphysician providers of mental health and substance use
8 disorder services within timeframes that are clinically appropriate
9 to care for their diagnoses.

10 (b) Existing law and regulations have been interpreted to set
11 clear timely access standards for health care service plans and
12 health insurers to meet enrollees' requests for initial appointments
13 with nonphysician providers of mental health and substance use
14 disorder services, but not to set similarly clear timely access
15 standards for the provision of followup appointments with these
16 providers for the many enrollees who need them.

17 (c) This loophole in existing law and regulations has resulted
18 in failures to provide enrollees followup appointments with
19 nonphysician providers of mental health and substance use disorder
20 services within the timeframes consistent with generally accepted
21 standards of care.

22 (d) Closing this loophole is urgently necessary to address the
23 widespread and lengthy delays in access to followup appointments
24 with nonphysician providers of mental health and substance use
25 disorder services experienced by thousands of Californians,
26 including individuals suffering from major disorders and reporting
27 suicidal ideation.

28 (e) Closing this loophole has grown even more urgent as the
29 prevalence of mental health and substance use disorders has
30 increased dramatically during the COVID-19 pandemic, and efforts

1 to meet increased demand have focused on providing initial
2 appointments while timely access to appropriate followup care has
3 further diminished.

4 SEC. 2. Section 1367.03 of the Health and Safety Code is
5 amended to read:

6 1367.03. (a) A health care service plan that provides or
7 arranges for the provision of hospital or physician services,
8 including a specialized mental health plan that provides physician
9 or hospital services, or that provides mental health services
10 pursuant to a contract with a full service plan, shall comply with
11 the following timely access requirements:

12 (1) A health care service plan shall provide or arrange for the
13 provision of covered health care services in a timely manner
14 appropriate for the nature of the enrollee's condition consistent
15 with good professional practice. A plan shall establish and maintain
16 provider networks, policies, procedures, and quality assurance
17 monitoring systems and processes sufficient to ensure compliance
18 with this clinical appropriateness standard. *A health care service*
19 *plan that uses a tiered network shall demonstrate compliance with*
20 *the standards established by this section based on providers*
21 *available at the lowest cost-sharing tier.*

22 (2) A health care service plan shall ensure that all plan and
23 provider processes necessary to obtain covered health care services,
24 ~~including~~ *including, but not limited to,* prior authorization
25 processes, are completed in a manner that assures the provision of
26 covered health care services to an enrollee in a timely manner
27 appropriate for the enrollee's condition and in compliance with
28 this section.

29 (3) If it is necessary for a provider or an enrollee to reschedule
30 an appointment, the appointment shall be promptly rescheduled
31 in a manner that is appropriate for the enrollee's health care needs,
32 and ensures continuity of care consistent with good professional
33 practice, and consistent with this ~~section.~~ *section and the*
34 *regulations adopted thereunder.*

35 (4) Interpreter services required by Section 1367.04 of this code
36 and Section 1300.67.04 of Title 28 of the California Code of
37 Regulations shall be coordinated with scheduled appointments for
38 health care services in a manner that ensures the provision of
39 interpreter services at the time of the ~~appointment.~~ *appointment*
40 *without imposing delay on the scheduling of the appointment.* This

1 subdivision does not modify the requirements established in Section
2 1300.67.04 of Title 28 of the California Code of Regulations, or
3 approved by the department pursuant to Section 1300.67.04 of
4 Title 28 of the California Code of Regulations for a plan’s language
5 assistance program.

6 (5) In addition to ensuring compliance with the clinical
7 appropriateness standard set forth in paragraph (1), a health care
8 service plan shall ensure that its contracted provider network has
9 adequate capacity and availability of licensed health care providers
10 to offer enrollees appointments that meet the following timeframes:

11 (A) Urgent care appointments for services that do not require
12 prior authorization: within 48 hours of the request for appointment,
13 except as provided in subparagraph (H).

14 (B) Urgent care appointments for services that require prior
15 authorization: within 96 hours of the request for appointment,
16 except as provided in subparagraph (H).

17 (C) Nonurgent appointments for primary care: within 10
18 business days of the request for appointment, except as provided
19 in subparagraphs (H) and (I).

20 (D) Nonurgent appointments with specialist physicians: within
21 15 business days of the request for appointment, except as provided
22 in subparagraphs (H) and (I).

23 (E) Nonurgent appointments with a nonphysician mental health
24 care or substance use disorder provider: within 10 business days
25 of the request for appointment, except as provided in subparagraphs
26 (H) and (I).

27 (F) Nonurgent followup appointments with a nonphysician
28 mental health care or substance use disorder provider: within 10
29 business days of the prior appointment for those undergoing a
30 course of treatment for an ongoing mental health or substance use
31 disorder condition, except as provided in subparagraph (H).

32 (G) Nonurgent appointments for ancillary services for the
33 diagnosis or treatment of injury, illness, or other health condition:
34 within 15 business days of the request for appointment, except as
35 provided in subparagraphs (H) and (I).

36 (H) The applicable waiting time for a particular appointment
37 may be extended if the referring or treating licensed health care
38 provider, or the health professional providing triage or screening
39 services, as applicable, acting within the scope of their practice
40 and consistent with professionally recognized standards of practice,

1 has determined and noted in the relevant record that a longer
2 waiting time will not have a detrimental impact on the health of
3 the enrollee.

4 (I) Preventive care services, as defined in subdivision (e), and
5 periodic followup care, including standing referrals to specialists
6 for chronic conditions, periodic office visits to monitor and treat
7 pregnancy, cardiac, mental health, or substance use disorder
8 conditions, and laboratory and radiological monitoring for
9 recurrence of disease, may be scheduled in advance consistent
10 with professionally recognized standards of practice as determined
11 by the treating licensed health care provider acting within the scope
12 of their practice.

13 *(J) A referral to a specialist by a primary care provider or*
14 *another specialist shall be subject to the relevant time-elapsed*
15 *standard in subparagraph (A), (B), or (D) and shall be subject to*
16 *the other provisions of this section.*

17 ~~(J)~~

18 (K) A plan may demonstrate compliance with the primary care
19 time-elapsed standards established by this subdivision through
20 implementation of standards, processes, and systems providing
21 advanced access to primary care appointments, as defined in
22 subdivision (e).

23 (6) In addition to ensuring compliance with the clinical
24 appropriateness standard set forth at paragraph (1), each dental
25 plan, and each full service plan offering coverage for dental
26 services, shall ensure that contracted dental provider networks
27 have adequate capacity and availability of licensed health care
28 providers to offer enrollees appointments for covered dental
29 services in accordance with the following requirements:

30 (A) Urgent appointments within the dental plan network shall
31 be offered within 72 hours of the time of request for appointment,
32 if consistent with the enrollee's individual needs and as required
33 by professionally recognized standards of dental practice.

34 (B) Nonurgent appointments shall be offered within 36 business
35 days of the request for appointment, except as provided in
36 subparagraph (C).

37 (C) Preventive dental care appointments shall be offered within
38 40 business days of the request for appointment.

1 (7) A plan shall ensure it has sufficient numbers of contracted
2 providers to maintain compliance with the standards established
3 by this section.

4 (A) This section does not modify the requirements regarding
5 provider-to-enrollee ratio or geographic accessibility established
6 by Section 1300.51, 1300.67.2, or 1300.67.2.1 of Title 28 of the
7 California Code of Regulations.

8 (B) A plan operating in a service area that has a shortage of one
9 or more types of providers shall ensure timely access to covered
10 health care services as required by this section, including applicable
11 time-elapsd standards, by referring an enrollee to, or, in the case
12 of a preferred provider network, by assisting an enrollee to locate
13 available and accessible contracted providers in neighboring service
14 areas consistent with patterns of practice for obtaining health care
15 services in a timely manner appropriate for the enrollee's health
16 needs. A plan shall arrange for the provision of specialty services
17 from specialists outside the plan's contracted network if unavailable
18 within the network if medically necessary for the enrollee's
19 condition. Enrollee costs for medically necessary referrals to
20 nonnetwork providers shall not exceed applicable copayments,
21 coinsurance, and deductibles. This requirement does not prohibit
22 a plan or its delegated provider group from accommodating an
23 enrollee's preference to wait for a later appointment from a specific
24 contracted provider. If medically necessary treatment of a mental
25 health or substance use disorder is not available in network within
26 the geographic and timely access standards set by law or regulation,
27 a health care service plan shall arrange coverage outside the plan's
28 contracted network in accordance with subdivision (d) of Section
29 1374.72.

30 (8) A plan shall provide or arrange for the provision, 24 hours
31 per day, 7 days per week, of triage or screening services by
32 telephone, as defined in subdivision (e).

33 (A) A plan shall ensure that telephone triage or screening
34 services are provided in a timely manner appropriate for the
35 enrollee's condition, and that the triage or screening waiting time
36 does not exceed 30 minutes.

37 (B) A plan may provide or arrange for the provision of telephone
38 triage or screening services through one or more of the following
39 means: plan-operated telephone triage or screening services,
40 telephone medical advice services pursuant to Section 1348.8, the

1 plan's contracted primary care and mental health care *or substance*
2 *use disorder* provider network, or another method that provides
3 triage or screening services consistent with this section.

4 (i) A plan that arranges for the provision of telephone triage or
5 screening services through contracted ~~primary care and mental~~
6 ~~health care~~ *care, mental health care, and substance use disorder*
7 providers shall require those providers to maintain a procedure for
8 triaging or screening enrollee telephone calls, which, at a minimum,
9 shall include the employment, during and after business hours, of
10 a telephone answering machine, an answering service, or office
11 staff, that shall inform the caller of both of the following:

12 (I) Regarding the length of wait for a return call from the
13 provider.

14 (II) How the caller may obtain urgent or emergency care,
15 including, if applicable, how to contact another provider who has
16 agreed to be on call to triage or screen by phone, or if needed,
17 deliver urgent or emergency care.

18 (ii) A plan that arranges for the provision of triage or screening
19 services through contracted ~~primary care and mental health care~~
20 *care, mental health care, and substance use disorder* providers
21 who are unable to meet the time-elapsed standards established in
22 subparagraph (A) shall also provide or arrange for the provision
23 of plan-contracted or operated triage or screening services, which
24 shall, at a minimum, be made available to enrollees affected by
25 that portion of the plan's network.

26 (iii) An unlicensed staff person handling enrollee calls may ask
27 questions on behalf of a licensed staff person to help ascertain the
28 condition of an insured so that the enrollee may be referred to
29 licensed staff. However, an unlicensed staff person shall not, under
30 any circumstances, use the answers to those questions in an attempt
31 to assess, evaluate, advise, or make a decision regarding the
32 condition of an enrollee or determine when an enrollee needs to
33 be seen by a licensed medical professional.

34 (9) Dental, vision, chiropractic, and acupuncture plans shall
35 ensure that contracted providers employ an answering service or
36 a telephone answering machine during nonbusiness hours, which
37 provide instructions regarding how an enrollee may obtain urgent
38 or emergency care, including, if applicable, how to contact another
39 provider who has agreed to be on call to triage or screen by phone,
40 or if needed, deliver urgent or emergency care.

1 (10) A plan shall ensure that, during normal business hours, the
2 waiting time for an enrollee to speak by telephone with a plan
3 customer service representative knowledgeable and competent
4 regarding the enrollee's questions and concerns shall not exceed
5 10 minutes.

6 (b) Dental, vision, chiropractic, and acupuncture plans shall
7 comply with paragraphs (1), (3), (4), (7), (9), and (10) of
8 subdivision (a).

9 (c) The obligation of a plan to comply with this section shall
10 not be waived if the plan delegates to its medical groups,
11 independent practice associations, or other contracting entities any
12 services or activities that the plan is required to perform. A plan's
13 implementation of this section shall be consistent with the Health
14 Care Providers' Bill of Rights, and a material change in the
15 obligations of a plan's contracting providers shall be considered
16 a material change to the provider contract, within the meaning of
17 subdivision (b) and paragraph (2) of subdivision (h) of Section
18 1375.7.

19 ~~(d) This section confirms requirements for plans to provide or~~
20 ~~arrange for the provision of access to health care services in a~~
21 ~~timely manner, and establishes additional metrics for measuring~~
22 ~~and monitoring the adequacy of a plan's contracted provider~~
23 ~~network to provide enrollees with timely access to needed health~~
24 ~~care services. This section does not do any of the following:~~

25 ~~(1) Establish professional standards of practice for health care~~
26 ~~providers.~~

27 ~~(2) Establish requirements for the provision of emergency~~
28 ~~services.~~

29 ~~(3) Create a new cause of action or a new defense to liability~~
30 ~~for any person.~~

31 *(d) A plan shall not prevent, discourage, or discipline a*
32 *contracting provider or employee for informing an enrollee or*
33 *subscriber about the timely access standards.*

34 (e) For purposes of this section:

35 (1) "Advanced access" means the provision, by an individual
36 provider, or by the medical group or independent practice
37 association to which an enrollee is assigned, of appointments with
38 a primary care physician, or other qualified primary care provider
39 such as a nurse practitioner or physician's assistant, within the
40 same or next business day from the time an appointment is

1 requested, and advance scheduling of appointments at a later date
2 if the enrollee prefers not to accept the appointment offered within
3 the same or the next business day.

4 (2) “Appointment waiting time” means the time from the initial
5 request for health care services by an enrollee or the enrollee’s
6 treating provider to the earliest date offered for the appointment
7 for services inclusive of time for obtaining authorization from the
8 plan or completing any other condition or requirement of the plan
9 or its contracting providers.

10 (3) “Preventive care” means health care provided for prevention
11 and early detection of disease, illness, injury, or another health
12 condition and, in the case of a full service plan includes all of the
13 basic health care services required by paragraph (5) of subdivision
14 (b) of Section 1345, and subdivision (f) of Section 1300.67 of Title
15 28 of the California Code of Regulations.

16 (4) “Provider group” has the meaning set forth as in subdivision
17 (g) of Section 1373.65.

18 (5) “Triage” or “screening” means the assessment of an
19 enrollee’s health concerns and symptoms via communication with
20 a physician, registered nurse, or other qualified health professional
21 acting within their scope of practice and who is trained to screen
22 or triage an enrollee who may need care for the purpose of
23 determining the urgency of the enrollee’s need for care.

24 (6) “Triage or screening waiting time” means the time waiting
25 to speak by telephone with a physician, registered nurse, or other
26 qualified health professional acting within their scope of practice
27 and who is trained to screen or triage an enrollee who may need
28 care.

29 (7) “Urgent care” means health care for a condition that requires
30 prompt attention, consistent with paragraph (2) of subdivision (h)
31 of Section 1367.01.

32 (f) (1) Contracts between health care service plans and health
33 care providers shall ensure compliance with the standards
34 developed under this chapter. These contracts shall require
35 reporting by health care providers to health care service plans and
36 by health care service plans to the department to ensure compliance
37 with the standards.

38 (2) Health care service plans shall report annually to the
39 department on compliance with the standards in a manner specified
40 by the department. The reported information shall allow consumers

1 to compare the performance of plans and their contracting providers
2 in complying with the standards, as well as changes in the
3 compliance of plans with these standards.

4 (3) The department shall develop standardized methodologies
5 for reporting that shall be used by health care service plans to
6 demonstrate compliance with this section and any regulations
7 adopted pursuant to it. The methodologies shall be sufficient to
8 determine compliance with the standards developed under this
9 section for different networks of providers if a health care service
10 plan uses a different network for Medi-Cal managed care products
11 than for other products or if a health care service plan uses a
12 different network for individual market products than for small
13 group market products. The department shall consult with
14 stakeholders in developing standardized methodologies under this
15 paragraph.

16 ~~(g) (1) When evaluating compliance with the standards, the~~
17 ~~department shall focus more upon patterns of noncompliance rather~~
18 ~~than isolated episodes of noncompliance.~~

19 ~~(2)~~

20 (g) (1) The director may investigate and take enforcement action
21 against plans regarding noncompliance with the requirements of
22 this section. Where substantial harm to an enrollee has occurred
23 as a result of plan noncompliance, the director may, by order,
24 assess administrative penalties subject to appropriate notice of,
25 and the opportunity for, a hearing in accordance with Section 1397.
26 The plan may provide to the director, and the director may
27 consider, information regarding the plan's overall compliance with
28 the requirements of this section. The administrative penalties shall
29 not be deemed an exclusive remedy available to the director. These
30 penalties shall be paid to the Managed Care Administrative Fines
31 and Penalties Fund and shall be used for the purposes specified in
32 Section 1341.45. The director shall periodically evaluate grievances
33 to determine if any audit, investigative, or enforcement actions
34 should be undertaken by the department.

35 ~~(3)~~

36 (2) The director may, after appropriate notice and opportunity
37 for hearing in accordance with Section 1397, by order, assess
38 administrative penalties if the director determines that a health
39 care service plan has knowingly committed, or has performed with

1 a frequency that indicates a general business practice, either of the
2 following:

3 (A) Repeated failure to act promptly and reasonably to assure
4 timely access to care consistent with this chapter.

5 (B) Repeated failure to act promptly and reasonably to require
6 contracting providers to assure timely access that the plan is
7 required to perform under this chapter and that have been delegated
8 by the plan to the contracting provider when the obligation of the
9 plan to the enrollee or subscriber is reasonably clear.

10 (C) The administrative penalties available to the director
11 pursuant to this section are not exclusive, and may be sought and
12 employed in any combination with civil, criminal, and other
13 administrative remedies deemed warranted by the director to
14 enforce this chapter.

15 ~~(4)~~

16 (3) The administrative penalties shall be paid to the Managed
17 Care Administrative Fines and Penalties Fund and shall be used
18 for the purposes specified in Section 1341.45.

19 (h) The department shall work with the patient advocate to
20 assure that the quality of care report card incorporates information
21 provided pursuant to subdivision (f) regarding the degree to which
22 health care service plans and health care providers comply with
23 the requirements for timely access to care.

24 (i) The department shall annually review information regarding
25 compliance with the standards developed under this section and
26 shall make recommendations for changes that further protect
27 enrollees. Commencing no later than December 1, 2015, and
28 annually thereafter, the department shall post its final findings
29 from the review on its internet website.

30 (j) The department shall post on its internet website any waivers
31 or alternative standards that the department approves under this
32 section on or after January 1, 2015.

33 (k) This section shall apply to Medi-Cal managed care plan
34 contracts entered into with the State Department of Health Care
35 Services pursuant to Chapter 7 (commencing with Section 14000)
36 or Chapter 8 (commencing with Section 14200) of Part 3 of
37 Division 9 of the Welfare and Institutions Code.

38 SEC. 3. Section 1367.031 of the Health and Safety Code is
39 amended to read:

1 1367.031. (a) A health care service plan contract that is issued,
2 renewed, or amended on or after July 1, 2017, shall provide
3 information to an enrollee regarding the standards for timely access
4 to care adopted pursuant to Section 1367.03 and the information
5 required by this section, including information related to receipt
6 of interpreter services in a timely manner, no less than annually.

7 (b) A health care service plan contract that is issued, renewed,
8 or amended on or after July 1, 2022, shall provide information to
9 an enrollee regarding the standards for timely access to care
10 required by Section 1367.032, adopted pursuant to Section 1367.03,
11 and the information required by this section, including information
12 related to receipt of interpreter services in a timely manner, no less
13 than annually.

14 (c) A health care service plan at a minimum shall provide
15 information regarding appointment wait times for urgent care,
16 nonurgent primary care, nonurgent specialty care, and telephone
17 screening established in Section 1367.032 or pursuant to Section
18 1367.03 to enrollees and contracting providers. The information
19 shall also include notice of the availability of interpreter services
20 at the time of the appointment pursuant to Section 1367.04. A
21 health care service plan may indicate that exceptions to
22 appointment wait times may apply if the department has found
23 exceptions to be permissible.

24 (d) The information required to be provided pursuant to this
25 section shall be provided to an enrollee with individual coverage
26 upon initial enrollment and annually thereafter upon renewal, and
27 to enrollees and subscribers with group coverage upon initial
28 enrollment and annually thereafter upon renewal. A health care
29 service plan may include this information with other materials sent
30 to the enrollee. The information shall also be provided in the
31 following manner:

32 (1) In a separate section of the evidence of coverage titled
33 “Timely Access to Care.”

34 (2) At least annually, in or with newsletters, outreach, or other
35 materials that are routinely disseminated to the plan’s enrollees.

36 (3) Commencing January 1, 2018, in a separate section of the
37 provider directory published and maintained by the health care
38 service plan pursuant to Section 1367.27. The separate section
39 shall be titled “Timely Access to Care.”

1 (4) On the internet website published and maintained by the
2 health care service plan, in a manner that allows enrollees and
3 prospective enrollees to easily locate the information.

4 (e) (1) A health care service plan shall provide the information
5 required by this section to contracting providers on no less than
6 an annual basis.

7 (2) A health care service plan shall also inform a contracting
8 provider of all of the following:

9 (A) Information about a health care service plan's obligation
10 under California law to provide or arrange for timely access to
11 care.

12 (B) How a contracting provider or enrollee can contact the health
13 care service plan to obtain assistance if a patient is unable to obtain
14 a timely referral to an appropriate provider.

15 (C) The toll-free telephone number for the Department of
16 Managed Health Care where providers and enrollees can file a
17 complaint if they are unable to obtain a timely referral to an
18 appropriate provider.

19 (3) A health care service plan may comply with this subdivision
20 by including the information with an existing communication with
21 a contracting provider.

22 (f) This section shall apply to Medi-Cal managed care plan
23 contracts entered into with the State Department of Health Care
24 Services pursuant to Chapter 7 (commencing with Section 14000)
25 or Chapter 8 (commencing with Section 14200) of Part 3 of
26 Division 9 of the Welfare and Institutions Code.

27 SEC. 4. Section 10133.53 of the Insurance Code is amended
28 to read:

29 10133.53. (a) (1) A health insurance policy that is issued,
30 renewed, or amended on or after July 1, 2017, that provides benefits
31 through contracts with providers for alternative rates pursuant to
32 Section 10133 shall provide information to an insured regarding
33 the standards for timely access to care adopted pursuant to Section
34 10133.5 and the information required by this section, including
35 information related to receipt of interpreter services in a timely
36 manner, no less than annually.

37 (2) A health insurance policy that is issued, renewed, or amended
38 on or after July 1, 2022, that provides benefits through contracts
39 with providers for alternative rates pursuant to Section 10133 shall
40 provide information to an insured regarding the standards for timely

1 access to care required by Section 10133.54, adopted pursuant to
2 Section 10133.5, and the information required by this section,
3 including information related to receipt of interpreter services in
4 a timely manner, no less than annually.

5 (b) A health insurer that contracts with providers for alternative
6 rates of payment pursuant to Section 10133 shall, at a minimum,
7 provide information regarding appointment wait times for urgent
8 care, nonurgent primary care, nonurgent specialty care, and
9 telephone screening established in Section 10133.54 or pursuant
10 to Section 10133.5 to insureds and contracting providers. The
11 information shall also include notice of the availability of
12 interpreter services at the time of the appointment pursuant to
13 Section 10133.8. A health insurer may indicate that exceptions to
14 appointment wait times may apply if the department has found
15 exceptions to be permissible.

16 (c) The information required to be provided pursuant to this
17 section shall be provided to an insured with individual coverage
18 upon initial enrollment and annually thereafter upon renewal, and
19 to insureds and group policyholders with group coverage upon
20 initial enrollment and annually thereafter upon renewal. An insurer
21 may include this information with other materials sent to the
22 insured. The information shall also be provided in the following
23 manner:

24 (1) In a separate section of the evidence of coverage titled
25 “Timely Access to Care.”

26 (2) At least annually, in or with newsletters, outreach, or other
27 materials that are routinely disseminated to the policy’s insureds.

28 (3) Commencing January 1, 2018, in a separate section of the
29 provider directory published and maintained by the insurer pursuant
30 to Section 10133.15. The separate section shall be titled “Timely
31 Access to Care.”

32 (4) On the internet website published and maintained by the
33 insurer, in a manner that allows insureds and prospective insureds
34 to easily locate the information.

35 (d) (1) A health insurer shall provide the information required
36 by this section to contracting providers on no less than an annual
37 basis.

38 (2) A health insurer shall also inform a contracting provider of
39 all of the following:

1 (A) Information about a health insurer's obligation under
2 California law to provide or arrange for timely access to care.

3 (B) How a contracting provider or insured can contact the health
4 insurer to obtain assistance if a patient is unable to obtain a timely
5 referral to an appropriate provider.

6 (C) The toll-free telephone number for the Department of
7 Insurance where providers and insureds can file a complaint if
8 they are unable to obtain a timely referral to an appropriate
9 provider.

10 (3) A health insurer may comply with this subdivision by
11 including the information with an existing communication with a
12 contracting provider.

13 SEC. 5. Section 10133.54 is added to the Insurance Code, to
14 read:

15 10133.54. (a) This section applies to policies of health
16 insurance, as defined by subdivision (b) of Section 106. The
17 requirements of this section apply to all health care services
18 covered by a health insurance policy.

19 (b) Notwithstanding Section 10133.5, a health insurer shall
20 comply with the timely access requirements in this section, but a
21 specialized health insurance policy as defined in subdivision (c)
22 of Section 106, other than a specialized mental health insurance
23 policy, is exempt from the provisions of this section, except as
24 specified in paragraph (6) and subdivision (c).

25 (1) A health insurer shall provide or arrange for the provision
26 of covered health care services in a timely manner appropriate for
27 the nature of the insured's condition, consistent with good
28 professional practice. An insurer shall establish and maintain
29 provider networks, policies, procedures, and quality assurance
30 monitoring systems and processes sufficient to ensure compliance
31 with this clinical appropriateness standard. An insurer that uses a
32 tiered network shall demonstrate compliance with the standards
33 established by this section based on providers available at the
34 lowest cost-sharing tier.

35 (2) A health insurer shall ensure that all insurer and provider
36 processes necessary to obtain covered health care services,
37 including, but not limited to, prior authorization processes, are
38 completed in a manner that assures the provision of covered health
39 care services to an insured in a timely manner appropriate for the
40 insured's condition and in compliance with this section.

1 (3) If it is necessary for a provider or an insured to reschedule
2 an appointment, the appointment shall be promptly rescheduled
3 in a manner that is appropriate for the insured’s health care needs,
4 and ensures continuity of care consistent with good professional
5 practice, and consistent with the objectives of Section 10133.5,
6 the regulations adopted pursuant to Section 10133.5, and this
7 section.

8 (4) Interpreter services required by Section 10133.8 of this code
9 and Article 12.1 (commencing with Section 2538.1) of Title 10 of
10 the California Code of Regulations shall be coordinated with
11 scheduled appointments for health care services in a manner that
12 ensures the provision of interpreter services at the time of the
13 appointment, consistent with Section 2538.6 of Title 10 of the
14 California Code of Regulations, without imposing delay on the
15 scheduling of the appointment. This subdivision does not modify
16 the requirements established in Section 10133.9 of this code and
17 Section 2538.6 of Title 10 of the California Code of Regulations,
18 or approved by the department pursuant to Section 2538.6 of Title
19 10 of the California Code of Regulations for an insurer’s language
20 assistance program.

21 (5) In addition to ensuring compliance with the clinical
22 appropriateness standard set forth in paragraph (1), a health insurer
23 shall ensure that its contracted provider network has adequate
24 capacity and availability of licensed health care providers to offer
25 insureds appointments that meet the following timeframes:

26 (A) Urgent care appointments for services that do not require
27 prior authorization: within 48 hours of the request for appointment,
28 except as provided in subparagraph (H).

29 (B) Urgent care appointments for services that require prior
30 authorization: within 96 hours of the request for appointment,
31 except as provided in subparagraph (H).

32 (C) Nonurgent appointments for primary care: within 10
33 business days of the request for appointment, except as provided
34 in subparagraphs (H) and (I).

35 (D) Nonurgent appointments with specialist physicians: within
36 15 business days of the request for appointment, except as provided
37 in subparagraphs (H) and (I).

38 (E) Nonurgent appointments with a nonphysician mental health
39 care or substance use disorder provider: within 10 business days

1 of the request for appointment, except as provided in subparagraphs
2 (H) and (I).

3 (F) Nonurgent followup appointments with a nonphysician
4 mental health care or substance use disorder provider: within 10
5 business days of the prior appointment for those undergoing a
6 course of treatment for an ongoing mental health or substance use
7 disorder condition, except as provided in subparagraph (H).

8 (G) Nonurgent appointments for ancillary services for the
9 diagnosis or treatment of injury, illness, or other health condition:
10 within 15 business days of the request for appointment, except as
11 provided in subparagraphs (H) and (I).

12 (H) The applicable waiting time for a particular appointment
13 may be extended if the referring or treating licensed health care
14 provider, or the health professional providing triage or screening
15 services, as applicable, acting within the scope of their practice
16 and consistent with professionally recognized standards of practice,
17 has determined and noted in the relevant record that a longer
18 waiting time will not have a detrimental impact on the health of
19 the insured.

20 (I) Preventive care services, as defined in subdivision (e), and
21 periodic follow up care, including standing referrals to specialists
22 for chronic conditions, periodic office visits to monitor and treat
23 pregnancy, cardiac, mental health, or substance use disorder
24 conditions, and laboratory and radiological monitoring for
25 recurrence of disease, may be scheduled in advance consistent
26 with professionally recognized standards of practice as determined
27 by the treating licensed health care provider acting within the scope
28 of their practice.

29 *(J) A referral to a specialist by a primary care provider or*
30 *another specialist shall be subject to the relevant time-elapsed*
31 *standard in subparagraph (A), (B) or (D) and shall be subject to*
32 *the other provisions of this section.*

33 (6) (A) The following types of health insurance policies shall
34 be subject to the requirements in subparagraph (B):

35 (i) A health insurance policy covering the pediatric oral or vision
36 essential health benefit.

37 (ii) A specialized health insurance policy that provides coverage
38 for the pediatric oral essential health benefit, as defined in
39 paragraph (5) of subdivision (a) of Section 10112.27.

1 (iii) A specialized health insurance policy that covers dental
2 benefits only, as defined in subdivision (c) of Section 106.

3 (B) In addition to ensuring compliance with the clinical
4 appropriateness standard set forth at paragraph (1), each health
5 insurance policy specified in subparagraph (A) shall ensure that
6 contracted oral or vision provider networks have adequate capacity
7 and availability of licensed health care providers, including
8 generalist and specialist dentists, ophthalmologists, optometrists,
9 and opticians, to offer insureds appointments for covered oral or
10 vision services in accordance with the following requirements:

11 (i) Urgent appointments within the plan network shall be offered
12 within 72 hours of the time of request for appointment, if consistent
13 with the insured's individual needs and as required by
14 professionally recognized standards of dental practice.

15 (ii) Nonurgent appointments shall be offered within 36 business
16 days of the request for appointment, except as provided in clause
17 (iii).

18 (iii) Preventive care appointments shall be offered within 40
19 business days of the request for appointment.

20 (iv) The applicable waiting time for a particular appointment
21 in this paragraph may be extended if the referring or treating
22 licensed health care provider, or the health professional providing
23 triage or screening services, as applicable, acting within the scope
24 of the provider's practice and consistent with professionally
25 recognized standards of practice, has determined and noted in the
26 relevant record that a longer waiting time will not have a
27 detrimental impact on the health of the insured.

28 (7) An insurer shall ensure it has sufficient numbers of
29 contracted providers to maintain compliance with the standards
30 established by this section.

31 (A) This section does not modify the requirements regarding
32 accessibility established by Article 6 (commencing with Section
33 2240) of Title 10 of the California Code of Regulations.

34 (B) An insurer shall ensure timely access to covered health care
35 services as required by this section, including applicable
36 time-elapsing standards, by assisting an insured to locate available
37 and accessible contracted providers in a timely manner appropriate
38 for the insured's health needs. An insurer shall arrange for the
39 provision of services outside the insurer's contracted network if
40 unavailable within the network if medically necessary for the

1 insured's condition. Insured costs for medically necessary referrals
2 to nonnetwork providers shall not exceed applicable in-network
3 copayments, coinsurance, and deductibles.

4 (8) An insurer shall provide or arrange for the provision, 24
5 hours per day, 7 days per week, of triage or screening services by
6 telephone, as defined in subdivision (f).

7 (A) An insurer shall ensure that telephone triage or screening
8 services are provided in a timely manner appropriate for the
9 insured's condition, and that the triage or screening waiting time
10 does not exceed 30 minutes.

11 (B) An insurer may provide or arrange for the provision of
12 telephone triage or screening services through one or more of the
13 following means: insurer-operated telephone triage or screening
14 services, telephone medical advice services pursuant to Section
15 10279, the insurer's contracted primary care and mental health
16 care or substance use disorder provider network, or other method
17 that provides triage or screening services consistent with this
18 section.

19 (i) An insurer that arranges for the provision of telephone triage
20 or screening services through contracted primary care and mental
21 health care and substance use disorder providers shall require those
22 providers to maintain a procedure for triaging or screening insured
23 telephone calls, which, at a minimum, shall include the
24 employment, during and after business hours, of a telephone
25 answering machine, an answering service, or office staff, that shall
26 inform the caller of both of the following:

27 (I) Regarding the length of wait for a return call from the
28 provider.

29 (II) How the caller may obtain urgent or emergency care,
30 including, if applicable, how to contact another provider who has
31 agreed to be on call to triage or screen by phone, or if needed,
32 deliver urgent or emergency care.

33 (ii) An insurer that arranges for the provision of triage or
34 screening services through contracted primary care and mental
35 health care and substance use disorder providers who are unable
36 to meet the time-elapsing standards established in subparagraph
37 (A) shall also provide or arrange for the provision of
38 insurer-contracted or operated triage or screening services, which
39 shall, at a minimum, be made available to insureds affected by that
40 portion of the insurer's network.

1 (iii) An unlicensed staff person handling insured calls may ask
2 questions on behalf of a licensed staff person to help ascertain the
3 condition of an insured so that the insured may be referred to
4 licensed staff. However, an unlicensed staff person shall not, under
5 any circumstances, use the answers to those questions in an attempt
6 to assess, evaluate, advise, or make a decision regarding the
7 condition of an insured or determine when an insured needs to be
8 seen by a licensed medical professional.

9 (9) A health insurance policy providing coverage for the
10 pediatric oral and vision essential health benefit, and a specialized
11 health insurance policy that provides coverage for dental care
12 expenses only, shall require that contracted providers employ an
13 answering service or a telephone answering machine during
14 nonbusiness hours, which provides instructions regarding how an
15 insured may obtain urgent or emergency care, including, if
16 applicable, how to contact another provider who has agreed to be
17 on call to triage or screen by phone, or if needed, deliver urgent
18 or emergency care.

19 (10) An insurer shall ensure that, during normal business hours,
20 the waiting time for an insured to speak by telephone with an
21 insurer customer service representative knowledgeable and
22 competent regarding the insured's questions and concerns shall
23 not exceed 10 minutes, or that the covered person will receive a
24 scheduled call-back within 30 minutes.

25 (c) Notwithstanding subdivision (b), a specialized health
26 insurance policy, as defined in subdivision (c) of Section 106,
27 other than a specialized mental health insurance policy, is exempt
28 from this section, except as specified in this subdivision. A
29 specialized health insurance policy that provides coverage for
30 dental care expenses only shall comply with paragraphs (1), (3),
31 (4), (6), (7), (9), and (10) of subdivision (b).

32 (d) *An insurer shall not prevent, discourage, or discipline a*
33 *contracting provider or employee for informing an insured or*
34 *policyholder about the timely access standards.*

35 ~~(d)~~

36 (e) For purposes of this section:

37 (1) "Appointment waiting time" means the time from the initial
38 request for health care services by an insured or the insured's
39 treating provider to the earliest date offered for the appointment
40 for services inclusive of time for obtaining authorization from the

1 insurer or completing any other condition or requirement of the
2 insurer or its contracting providers.

3 (2) “Preventive care” means health care provided for prevention
4 and early detection of disease, illness, injury, or other health
5 condition and, in the case of a full service insurer includes, but is
6 not limited to, all of the services required by all of the following
7 laws:

8 (A) Section 146.130 of Title 45 of the Code of Federal
9 Regulations.

10 (B) Section 10112.2 (incorporating the requirements of Section
11 2713 of the federal Public Health Service Act (42 U.S.C. Sec.
12 300gg-13)).

13 (C) Clause (ii) of subparagraph (A) of paragraph (2) of
14 subdivision (a) of Section 10112.27.

15 (3) “Provider group” has the meaning set forth in subdivision
16 (v) of Section 10133.15.

17 (4) “Triage” or “screening” means the assessment of an insured’s
18 health concerns and symptoms via communication with a
19 physician, registered nurse, or other qualified health professional
20 acting within their scope of practice and who is trained to screen
21 or triage an insured who may need care for the purpose of
22 determining the urgency of the insured’s need for care.

23 (5) “Triage or screening waiting time” means the time waiting
24 to speak by telephone with a physician, registered nurse, or other
25 qualified health professional acting within their scope of practice
26 and who is trained to screen or triage an insured who may need
27 care.

28 (6) “Urgent care” means health care for a condition which
29 requires prompt attention, consistent with paragraph (2) of
30 subdivision (h) of Section 10123.135.

31 SEC. 6. No reimbursement is required by this act pursuant to
32 Section 6 of Article XIII B of the California Constitution because
33 the only costs that may be incurred by a local agency or school
34 district will be incurred because this act creates a new crime or
35 infraction, eliminates a crime or infraction, or changes the penalty
36 for a crime or infraction, within the meaning of Section 17556 of
37 the Government Code, or changes the definition of a crime within

1 the meaning of Section 6 of Article XIII B of the California
2 Constitution.

O

From: [Mundy, Erin \(BOS\)](#)
To: [BOS Legislation, \(BOS\)](#)
Cc: [Mandelman, Rafael \(BOS\)](#)
Subject: Re: Resolution for introduction
Date: Tuesday, May 18, 2021 2:41:08 PM
Attachments: [image001.png](#)

Thanks. No position from CSAC or League of CA Cities. Copy of the bill is attached. Since we are requesting this be sent to the next printed agenda without committee reference, also confirming that this item is routine, not contentious in nature, and of no special interest.

Thank you,
Erin

Erin Mundy
Legislative Aide
Supervisor Rafael Mandelman
(415) 554-6968 - Voice
(415) 554-6909 - Fax
erin.mundy@sfgov.org

From: BOS Legislation, (BOS) <bos.legislation@sfgov.org>
Sent: Tuesday, May 18, 2021 2:25 PM
To: Mundy, Erin (BOS) <erin.mundy@sfgov.org>; BOS Legislation, (BOS) <bos.legislation@sfgov.org>
Cc: Mandelman, Rafael (BOS) <rafael.mandelman@sfgov.org>
Subject: RE: Resolution for introduction

Hi Erin,

Pursuant to [Board Rule 2.8.2](#), please provide the following to complete this submission:

- a copy of Senate Bill 221
- confirm that organizations such as the [California State Association of Counties](#) and [League of California Cities](#) have *not* taken a position on these bills. If they have, please provide a copy of their statement for completeness of the file.

Thank you,
Jocelyn Wong
San Francisco Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102
T: 415.554.7702 | F: 415.554.5163
jocelyn.wong@sfgov.org | www.sfbos.org

(VIRTUAL APPOINTMENTS) To schedule a “virtual” meeting with me (on Microsoft Teams), please

ask and I can answer your questions in real time.

Due to the current COVID-19 health emergency and the Shelter in Place Order, the Office of the Clerk of the Board is working remotely while providing complete access to the legislative process and our services



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From: Mundy, Erin (BOS) <erin.mundy@sfgov.org>
Sent: Tuesday, May 18, 2021 1:49 PM
To: BOS Legislation, (BOS) <bos.legislation@sfgov.org>
Cc: Mandelman, Rafael (BOS) <rafael.mandelman@sfgov.org>
Subject: Resolution for introduction

Hello,

Supervisor Mandelman will be introducing the attached resolution today.

Thank you,
Erin

Erin Mundy
Legislative Aide
Supervisor Rafael Mandelman
(415) 554-6968 - Voice
(415) 554-6909 - Fax
erin.mundy@sfgov.org

Introduction Form

By a Member of the Board of Supervisors or Mayor

Time stamp
or meeting date

I hereby submit the following item for introduction (select only one):

- 1. For reference to Committee. (An Ordinance, Resolution, Motion or Charter Amendment).
- 2. Request for next printed agenda Without Reference to Committee.
- 3. Request for hearing on a subject matter at Committee.
- 4. Request for letter beginning : "Supervisor inquiries"
- 5. City Attorney Request.
- 6. Call File No. from Committee.
- 7. Budget Analyst request (attached written motion).
- 8. Substitute Legislation File No.
- 9. Reactivate File No.
- 10. Topic submitted for Mayoral Appearance before the BOS on

Please check the appropriate boxes. The proposed legislation should be forwarded to the following:

- Small Business Commission
- Youth Commission
- Ethics Commission
- Planning Commission
- Building Inspection Commission

Note: For the Imperative Agenda (a resolution not on the printed agenda), use the Imperative Form.

Sponsor(s):

Rafael Mandelman

Subject:

Urging Passage of California State Senate Bill No. 221 (Wiener) – Health Care Coverage: Timely Access to Care

The text is listed:

Resolution urging passage of California State Senate Bill No. 221, authored by State Senator Scott Wiener, to establish clear timely access standards for mental health care follow-up appointments needed by patients in ongoing, medically necessary treatment for mental health and substance use disorders.

Signature of Sponsoring Supervisor: RM

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