Date of Hearing: January 13, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1126 (Patterson) – As Amended January 5, 2026

SUBJECT: Medi-Cal managed care plans: enrollees with other health care coverage.

SUMMARY: Implements several changes to help beneficiaries enrolled in commercial health coverage and who use Medi-Cal as a payer of last resort to maintain their providers as they transition from fee-for-service (FFS) Medi-Cal to Medi-Cal managed care. Specifically, **this bill**:

1) Limits administrative and contracting requirements for providers when billing Medi-Cal managed care plans, for services provided to beneficiaries for whom the Medi-Cal program is a payer of last resort.

2) Specifies that a Medi-Cal managed care plan may require a letter of agreement under certain circumstances, for situations described in 1) above.

3) Requires the Department of Health Care Services (DHCS) to issue guidance or take other actions it deems necessary to provide sufficient clarity on this topic.

EXISTING LAW:

1) Establishes an entitlement to services for individuals with developmental disabilities under the Lanterman Developmental Disabilities Services Act (Lanterman Act). [Welfare and Institutions Code Section (WIC) § 4500, *et seq*.]

2) Establishes a system of nonprofit regional centers throughout the state to identify needs and coordinate services for eligible individuals with developmental disabilities and requires the Department of Developmental Services (DDS) to contract with regional centers to provide case management services and arrange for or purchase services that meet the needs of individuals with developmental disabilities, as defined. [WIC § 4620, *et seq.*]

3) Requires a regional center to identify and pursue all possible sources of funding for consumers receiving regional center services, including Medi-Cal and private entities, to the maximum extent they are liable for the cost of services, aid, insurance, or medical assistance to the consumer. [WIC § 4646]

4) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [WIC § 14000, *et seq*.]

5) Establishes the California Advancing and Innovating Medi-Cal (CalAIM) Act as a set of Medi-Cal transformation initiatives and requires the implementation of the time-limited CalAIM initiative to support a number of goals, including transitioning and transforming the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility. [WIC § 14184.100]

6) Authorizes DHCS to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, with certain exceptions. [WIC § 14184.200]

7) Prohibits a person having private health care coverage from being entitled to receive the same health care items or services furnished or paid for by a publicly funded health care program. [WIC § 10020 (a)]

8) Requires a carrier of private health care coverage to reimburse a publicly funded health care program for the cost incurred in rendering health care paid for by the public program, to the extent of the benefits provided under the terms of the policy for the items provided or the services rendered. [WIC § 10020 (c)]

9) Requires health plans and other entities to provide to DHCS beneficiary information and access to real-time, electronic eligibility verification, in a format provided by DHCS, for purposes of cost avoidance. [WIC § 14124.90]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, children and adults with developmental disabilities have been faced with a dilemma of choosing between their existing insurance and medical team or access to their enrolled regional center. The author explains that DHCS recently moved to a "managed care" approach for servicing these individuals, and that this change caused a high level of confusion in the coordination of care. This confusion between providers, the plans, and DHCS has resulted in this vulnerable population unable to bill their primary coverage, thus resulting in the loss of access to their specialized medical teams. The author indicated his office has been working closely with DHCS and while they indicate families should not have to make these difficult decisions, the reality is implementation has been rocky. The author acknowledges and appreciates the efforts of DHCS. The author notes that if DHCS can fix the acknowledged problems administratively, this bill would not be necessary.

2) **BACKGROUND.** Medi-Cal provides benefits through both a FFS and managed care delivery system. Medi-Cal is also the payer of last resort if services can be covered by another payer, such as an individual's other health coverage (OHC), which may be through a private commercial health plan. If an individual has OHC, DHCS must ensure the OHC pays for any services covered by that health plan or insurer prior to Medi-Cal paying for services, and seek to recover costs from third parties like OHC that may be liable for payment of such costs.

   Individuals with developmental disabilities who receive services from a regional center, and need a higher level of care, such as home and community-based services, are generally required to enroll in Medi-Cal as a "generic resource" if they are eligible. This is true even if they have other health coverage, because the regional center is a "payer of last resort," even after Medi-Cal. This means the regional center must ensure Medi-Cal or other entities pays for services to which an individual may be entitled, prior to funding those services from the regional center budget. As a condition of accepting regional center services, an individual must enroll in Medi-Cal so they can access Medi-Cal covered services that are not available

under their private health plans, such as In-Home Supportive Services (IHSS), a Medi-Cal benefit that provides nonmedical personal care services.

Some children with more significant intellectual and developmental disabilities who are eligible for regional center services can become eligible for Medi-Cal through a process called "Institutional Deeming." This is a special Medi-Cal eligibility rule that considers only the personal income and resources of a person under the age of 18 who meets the disability-related criteria for a special Medi-Cal program called the Home and Community-Based Services Developmental Disabilities Waiver. Through "Institutional Deeming" and enrollment in the aforementioned Waiver, a child may obtain Medi-Cal benefits for needed services regardless of their family's income. Children who receive Medi-Cal eligibility through this process are likely to be in families with higher incomes and therefore have commercial health insurance that covers most of their medical services.

Because receipt of regional center services obligates families to enroll their children in Medi-Cal even if they are already enrolled in OHC, and because Medi-Cal has strict rules requiring OHC to pay for any services the OHC is financially liable for, families in this situation may confront sometimes confounding "coordination of benefits" issues between their commercial OHC and Medi-Cal. Providers of these services are faced with similar challenges with respect to appropriately billing and receiving payment from OHC and Medi-Cal, and this has apparently worsened as children have transitioned from FFS Medi-Cal, which is administered directly by DHCS, to a number of different managed care plans.

This bill was prompted by complaints from individuals who indicated they were losing access to providers contracted with their private OHC, because of the transition of their Medi-Cal from FFS to managed care. More detailed background on several of these components is provided below.

a) Medi-Cal is the Payer of Last Resort. Federal law requires state Medicaid programs to take reasonable measures to ascertain the legal liability of third parties, including other health plans and insurers, to pay for services covered under Medicaid. A beneficiary is required to utilize their private coverage prior to their Medi-Cal benefits when the same service or benefit is available under the beneficiary's private health coverage. When this occurs, Medi-Cal will be secondary to the other health coverage, covering allowable costs not paid by the primary insurance (for instance, copayments) up to the Medi-Cal rate.

b) Regional Centers. Pursuant to the Lanterman Act, some individuals with developmental disabilities or related risk factors qualify for services offered through 21 regional centers contracted with the state DDS. Regional centers serve as fixed points of contact in the community for consumers and their families to access services and supports. Regional center staff assist consumers to obtain necessary services and supports from "generic agencies," like state agencies that offer health benefits, and purchase other services as necessary. They are responsible for the provision of outreach; intake, assessment, evaluation and diagnostic services; and case management/service coordination for persons with developmental disabilities and persons who are at risk of becoming developmentally disabled.

c) Mandatory Transition to Managed Care. Over the last several years, most of the Medi-Cal population has transitioned from FFS into Medi-Cal managed care. Under CalAIM initiative, several additional eligibility groups were transitioned into managed

care in 2022 and 2023 on a mandatory basis. Prior to CalAIM, enrollment into the FFS delivery system or the managed care delivery system was based upon specific geographic areas, the health plan model, and/or the aid code that a beneficiary is determined to qualify for. DHCS introduced mandatory enrollment in managed care as part of CalAIM to guarantee a similar beneficiary experience across counties, and to simplify, standardize, and streamline Medi-Cal program administration.

Mandatory managed care enrollment means that Medi-Cal beneficiaries who were enrolled in FFS, and were either excluded from managed care or able to choose managed care on a voluntary basis, are now required to enroll in a managed care plan. Beneficiaries with OHC who do not have Medicare transitioned on January 1, 2022, while beneficiaries who are dually eligible for Medi-Cal and Medicare transitioned effective January 1, 2023.

Certain exceptions remain in statute. These include, for instance, individuals eligible for only restricted-scope Medi-Cal benefits, those made eligible on the basis of a "share of cost," meaning their income is not low enough to qualify for full-scope Medi-Cal without a share of cost, and those made eligible on the basis of a federally approved Medi-Cal Presumptive Eligibility program, during the relevant period of presumptive eligibility. Individuals who are Native American and youth in the foster system are also exempt from managed care enrollment.

d) Maintaining Providers during an Individual's Transition to Managed Care. State law provides additional, temporary exceptions whereby individuals who transition to a managed care plan can retain relationships with their providers who are not contracted providers with the plan.

i) Medical Exemption Request (MER). Beneficiaries can file a MER to request a temporary exemption from enrollment into a managed care plan only until the member's medical condition has stabilized to a level that would enable the member to transfer to a network provider of the same specialty without deleterious medical effects. Members may get a medical exemption if a member has a complex medical condition, as defined in regulation.

ii) Continuity of Care. Members transitioning from Medi-Cal FFS to a Medi-Cal managed care plan may request continuity of care from their plan to remain with their current FFS provider for up to 12 months after the enrollment date with the managed care plan. The plan must honor the continuity of care request if the following conditions are met: the individual can establish a pre-existing relationship exists with that provider; the plan has no quality concerns with the provider; and the plan and provider can agree to a rate.

Anecdotally, some of the individuals whose experience has prompted this bill have applied for and been deemed eligible for MERs, but a MER is a temporary, not permanent, exemption from managed care enrollment. Once an individual is stabilized and/or continuity of care has run its course, for individuals *without* OHC who rely on Medi-Cal to pay their health care costs, an individual may be required to change providers to a provider in the Medi-Cal managed care plan's network. The situation for an individual *with* OHC is further described below.

e) How Medi-Cal Managed Care Interacts with OHC. Most private plans have cost-sharing like copayments or coinsurance, which Medi-Cal will pay on behalf of the Medi-Cal enrollee when an individual has OHC. Medi-Cal prohibits billing patients for cost-sharing. Providers must bill Medi-Cal to recover the cost-sharing amount owed by the Medi-Cal enrollee.

Prior to the transition to managed care, a provider would bill Medi-Cal FFS directly for services not covered by their patient's OHC, or to request reimbursement for cost-sharing required by the patient's OHC.

However, once an individual is enrolled in Medi-Cal managed care, an individual's provider must bill the individual's Medi-Cal managed plan for copayments or other costs not covered by the OHC, instead of billing DHCS. These providers must therefore interact with Medi-Cal managed care plans, even if the provider is not in the network of a Medi-Cal managed care plan and the service is primarily being billed to the OHC. Billing multiple plans may be more complicated for the provider, who must validate their patient's enrollment and bill the appropriate plan instead of simply billing DHCS for all Medi-Cal claims through Medi-Cal FFS. Furthermore, DHCS's contracts prohibit Medi-Cal managed care plans from paying claims for services provided to a member with OHC, without proof that the provider has first exhausted all sources of other payment. Administrative processes and documentation requirements to provide such proof are not standardized across plans, meaning plans may require slightly different forms of proof or have different portals or means to accept this information.

Anecdotally, according to the bill's author and affected constituents, these billing requirements have created friction between certain patients, providers, and managed care plans with the recent expansion of mandatory enrollment into Medi-Cal managed care.

f) Can Individuals With OHC Keep Their Providers When Their Medi-Cal Services Transition from FFS to Managed Care? Individuals who rely on OHC as a primary payer for their health care should be able to maintain their providers who are paid primarily by the OHC. The providers should be able to simply bill the Medi-Cal managed care plan instead of FFS Medi-Cal for any allowable costs not covered by the OHC.

According to DHCS, if an individual is seeing providers contracted with their OHC who are billing the OHC for services, and Medi-Cal is only paying for other allowable costs such as the patient copayment, the provider is able to bill the Medi-Cal managed care plan for the copayment, even if the provider is not contracted with that plan. This guidance is reflected in a fact sheet published by DHCS, titled "*Overview of Mandatory Managed Care Enrollment*." The fact sheet also reiterates an individual can keep their OHC when they become mandatorily enrolled into managed care.

However, anecdotally, the fact sheet has not resolved issues for individuals seeking to maintain their team of providers. Some providers may refuse to render services to individuals enrolled in Medi-Cal managed care for a variety of reasons, including the providers' choice to adopt a policy of not engaging with Medi-Cal managed care whatsoever, or a lack of understanding that they are allowed to bill the Medi-Cal managed care plan for allowable costs even if they are not contracted with the plan.

DHCS has been working in recent years, in conversation with the author of this bill, to resolve concerns of health care providers and patients, including through issuing guidance and working to provide technical assistance directly to specific providers.

3) PREVIOUS LEGISLATION.

a) AB 974 (Patterson) of 2025 was similar to this bill and was held in the Assembly Appropriations Committee.

b) AB 3156 (Patterson) of 2024 was similar to this bill and was vetoed by Governor Newsom, who stated, "I am supportive of policies that allow Medi-Cal members with other health coverage to continue to see their providers. However, the timelines specified in this bill are not feasible. DHCS has worked extensively to educate Medi-Cal managed care plans (MCPs) on enrollee rights and how providers who are not enrolled in Medi-Cal can still bill Medi-Cal for appropriate services. DHCS will continue to work with MCPs, stakeholders, and patient advocates to address administrative barriers to ensure continuity of care for Medi-Cal enrollees."

AB 1126 does not include "infeasible timelines" as described in the veto message.

c) AB 1608 (Patterson) of 2023 addressed the same issue as this bill, but took the approach of exempting a beneficiary who receives services from a regional center, and uses a Medi-Cal fee-for-service delivery system as a secondary form of health coverage, from enrollment in Medi-Cal managed care. AB 1608 was not heard in the Assembly Health Committee.

d) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, establishes statutory authority for various aspects of the CalAIM initiative, including authority to standardize enrollment of most populations in managed care.

e) AB 203 (Committee on Budget), Chapter 188, Statutes of 2007, establishes in state law a set of federal requirements regarding recovery of costs incurred by Medi-Cal for health care services covered by third-party payers.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file

Opposition

None on file

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