Date of Hearing: March 24, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2457 (Connolly) – As Introduced February 20, 2026

SUBJECT: Health care provider credentialing.

SUMMARY: Extends the application of existing provider credentialing requirements, including the utilization of the Council for Affordable Quality Healthcare (CAQH) credentialing form, to Medi-Cal managed care (MCMC) plans. Specifically, **this bill**:

1) Requires MCMC plans to use the most recent version of the CAQH credentialing form and comply with the CAQH credentialing process.

2) Requires a MCMC plan, or its delegate that credentials health care providers for its networks, to make a determination regarding the credentials of a provider within 90 days after receiving a completed provider credentialing application, as specified. Requires, upon receipt of the application, the plan or its delegate to notify the applicant within 10 business days to verify receipt and inform the applicant whether the application is complete. Requires the plan or its delegate to activate the provider upon successful approval and notify the application of the activation within 10 days of approval if it occurs prior to the end of the 90-day timeline. Requires the 90-day timeline to apply only to the credentialing process, not contracting timelines. Requires, if the 90-day requirement is not met, for the plan to provisionally approve a provider for 120 days unless specified exemptions apply.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans and the California Department of Insurance (CDI) to regulate health insurance. [Health and Safety Code (HSC) § 1340, *et seq*.; Insurance Code (INS) § 106, *et seq*.]

2) Requires a health plan or health insurer, or its delegate, to subscribe to and use the most recent version of the CAQH credentialing form, and to comply with the CAQH credentialing process. [HSC § 1380.2; INS § 10110.9]

3) Requires a health plan or insurer, excluding MCMC plans, or its delegate, to make a determination regarding the credentials of a provider within 90 days after receiving a completed provider credentialing application, as specified. Requires, upon receipt of the application, the plan or insurer or its delegate to notify the applicant within 10 business days to verify receipt and inform the applicant whether the application is complete. Requires the plan or insurer or its delegate to activate the provider upon successful approval and notify the application of the activation within 10 days of approval if it occurs prior to the end of the 90-day timeline. Requires the 90-day timeline to apply only to the credentialing process, not contracting timelines. Requires, if the 90-day requirement is not met, for the plan or insurer to provisionally approve a provider for 120 days unless any of the following apply:

    a) The applicant is subject to discipline by the licensing entity for that applicant;

b) The applicant has one or more adverse action reports, or one or more reports of malpractice payments filed with the National Practitioner Data Bank; or,

c) The applicant has not been credentialed by the health care service plan in the past five years. [HSC § 1374.198; INS § 10144.56]

4) Permits a health plan to require a nonphysician provider to complete an appropriate credentialing process. [HSC § 1366.4]

5) Requires a health plan and disability insurer, for provider contracts issued, amended, or renewed on and after January 1, 2023, that provides coverage for mental health and substance use disorders and credentials health care providers of those services for the health plan or insurer's networks, to assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Requires a health plan or insurer, upon receipt of the application by the credentialing department, to notify the applicant within seven business days, to verify receipt and inform the applicant whether the application is complete. [HSC § 1374.197 and INS § 10144.56]

6) Establishes a 60-day timeframe for a health plan or insurer that provides coverage for mental health and substance use disorders to credential health care providers of those services for its networks. [HSC § 1374.197 and INS § 10144.56]

7) Permits a health plan to require a terminated provider, whose services are continued beyond the contract termination date, to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider before termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. Authorizes the plan, if the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, to not continue the provider's services beyond the contract termination date. Applies these permissions to a nonparticipating provider, as well. [HSC § 1373.96 and INS § 10133.56]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, every Californian deserves speedy access to high quality health care. The author continues that this bill offers a solution to limited access to health care by requiring MCMC plans to adopt a streamlined credentialing form, thereby eliminating potential delays for both the provider and patient. The author concludes that this bill will remove administrative burdens and help deliver vital health care to underserved Californians in rural and low-income areas.

2) **BACKGROUND.** Credentialing is the process by which documentation for each individual physician or provider is reviewed to determine participation in a health plan's network. Such documentation may include, but is not limited to, the applicant's education, training, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history, professional competency, and physical and mental impairments. A provider who wishes to contract with multiple health plans and insurers responds to multiple credentialing questionnaires and processes which may be very similar or in some cases there may be differences.

a) **CAQH**. CAQH was formed by health plans who came together nearly 25 years ago with the desire to make health care work better. CAQH has a unified data management platform to expedite the collection, verification, and ongoing monitoring of provider data. CAQH reports that more than 2.5 million providers and over 1,000 health care organizations are actively using their credentialing platform. According to CAQH, their verification process returns 95% of credentialing files within 8-14 days from the date of request, and CAQH credentialing applications are accepted in all 50 states, even those with unique state forms.

   AB 1041 (Bennet), Chapter 630, Statutes of 2025, requires state regulated commercial plans, excluding MCMC plans, to adopt the CAQH credentialing form and process by January 1, 2028. This bill would extend that requirement to MCMC plans.

b) **Other states**. The Georgia Uniform Healthcare Practitioner Credentialing Application Form and the Georgia Uniform Practitioner Healthcare Credentialing Reappointment Form were developed through the cooperative efforts of the Georgia Hospital Association, the Georgia In-House Counsel Association, the Georgia Association Medical Staff Services, and the Georgia Association of Health Plans. In addition, the Medical Association of Georgia provided input, consultation, and collaboration. These standardized documents were created with the objective of reducing the burdensome task of completing numerous non-standardized and redundant credentialing forms by the physicians themselves and their respective office staff. In 2020, the Oregon Health Authority (OHA) in consultation with health system partners and legislative sponsors, decided to officially end the Oregon Common Credentialing Program (OCCP), which had previously been suspended in 2018. The OCCP was intended by legislators to simplify credentialing processes, reduce burden on practitioners, and eliminate duplication. While there is broad consensus that the concept of centralizing credentialing information has merit, the OHA encountered significant challenges (budget shortfall) that make it difficult to implement a cost-effective program that would benefit all Oregon practitioners.

c) **Provider shortages**. The author and sponsor of this bill argue that issues with the current credentialing process can exacerbate existing physician shortages, as qualified physicians are unable to see patients while they await credentialing approval. According to the California Future of Health Workforce Commission seven million Californians, the majority of them Latino, African American, and Native American, live in Health Professional Shortage Areas, or HPSAs, a federal designation for counties experiencing shortfalls of primary care, dental care, or mental health care providers. These shortages are most severe in some of California's largest and fastest-growing regions, including the Inland Empire, Los Angeles, and San Joaquin Valley, and in most rural areas. This looming crisis will be most acute in primary care, behavioral health, and among workers who care for older adults. In just 10 years, for example, California is projected to face a shortfall of more than 4,100 primary care clinicians and 600,000 home care workers, and will have only two-thirds of the psychiatrists it needs.

3) **SUPPORT.** The Physician Association of California (PAC) is sponsoring this bill, stating that for a physician to treat Medi-Cal patients, they must have their MCMC provider credentialing application approved. PAC argues that while there are important safety measures and guardrails in the credentialing process, there is also a significant number of administrative burdens, redundancies, and unnecessary delays that ultimately affect patients.

PAC continues that it is common for a physician to wait anywhere between 90 and 180 days between submitting their credentialing application to receiving an approval. PAC argues that the differing credentialing requirements among various MCMC plans exacerbate California's existing provider shortages and are particularly impactful to underserved populations in rural and low-income areas. PAC continues that this bill will require all MCMC plans to adopt a streamlined credentialing form and process that is now required of commercial plans under AB 1041 (Bennett).

4) PREVIOUS LEGISLATION.

a) AB 1041 (Bennett), Chapter 630, Statutes of 2025 applies the provisions of this bill to DMHC and CDI regulated health plans and insurers, excluding MCMC plans.

b) AB 815 (Wood) of 2023 would have required health plans and insurers to assess and verify health care provider qualifications within 90 days after receiving a completed provider application and requires a provider to be notified within 10 business days to verify receipt and if the application is complete. AB 815 would have required the California Health and Human Services Agency to create and maintain a physician credentialing board to develop a standardized credentialing form to be used by every health plan and insurer. AB 815 was held on the Senate Appropriations suspense file.

c) AB 2581 (Salas), Chapter 533, Statutes of 2022, requires a health plan or disability insurer that provides coverage for mental health and substance use disorders and credentials health care providers of those services for the health care service plan's or disability insurer's networks, to assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application.

d) SB 964 (Hernandez), Chapter 573, Statutes of 2014, requires a health plan to annually report specified network adequacy data, as specified, to DMHC as a part of its annual timely access compliance report, and requires DMHC to review the network adequacy data for compliance.

e) AB 2179 (Cohn), Chapter 797, Statutes of 2002, requires DMHC and CDI to develop and adopt regulations to ensure that enrollees have access to needed health care services.

REGISTERED SUPPORT / OPPOSITION:

Support

Physician Association of California (sponsor)
America's Physician Groups (sponsor)
Council for Affordable Quality Healthcare
Seneca Family of Agencies

Opposition

None on file

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