Date of Hearing: January 22, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 1126 (Patterson) – As Amended January 5, 2026

Policy Committee: Health Vote: 15 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires the Department of Health Care Services (DHCS) implement several changes to help Medi-Cal managed care enrollees who have other health coverage (OHC) and for whom Medi-Cal is a payer of last resort to maintain their providers.

Specifically, pertaining to a Medi-Cal managed care enrollee who has OHC and for whom Medi-Cal is a payer of last resort, this bill:

1) Requires DHCS limit administrative and contracting requirements for providers when billing Medi-Cal managed care plans for services provided.

2) Prohibits DHCS from requiring a provider that is enrolled as a Medi-Cal fee-for-service provider to also enroll as a Medi-Cal managed care provider to bill a managed care plan for covered services.

3) Allows a Medi-Cal managed care plan to require a letter of agreement with a non-contracting provider, under specified circumstances.

4) Requires DHCS issue guidance or take other actions it deems necessary to provide sufficient clarity on this issue.

5) Requires DHCS annually update the Assembly Committee on Health and the Senate Committee on Health on the implementation of the provisions of this bill.

FISCAL EFFECT:

Costs to DHCS of an unknown, but likely absorbable, amount in fiscal years 2026-27 through 2029-30.

COMMENTS:

1) **Purpose.** 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. DHCS recently moved to a managed care approach for servicing these individuals, [causing] a high level of confusion in the coordination of

> care. Confusion between providers, the plans, and DHCS has resulted in this vulnerable population being unable to bill their primary coverage, thus resulting in the loss of access to their specialized medical teams. [While DHCS acknowledges] families should not have to make these difficult decisions, the reality is implementation has been rocky. If DHCS can fix the acknowledged problems administratively, this bill would not be necessary.

2) **Background.** This bill was prompted by complaints from a group of individuals who indicated the transition of their Medi-Cal from fee-for-service to managed care was causing them to lose access to providers contracted with their private OHC. Please refer to the Assembly Health Committee Analysis for an explanation of the problem this bill seeks to solve. DHCS states it has been working towards a solution for the author's constituents whose experience prompted this bill.

3) **Related and Prior Legislation**. The author has introduced three bills to address the problem this bill is intended to solve:

   AB 974, of the current legislative session, was similar to this bill but would have also required DHCS to solicit input from stakeholders. AB 974 was held in this committee.

   AB 3156, of the 2023-24 Legislative Session, was vetoed by the Governor, citing infeasible timelines.

   AB 1608, of the 2023-24 Legislative Session, was referred to, but not heard in the Assembly Health Committee. AB 1608 would have exempted from enrollment in Medi-Cal managed care 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.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081