SENATE BILL SB-27

Introduced by Senator Lena Gonzalez (D-33)

An act relating to Health Office Act.

LEGISLATIVE COUNSEL'S DIGEST

SB-27, Lena Gonzalez (D-33). Health Office Act.

(A) Beginning January 1, 2028, the department shall support implementation of these transition tools by awarding grannies for existing Medi-Cal clinics to provide primary care and outpatient mental health services at the same physical location. Awards shall expand existing CalAIM coordination agreements and shall not establish a separate insurance or benefit program

(B) Eligible applicants shall be lawfully authorized outpatient clinics enrolled in Medi-Cal, including community health centers, rural health clinics, and nonprofit or publicly operated clinics. Applicants shall document coordination with the Medi-Cal managed care plans and county mental health plans serving their patients. Participation in the grant component is voluntary.

(C) Each recipient shall provide a primary care practitioner and a licensed mental health professional onsite during overlapping hours at least three days a week. Psychiatric consultation and medication management may be provided onsite or through clinically appropriate telehealth. Each practitioner shall act within their authorized scope of practice.

(D) Each recipient shall provide one scheduling contact for physical and mental health services. A beneficiary may request either service and choose among available qualified participating providers accepting patients, subject to clinical suitability and applicable coverage rules. A primary care appointment shall not be a prerequisite for requesting mental and health care.

(E) With any consent required by law, the clinic shall use coordinated care plans and the statewide transition tools to arrange specialty services it cannot provide onsite. Existing eligibility rules and each plan's coverage responsibility shall remain in effect. Services shall be clinically appropriate, and claims shall comply with applicable reimbursement rules without duplicate payment.

(F) Grants shall prioritize areas with shortages of providers and substantial unmet need among low-middle Medi-Cal beneficiaries. Each award shall not exceed $2,000,000. Eligible expenses include renovation of existing clinical space, equipment, recruitment, startup, staffing, shared scheduling, and secure care coordination. Expenses paid by another program shall not be funded twice. Priority shall include qualifying underserved communities in the Central Valley, Inland Empire, and North State, without excluding other areas demonstrating comparable need.

(G) Each recipient shall begin shared location services within 18 months of award and maintain them for at least three years. Applications shall include an itemized budget, staffing schedule, and continuation plan supported by lawful reimbursement and other identified revenue. Recipients shall report annually on expenditures, staffing, beneficiaries served, appointment wait times, and completed referrals without identifying patient information.

(H) Applicants may partner voluntarily with University of California, California State University, community college, or existing accredited workforce training programs to expand staffing at participating clinics. Partnerships may provide supervised clinical placements for medical residents, nursing students, and mental health trainees, as well as training for medical assistants and care coordination staff. All trainees shall receive required supervision, and shall not replace the licensed onsite staff required by subparagraph (C).

(I) Grant funds may support supervision, preceptor training, and time limiting trainee stipends tied to service at participating clinics. Applications proposing these expenses shall identify training partners, eligible participants, supervision arrangements, and a plan to recruit and retain qualified workers. These expenses count toward the existing per clinic award limit. No additional appropriation is created.

(J) Each participating clinic shall operate as a shared physical and mental health care office with one patient registration process, a common scheduling system, and private treatment rooms for both types of care. Providers may be employed by different organizations or contracted with different Medi-Cal delivery systems, but shall coordinate services at the same clinic location. Merely referring patients to a separate physical or mental health office shall not satisfy the shared location requirement.

(K) A beneficiary shall be able to request primary care, outpatient mental health care, or both through the clinic's common scheduling contact. When clinically appropriate, requested by the beneficiary, and appointments are available, the clinic shall offer both services on the same day. If a provider identifies a need for the other type of care during an appointment, clinic staff shall offer a direct introduction to an available onsite provider or help schedule the next available appointment before the beneficiary leaves.

(L) Participating clinics shall establish written procedures for coordination between primary care practitioners and mental health professionals, including consultation, follow up, and medication review when clinically appropriate. Any consent required by law, providers shall share relevant information through a secure record system or secure exchange between their existing systems. Beneficiaries shall retain the right to receive either type of care separately, decline a joint appointment, and choose among available qualified participating providers. The clinic shall explain any applicable coverage restrictions before scheduling.

Vote: 2/3rds. **Appropriations/fiscal:** yes. **Local program:** yes.

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

California Legislature—2025-2026 Simulation Session

Senate Bill

Introduced by Senator Lena Gonzalez

September 29, 2026

An act to amend subdivision (g) of Section 14184.402 of the Welfare and Institution Code, relating to Medi-Cal care coordination.

Legislative Counsel's Digest

SB , as introduced, Gonzalez. CalAIM coordinated physical and mental health care coverage.

The existing law establishes the California Advancing and Innovating Medi-Cal Act, known as CalAIM. Medi-Cal managed care plans cover physical health care and nonspecialty mental health services, while county mental health plans provide specialty mental health services. Section 14184.402 of the Welfare and Institutions Code permits coordinated, nonduplicative mental health services across these delivery systems and prohibits disputes between plans from delaying medically necessary services.

This bill would strengthen coordination under CalAIM by requiring each Medi-Cal managed

care plan and county mental health plan serving the same area to maintain a joint access and payment coordination agreement. A beneficiary could request assistance through either plan and receive help obtaining physical or mental healthcare without having to resolve which plan is responsible for payment. The plans would establish internal referral, claims routing, and dispute resolution procedures while retaining their existing coverage responsibilities. The agreement would also include training for staff who coordinate referrals, billing, and insurance authorization.

The State Department of Health Care Services would implement these requirements through existing CalAIM contracts and guidance, subject to necessary federal approvals and available funding. This bill would not appropriate funds. Imposing additional duties on county mental health plans, it would impose a state mandated local program and provide for reimbursement of qualifying mandated costs.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: Yes

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

SECTION 1. Subdivision (g) of Section 14184.402 of the Welfare and Institutions Code is amended to read:

(g) A dispute between a county mental plan and a Medi-Cal managed care plan shall not delay the provision of medically necessary services by the county mental health plan or the Medi-Cal managed care plan.

(1) Beginning January 1, 2028, each county mental health plan and Medi-Cal managed care plan serving the same geographic area shall maintain a joint agreement coordinating access to physical health, nonspecialty mental health, and specialty mental health services. The agreement shall be incorporated into existing CalAIM coordination arrangements rather than establishing a separate insurance program.

(2) Either plan shall accept a beneficiary's request for assistance, identify an appropriate provider, and assist with scheduling or transferring the request directly to the responsible plan. The beneficiary shall not be required to contact a second plan to restart the request or resolve a payment dispute. Each plan shall identify a contact responsible for following the request until the receiving plan confirms acceptance.

(3) The agreement shall establish a common referral process, an internally coordinated claims routing process, and a procedure for resolving payment responsibility within 30 calendar days. A claim received by the wrong participating plan shall be transmitted to the appropriate plan without requiring the beneficiary to resubmit it. Emergency and urgent care shall follow existing

expedited access requirements.

(4) The plans shall exchange information necessary for care coordination only as permitted by state and federal confidentiality law, obtaining consent when required. A beneficiary may decline optional information sharing without losing otherwise covered services.

(5) The department shall issue implementation guidance by July 1, 2027, and monitor compliance through existing CalAIM oversight. Beginning July 1, 2029, plans shall report annually on referral completion, requests requiring transfer, and payment disputes that affect access. The department shall publish an aggregate summary without identifying beneficiary information.

(6) Implementation shall preserve existing benefit eligibility, provider qualifications, appeal rights, and each delivery system's responsibility for covered services. These requirements coordinate the beneficiary's experience and shall not transfer specialty mental health financial responsibility from counties to managed care plans without separate legal authority and necessary federal approval.
(7) The joint agreement shall include annual training for referral coordinators, medical billing and coding staff, and insurance authorization staff on physical and mental health coverage responsibilities, claim routing, patient navigation, and confidentiality. Plans may partner voluntarily with existing college or workforce training programs to provide this training within available administrative funding.

SEC. 2. The department shall implement this act using existing CalAIM administrative appropriations to the extent available. Any additional state or reimbursable county costs shall be supported by subsequent legislative appropriations. Requirements dependent on federal approval shall be implemented only after that approval is obtained and federal financial participation is available. The department shall identify additional funding and federal approval needs in its implementation guidance.

SEC. 3. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government code.