AMENDED IN SENATE APRIL 17, 2020

SENATE BILL No. 1110

Introduced by Senator Hurtado

February 19, 2020

An act to amend Section 15885 of the Welfare and Institutions Code, relating to health care coverage; add and repeal Article 2.8 (commencing with Section 127960) of Chapter 2 of Part 3 of Division 107 of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL’S DIGEST


Existing law establishes various programs to facilitate the expansion of the health care workforce in rural and underserved communities, including, but not limited to, the Health Professions Career Opportunity Program, the California Registered Nurse Education Program, and the Steven M. Thompson Medical School Scholarship Program.

This bill would create the California Medicine Scholars Program, a 5-year pilot program commencing January 1, 2022, which would be established and facilitated by the State Department of Health Care Services. The purpose of the pilot program would be to establish a regional pipeline program for community college students to pursue premedical training and enter medical school, in an effort to address the shortage of primary care physicians in California and the widening disparities in access to care in vulnerable and underserved communities, including building a comprehensive statewide approach to increasing the number and representation of minority primary care physicians in the state. The bill would require the department to contract with the nonprofit Marcus Foster Education Institute to be the managing agency.
for the pilot program, as specified. The bill would require the pilot program to consist of 4 regional hubs of excellence (RHEs) to achieve its objectives. The bill would require each RHE to include, at a minimum, 3 community colleges, one public or private 4-year undergraduate institution, one public or private medical school, and 3 local community organizations, as specified. The bill would require the managing agency to appoint an objective selection committee, with specified membership, to evaluate prospective RHE applications and select the RHEs that would be participating in the pilot program. The bill would require each RHE selected to participate in the pilot program to enter into memoranda of understanding between the partnering entities setting forth participation requirements, and to perform other specified duties, including the establishment of an advisory board to oversee and guide the programmatic direction of the RHE. The bill would require the selection process to be completed by June 30, 2021.

The bill would require each RHE to recruit and select 50 California Medical Scholars each year from 2022 to 2025, inclusive, in accordance with specified criteria. The bill would require each RHE, by December 31, 2022, and by December 31 of each year thereafter, up to and including 2025, to provide a status report on the implementation of the pilot program to the managing agency and the department, including data and information collected by each RHE during the applicable program year. The bill would require the managing agency and the department to jointly prepare and submit to the Legislature a final report evaluating the success of the pilot program, including the data and information provided by the RHEs, in accordance with specified metrics. The bill would declare that its provisions are severable.

This bill would make these provisions inoperative on June 30, 2026, and would repeal the provisions as of January 1, 2027.

Existing law establishes the California Major Risk Medical Insurance Program (MRMIP) to provide major risk medical coverage to persons who, among other things, have been rejected for coverage by at least one private health plan. Existing law authorizes the Department of Health care services to take various actions with respect to the MRMIP, including excluding coverage or benefits for charges or expenses incurred by a plan subscriber during the first 6 months of any condition that, during the 6 months preceding enrollment, medical advice, diagnosis, care, or treatment was recommended or received for the condition. Existing law waives this exclusion from coverage if the subscriber was covered during that time.
period under creditable coverage, as defined, that was terminated as long as the subscriber applied for enrollment in the MRMIP not later than 63 days following termination of that creditable coverage.

This bill extends this time period to 70 days.


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

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

(a) California is facing a growing shortage of primary care physicians.

(b) It is projected that, by 2030, our state will face a skills gap of 1.1 million workers with bachelor’s degrees. Failure to keep up with demand for skilled workers will curtail economic growth, limit economic mobility, and increase inequality. The result will be a less productive California economy, limited social mobility, and lower incomes and tax revenue.

(c) In addition, our health care workforce continues to lose hundreds of thousands of doctors and nurses each year, with the majority of them leaving before retirement age. Reducing attrition would change the projected shortages more than any other single factor.

(d) Attracting and keeping quality physicians in California is a constant challenge that has reached crisis proportions in some areas, and is a particularly acute challenge in rural areas.

(e) According to a 2017 report from the University of California San Francisco Healthforce Center, California is predicted to see a shortage of over 4,000 primary care clinicians by 2030. In regions such as the central valley, the Inland Empire, and the Imperial Valley, communities are already experiencing the pains of a shortage. Patients in these regions face longer than average wait times to see a physician or extensive time to travel to the closest physician. These barriers discourage working families from seeking regular care. As a result, the state incurs higher costs to cover Medi-Cal patients who are pushed to utilize urgent care and emergency rooms once they are affected by more acute medical conditions that could have been prevented with earlier and more regular access to a primary care physician.
Although the need is great in the Inland Empire, that region, unlike the San Joaquin Valley, has an established medical school with the University of California, Riverside, School of Medicine. A second, privately funded medical school, the California University of Science and Medicine, was also just accredited in 2018. By comparison, since 2015, the central valley region has only begun to establish a medical school presence through the University of California, San Francisco (UCSF), Fresno, San Joaquin Valley Program in Medical Education (PRIME) program and only in the last year has seen the establishment of a second medical school in the central valley with the privately funded California Health Sciences University, and the development of the University of California (UC), Merced, Center for Medical Education and Health Sciences.

The central valley also has shown strong evidence of a partnership development to address preparing community college students through the existence of multiple health workforce pathways through the California Community Colleges’ Health Workforce Initiative, the Rural Health Equity and Learning Collaborative (HEAL) program at Bakersfield College, the engagement of the University of California, the California State University, and community colleges through the Central Valley Higher Education Consortium, the new partnership between UC Merced and UCSF Fresno, and the San Joaquin Valley Coalition for Medical Education.

As of 2015, the majority of California’s population has been made up of minority groups. Therefore, it is now critical that efforts to increase access to care are driven by efforts to increase the number of diverse physicians entering the practice. African American, Native American, Pacific Islander, and Latino physicians are significantly underrepresented across California. Researchers from the University of California, Los Angeles, Latino Policy & Politics Initiative (LPPI) reported in 2018 that the scarcity of Latino physicians in California has led to a deficit of 54,655 Latino physicians required to achieve parity with non-Latino white physicians. Should existing trends in recruitment and training of physicians in the state efforts continue, LPPI researchers calculated it will take California five centuries to achieve parity. A total of six legislative districts have populations that are at least 65 percent African American, Latino, or Native
American and at least 15 percent noncitizen, including Congressional Districts 16 and 21, State Senate Districts 12 and 14, and State Assembly Districts 31 and 32.

(i) Researchers have also found that Black and Latino doctors are more likely to practice in communities that reflect their cultural background. Further studies have found evidence that the gaps in mortality between black and white patients can be reduced when black patients are treated by black physicians. Without a comprehensive, statewide strategy to increase the number of diverse doctors, the existing realities of continuing disparities in care and other indicators of well-being for communities of color hamper the state’s bold leadership in actually improving health outcomes for our most vulnerable populations.

(j) Doctor shortage is a significant deterrent to recruitment. Doctors are facing an enormous amount of debt when finishing medical school. This profession requires extensive education, training, and skills. In addition to bringing more young people into the profession, we must also find ways to keep quality doctors in California.

(k) Currently, the California Community Colleges do not offer a pipeline for students that would facilitate their ability to attend medical school.

(l) The California Community Colleges comprise the largest system of higher education in the nation, with 2.1 million students attending 113 colleges.

(m) While our state’s universities offers extensive and innovative health and science programs, many communities are not geographically close to a four-year university that offer the courses for students entering medical school.

(n) Existing and proposed pipeline programs for increasing the diversity and capacity of the health care workforce, including UC PRIME and the proposed California Health Careers Opportunity Program (HCOP), have provided exemplary lessons to date in support of medical students to serve minority populations and fill critical gaps in the overall need for health workers.

(o) Across the segments of higher education in California, the diversity in the state’s community colleges most closely reflects the diversity of the state’s population. Among aspiring and enrolled medical school students, research from the Healthforce Center at UCSF has found that the cost of higher education proved to be
one of the single greatest barriers to underrepresented minorities 
seeking to pursue a medical degree. With the steadily rising cost 
of tuition in the University of California, the California State 
University, and among private, not-for-profit colleges in California, 
coupled with rising costs of living across the state, first-generation 
and underrepresented minority students are increasingly choosing 
to start their postsecondary education in community colleges 
despite being academically competitive applicants to the 
aforementioned institutions. Among first-time postsecondary Latino 
and Black enrollees in California’s higher education institutions, 
nearly two-thirds enter via the community colleges.

(p) The California community colleges have made notable gains 
in improving their infrastructure for on-time transfer and career 
preparation in health-training pathways as a result of recent state 
legislation and state-funded initiatives, including the California 
Guided Pathways Project and the Strong Workforce Program. 
While these initiatives have improved the capacity of the community 
colleges to support underrepresented minorities to transfer or 
pursue health care workforce opportunities, they have not yet led 
to specific practices to adopt advisory or other resources for 
students who may wish to consider a path to transfer and eventual 
medical school application that initiates their premedical training.

(q) In light of the overall increases in postsecondary enrollment 
among first-time college students, if the state seeks to expand its 
physician pool, building this pathway opportunity from the 
community college system seems like a natural first step. National 
studies in 2014 and 2018 out of the University of California, Davis, 
School of Medicine have also found that over 25 percent of United 
States medical school graduates utilize a community college at 
some point in their higher education path. Furthermore, these 
studies found that graduates who attended community college 
while in high school, in a traditional post-high school transfer 
pathway, or after completion from a four-year undergraduate 
college or university, were more likely to train in family medicine 
than medical graduates who did not attend a community college.

(r) It is, therefore, the intent of the Legislature to create a pilot 
program to build upon existing programs to improve the 
premedical infrastructure by creating a pipeline from the 
California Community Colleges’ system, the second largest and
most diverse higher education system in the world, to the practice of primary medicine.

SEC. 2. Article 2.8 (commencing with Section 127960) is added to Chapter 2 of Part 3 of Division 107 of the Health and Safety Code, to read:

Article 2.8. California Medicine Scholars Program

127960. (a) The State Department of Health Care Services shall establish and facilitate the California Medicine Scholars Program (CMSP), as a five-year pilot program, commencing January 1, 2022. The pilot program shall expand upon the existing work of the California Medicine Coalition under the leadership of the nonprofit Marcus Foster Education Institute (MFEI), in accordance with this article. The purpose of the pilot program is to establish a regional pipeline program for community college students to pursue premedical training and enter medical school, in an effort to address the shortage of primary care physicians in California and the widening disparities in access to care in vulnerable and underserved communities, by building a comprehensive statewide approach to increasing the number and representation of minority primary care physicians in the state. The program shall be implemented through the creation of four regional hubs of excellence (RHEs), as described in Section 127962.

(b) The department shall contract with the MFEI in its capacity as the operating intermediary for the California Medicine Coalition to serve as the managing agency of the pilot program in accordance with this article. By June 30, 2021, the MFEI shall provide dedicated staffing for the pilot program’s planning and management and programmatic operations shall be overseen by the MFEI’s executive board.

(c) Implementation of the pilot program is contingent upon the appropriation by the Legislature of sufficient funds for its purposes.

127961. The duties of the managing agency shall include, but not be limited to, all of the following:

(a) Program data collecting, tracking, and reporting to the department.

(b) Providing ongoing technical assistance to RHEs in setup and implementation, convening the RHE project leads, and
providing statewide professional development to RHE administrators and educators.

(c) Managing and disseminating statewide communications and publications, and coordinating statewide annual meetings of higher education and health industry leaders and professional development for administrators and educators across the RHEs.

(d) Coordinating annual events for all California Medicine Scholars across the RHEs, to foster a statewide cohort of aspiring primary care physicians coming out of California’s community colleges.

127962. (a) (1) Each RHE shall be selected through a competitive process, whereby interested collaborations of higher education institutions, community organizations, and local health centers may apply to an issued request for applications and selected by the committee convened pursuant to subdivision (b).

(2) Each proposed RHE shall include, at a minimum, the following institutions and entities:

(A) Three California community colleges.

(B) One public or private four-year undergraduate institution in California.

(C) One public or private medical school in California.

(D) Three local community organizations, at least one of which shall be a local community health center.

(3) At least one of the selected RHEs shall be located in the central valley.

(b) (1) The managing agency shall appoint an objective RHE selection committee that includes, at a minimum, the following members:

(A) One state-level representative from each of the following:

(i) The California Community Colleges.

(ii) The University of California.

(iii) The California State University.

(iv) The California Primary Care Association.

(B) One or more individuals with legal expertise, particularly in the requirements of the California Civil Rights Initiative, who shall review the committee’s preliminary RHE selections to ensure adherence to those requirements.

(2) The selection committee shall establish evaluation criteria based on applying each applicant’s submission of baseline metrics on student enrollment, transfer and academic measures for
community colleges and four-year institutions, the capacity to establish and prior existence of the proposed partnerships, and the proposed region’s need for primary care physicians.

(c) The RHE selection process shall be completed by June 30, 2021. Once an RHE is selected and established, the RHE shall implement the pilot program in accordance with requirements established in memoranda of understanding that shall be entered into by the RHE participating entities by January 1, 2022. The requirements shall include, at a minimum, all of the following:

(1) To hire an RHE project lead, whose position shall be fully funded with state or other funds provided for the purposes of the pilot program and the RHEs.

(2) For each RHE participating educational institution, to identify a faculty advocate, a program lead, and a data and research lead to represent the various interests of the RHE partners. In addition, participating local health centers and other community organizations shall jointly identify programmatic and data leads.

(3) To implement data sharing, analysis, and the continuous testing of data-informed practices, to foster a statewide collaboration of mutual accountability for improvement, consistent with applicable state and federal law.

(4) To establish an advisory board, comprised of local business, education, health industry, and other community leaders to oversee and guide the programmatic direction of the RHE with the RHE project lead. The advisory board shall help to guide the unique establishment of regionally specific RHE partnerships and opportunities for students along the pathway to support the accomplishment of its targets for student outcomes. These opportunities may include, but need not be limited to, scholarships, internships, shadows of clinical rotations, and research or community service that ensure students gain a familiarity with the unique needs and challenges for primary care in their region and are instilled with a sensitivity to the culture and unique patient populations of the region.

127963. (a) By January 1, 2022, each RHE shall be operational and shall have recruited and selected at least 50 California Medicine Scholars across every partnering community college, with 15-20 students per college, for a total of 200 students in the initial CMSP cohort statewide. Participating students shall
have completed at least one semester of study in a California community college prior to selection.

(b) (1) Subsequent recruitment and selection of California Medicine Scholars shall occur by each RHE by January 1 of every year from 2023 to 2025, inclusive, consistent with the criteria established in subdivision (a). The final year of recruitment and selection of California Medicine Scholars shall also be a critical measurement point to evaluate the initial success of the program, as provided in Section 127964, with a focus on supporting all 200 of the first pilot cohort to be eligible for transfer and acceptance into a participating University of California, California State University, or four-year private college in one of the four RHEs.

(2) An RHE shall encourage students who elect to leave the program to independently pursue careers in health or the health sciences.

127964. (a) By December 31, 2022, and by December 31 of every year from 2023 to 2025, inclusive, each RHE shall provide a status report on the implementation of the pilot program to the managing agency and the department. The report shall include data and information collected by each RHE during the program year as required by this article.

(b) (1) By June 30, 2026, the managing agency and the department shall jointly prepare and submit to the Legislature a final report evaluating the success of the California Medicine Scholars Program, including the data and information provided by the RHEs under subdivision (a). The report shall evaluate the program based on all of the following metrics:

(A) The competitive selection and establishment of the four RHEs across California with a full-time RHE program lead in each RHE, and the participation of at least the institutions for each RHE as described in Section 127962.

(B) The implementation and adoption of premedical advising standards or standardized guidelines as set out by the managing agency and specific to each RHE by at least 12 California community colleges, and four-year undergraduate institutions across the four proposed RHEs and endorsed by the participating schools of medicine, by June 30, 2023.

(C) The implementation and adoption of a student-identifying marker in the institutional data systems of the RHE participating community colleges and four-year undergraduate institutions to
identify students as “California Medicine Scholars,” by June 30, 2022.

(D) The application and selection of at least 400 full-time enrolled students in a California community college who have completed a minimum of one term in the community college, who are identified as “California Medicine Scholars” in their participating colleges by January 1, 2022, and the application and selection of at least 150 additional California Medicine Scholars who match the above criteria by January 1, 2023, as provided in Section 127963.

(E) At least 200 California Medicine Scholars’ enrollment and completion of a health internship, research apprenticeship, or at least 6 weeks of part-time employment in a health, public health, or primary care-related position or setting by June 30, 2023, while enrolled as California community college students.

(F) An overall increase in the percentages of African American, Hispanic or Latino, and Native American student populations enrolled full time in participating California community colleges who successfully achieve transfer-level math and English by the completion of their second year enrolled in a California community college. For purposes of this subparagraph “transfer-level math and English” has the same meaning as defined by the California Community Colleges’ management information systems.

(G) An overall increase in the rate of acceptance to participating four-year undergraduate institutions for transfer students applying from participating California community colleges.

(H) At least 80 percent of the California Medicine Scholars eligible to transfer, and accepted to attend, a participating four-year undergraduate institution after completing two years of full-time enrollment in a California community college.

(I) The establishment of a CMSP planning and management office with four full-time and one part-time employees hired by June 30, 2021, as described in Section 127960.

(J) The execution of memoranda of understanding and data sharing agreements among all participating entities within each of the RHEs, with each other, and with the CMSP planning and management office by January 1, 2022.

(2) A report submitted under this subdivision shall be submitted in compliance with Section 9795 of the Government Code.
The provisions of this article are severable. If any provision of this article or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

This article shall become inoperative on June 30, 2026, and, as of January 1, 2027, is repealed.

SECTION 1. Section 15885 of the Welfare and Institutions Code is amended to read:

15885. (a) The department may permit the exclusion of coverage or benefits for charges or expenses incurred by a subscriber during the first six months of enrollment in the program for any condition for which, during the six months immediately preceding enrollment in the program, medical advice, diagnosis, care, or treatment was recommended or received as to the condition during that period.

(b) The exclusion from coverage of this section shall be waived to the extent to which the subscriber was covered under any creditable coverage, as defined in Section 10900 of the Insurance Code, that was terminated, provided the subscriber has applied for enrollment in the program not later than 70 days following termination of the prior coverage, or within 180 days of termination of coverage if the subscriber lost the subscriber’s previous creditable coverage because the subscriber’s employment ended, the availability of health coverage offered through employment or sponsored by an employer terminated, or an employer’s contribution toward health coverage terminated. The exclusion from coverage of this section shall also be waived as to any condition of a subscriber previously receiving coverage under a plan of another state similar to the program established by this chapter if the subscriber was eligible for benefits under that other-state coverage for the condition. The department may establish alternative mechanisms applicable to enrollment in participating health plans. These mechanisms may include, but are not limited to, a postenrollment waiting period.