
SENATE COMMITTEE ON HEALTH

Senator Akilah Weber Pierson, Chair

BILL NO: AB 1126
AUTHOR: Patterson
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HEARING DATE: June 3, 2026
CONSULTANT: Jen Flory

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

SUMMARY: Requires the Department of Health Care Services to ensure that providers serving Medi-Cal recipients with other health coverage do not face administrative requirements significantly in excess of the requirements in the Medi-Cal fee-for-service delivery system and to take the actions it deems necessary to ensure these recipients are able to coordinate their care as seamlessly as possible. Requires Medi-Cal plans allow providers in the fee-for-service delivery system to bill the plan for services rendered to Medi-Cal recipients with other health coverage, without requiring an in-network provider contract.

Existing law:

- 1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), and under which qualified low-income individuals receive health care services. [WIC §14000, et seq.]
- 2) Authorizes the DHCS Director to contract, on a bid or nonbid basis, with any qualified individual, organization, or entity to provide services to, arrange for, or case manage the care of Medi-Cal beneficiaries; and, establishes managed care models that DHCS contracts with in each county. [WIC §14087.3, §14089, §14087.98, §14087.967 and §14087.5]
- 3) 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]
- 4) Authorizes DHCS to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan (Medi-Cal plan) across all aid code groups and Medi-Cal managed care models statewide, with certain exceptions. [WIC §14184.200]
- 5) Requires Medi-Cal plans to comply with continuity-of-care requirements that allow recipients to complete covered services with a nonparticipating provider, as specified, when enrolling in a Medi-Cal plan if the covered services involve an acute or serious chronic condition, a pregnancy, a terminal illness, care of a newborn, or performance of a surgery that is part of a course of treatment. Except for treatment related to terminal illness, limits coverage of services with a nonparticipating provider to 12 months after the date of enrollment in the plan. [WIC §14184.200 and HSC §1373.96]
- 6) Requires states and local agencies administering the Medicaid program to take all reasonable measures to ascertain the legal liability of third parties, including health plans, to pay for care and services available under the plan. [42 USC §1396(a)]

- 7) Prohibits a person with private health care coverage from receiving the same health care items or services paid for by a publicly funded health care program. If the person does receive health care paid for by a publicly funded health care program, requires the person's private health care coverage to reimburse the publicly funded health care program for those items or services. [WIC §10020]
- 8) Requires any provider seeking payment from the Medi-Cal program to first seek payment from any other health coverage that the patient has when the provider is aware of this coverage and the coverage extends to these services before submitting a claim to DHCS for the balance of the services. Allows a provider to submit a claim to DHCS if the other health coverage does not pay the claim within 90 days of billing. [WIC §14023.7]
- 9) Prohibits a provider who obtains proof of Medi-Cal eligibility from seeking payment for the cost of covered health care services from the Medi-Cal recipient and authorizes DHCS to impose sanctions or penalties for violations, as specified. [WIC § 14019.4]
- 10) Requires providers to notify DHCS of any potential contractual or legal entitlement or other third-party liability within 60 days of discovery and gives DHCS the right to recover any contractual or legal entitlement or other third-party liability for the cost incurred in rendering care. [WIC §14024]
- 11) Requires any health insurer or managed care plan to provide to DHCS at least once a month eligibility and coverage information for each subscriber, policyholder, enrollee, or insured so that DHCS can comply with federal law regarding third-party health coverage and be the payer of last resort. Also requires any health insurer or health care plan to provide DHCS with access to real-time, electronic eligibility verification, at no cost, in a manner specified by DHCS. [WIC §14124.90]
- 12) Establishes an entitlement to services for individuals with developmental disabilities under the Lanterman Developmental Disabilities Services Act (Lanterman Act), including a right to treatment and habilitation services and supports in the least restrictive environment, a right to prompt medical care and treatment, and a right to make choices in their own lives. [WIC §4500, et seq. and §4502]
- 13) Establishes a system of nonprofit regional centers throughout the state to identify needs and coordinate services for eligible individuals with developmental disabilities and requires 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.]

This bill:

- 1) Requires DHCS to ensure that a provider not contracted with a Medi-Cal recipient's Medi-Cal plan does not face administrative requirements significantly in excess of the requirements for billing the Medi-Cal fee-for-service delivery system when billing a Medi-Cal plan for allowable costs not paid by a Medi-Cal recipient's other health coverage.
- 2) Specifies that a Medi-Cal provider participating in the Medi-Cal fee-for-service delivery system is not required to have an in-network contract with a Medi-Cal plan in order to provide services to a Medi-Cal plan enrollee with other health coverage, excluding Medicare.

Allows a Medi-Cal plan to require a letter of agreement in order to bill in the following circumstances:

- a) The covered service requires prior authorization;
 - b) The covered service is not covered by the other health coverage, but is a covered service by the Medi-Cal plan; or,
 - c) The recipient meets the requirement for continuity of care or the completion of services through a Medi-Cal plan pursuant to existing law.
- 3) Specifies that absent a letter of agreement for a) and b) above, a provider may be responsible for billed amounts for any services that exceed the allowable fee-for-service rate or any applicable limitations on the number or duration of services provided. Prohibits a provider from billing a Medi-Cal recipient for amounts in excess of what the Medi-Cal plan pays, pursuant to existing law.
 - 4) Requires DHCS to take the actions it deems necessary to clarify the conditions for billing Medi-Cal plans for recipients who have other health coverage. Permits these actions to include updating regulations, providing revised guidance to plans and providers, increasing reporting requirements, and taking enforcement action, as it deems necessary.
 - 5) States the intent of the Legislature is that DHCS offer educational resources to Medi-Cal recipients needing assistance with understanding continuity of care and coordinating Medi-Cal plan coverage with their other health coverage when requested by the Medi-Cal recipient.
 - 6) Requires DHCS to report to the Assembly and Senate Health Committees on the effectiveness of implementing this bill annually from 2027 through 2030.
 - 7) Authorizes DHCS to implement this bill in whole or in part via guidance, instead of regulation, and conditions implementation on the receipt of any necessary federal approvals and continued federal financial participation.

FISCAL EFFECT: According to the Assembly Appropriations Committee, this bill has costs to DHCS of an unknown, but likely absorbable, amount in fiscal years 2026-27 through 2029-30.

PRIOR VOTES:

Assembly Floor:	70 - 0
Assembly Appropriations Committee:	15 - 0
Assembly Health Committee:	15 - 0

COMMENTS:

- 1) *Author's statement.* 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. Two years ago, DHCS moved to a “managed care” approach for servicing these individuals. This has caused a high level of confusion in the coordination of care between providers, the plans, and DHCS that has resulted in this vulnerable population unable to bill their primary coverage, thus resulting in the loss of access to their specialized medical teams. We have 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, to say the least. We are appreciative of the efforts

of DHCS. If DHCS fixes the acknowledged problem, this bill will not be necessary and my office will drop the measure.

- 2) *Other health coverage.* The Medi-Cal program is open to all who meet the eligibility requirements, including people who have another form of health coverage such as Medicare or commercial coverage through an employer. However, under federal law, the Medi-Cal program is the payer of last resort and Medi-Cal must seek any payment available from third parties. Medi-Cal recipients must report any other health coverage they have and health plans and insurers must report to DHCS information on all participants in order to identify all Medi-Cal recipients with other health coverage. When a recipient has other health coverage, the other coverage is the primary form of coverage, and the Medi-Cal program covers services that are not included in the other health coverage. While this may be a simple concept in theory, in practice, it has often been difficult for Medi-Cal recipients to coordinate two forms of coverage and obtain the benefits of both, particularly recipients with commercial coverage who are required to enroll in a Medi-Cal plan. Medi-Cal providers must bill the other health coverage for any services covered and bill Medi-Cal only for the excluded services. Medi-Cal recipients also face difficulties finding providers who accept both their primary coverage and have a contract with their Medi-Cal plan.
- 3) *Challenges in coordinating coverage for regional center clients.* Individuals with developmental disabilities are eligible for a range of services from California's regional centers including assessments, eligibility determinations, case management and coordination, counseling, family support, genetic counseling, early intervention services, and purchase of necessary services that are included in their individual program plan. Because many regional center clients have significant health needs that go beyond the coverage of traditional commercial plans, enrollment in Medi-Cal helps the individual and family obtain these additional services, but Medi-Cal covers only what the commercial plan does not. In particular, Medi-Cal has special programs administered by DDS, the Home and Community Based Services Waiver for Californians with Developmental Disabilities and the Self-Determination Program Waiver for Individuals with Developmental Disabilities. These programs allow eligible individuals to get all of the Medi-Cal covered services as well as additional care to allow individuals who would otherwise be institutionalized, to stay in the community or allow individuals with developmental disabilities to live with as much independence as possible. These waiver programs are available to individuals in higher income families because the waiver programs have a rule, known as "institutional deeming," that allows an individual to be determined eligible based on solely their own income without taking into account the income of their parents.

Recently, as part of the CalAIM initiative, DHCS moved many populations into mandatory managed care who were previously receiving services through the Medi-Cal fee-for-service delivery system, including individuals receiving regional center services. This move has created difficulties for many families trying to preserve relationships with providers that may not be a part of the individual's new Medi-Cal plan. Individuals who have been mandatorily moved into Medi-Cal plans can use continuity-of-care protections to continue seeing an existing provider who is not part of the Medi-Cal plan for up to 12 months to manage serious acute or chronic conditions. Additionally, in some cases, if an individual is not medically stable, they may seek a temporary exemption from enrollment in a Medi-Cal plan until their condition stabilizes. As mentioned above, Medi-Cal is also the payer of last resort, thus the providers for individuals with another primary form of health coverage must coordinate with both the other form of health coverage and the Medi-Cal plan. If the provider is in-network in

both plans, this coordination is far easier, but not all providers are in both networks. Given the higher income limits of the Medi-Cal waiver programs that many regional center clients enroll in, many of these individuals have another form of health coverage through a parent's commercial coverage.

- 4) *Prior legislation.* AB 974 (Patterson of 2025) and AB 3156 (Patterson of 2024) were substantively similar to this bill. *AB 974 was held on the Assembly Appropriations suspense file. AB 3156 was vetoed by Governor Newsom, who said in his veto message: "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 plans 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 Medi-Cal plans, stakeholders, and patient advocates to address administrative barriers to ensure continuity of care for Medi-Cal enrollees."* This bill does not have the same timelines as AB 3156.

AB 1608 (Patterson of 2023) would have exempted Medi-Cal recipients from Medi-Cal managed care who received services from a regional center and have another primary form of health coverage. *AB 1608 was not heard in the Assembly Health Committee.*

AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) establishes, among other things, authority for DHCS to standardize enrollment of most populations in managed care, with limited exceptions.

- 5) *Support.* The California Association of Medical Product Suppliers (CAMPS) writes in support stating that their member companies provide, among other things, adaptive equipment for children and adults to remain in their homes or other community settings. Their members have had difficulty navigating the new reimbursement environment of complex formulas and policies as California has expanded its conversion of fee-for-service Medi-Cal to Medi-Cal managed care. Individuals who use regional center services must enroll in Medi-Cal to access the services that are not available through their health plans. Then they must coordinate the coverage of their private, commercial health care and their Medi-Cal managed care plan. They are required to demonstrate to their Medi-Cal plan that their commercial plan will not pay for a service before seeking that service from a Medi-Cal plan, yet the processes and documentation requests are not the same across plans. CAMPS believe that this transition to Medi-Cal managed care should not result in undue burden, stress, and uncertainty for these families.
- 6) *Policy comment.* This bill is very similar to AB 3156, which was vetoed due largely to the implementation timelines imposed. This bill does not have those timelines. In the meantime, the author and DHCS have shared with the committee that DHCS and the author's office had a meeting with constituents last October to discuss how the move into Medi-Cal managed care has reduced access to care for some constituents needing specialty care, particularly those with other forms of health coverage. No solutions were proposed at that meeting. Thus the need for solutions to streamline access to care through Medi-Cal plans for recipients in these circumstances continues.

SUPPORT AND OPPOSITION:

Support: California Association of Medical Product Suppliers

Oppose: None received.

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