CALIFORNIA UPDATE

August 28, 2026

Welcome to America's Physician Groups' *California Update*. Each week APG reports the latest on health care happenings in the Golden State.

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The Week In Review

This week, APG secured unanimous legislative approval of AB 2594 to extend the California Schools VEBA direct-contracting pilot, obtained important flexibility from DMHC for implementation of federal electronic prior authorization requirements, and opposed AB 539 and AB 1018 because of their potential effects on coordinated clinical care. APG also pressed OHCA to ensure that physician organizations are held accountable only for costs they can control and urged DHCS to provide timely, standardized, and workable requirements for delegated entities under the 2025 Medi-Cal Medical Loss Ratio reporting framework. Read about it below.

APG Moves To Oppose AB 539 On Year-Long Authorization Approvals

APG submitted its final opposition letter on **AB 539 (Schiavo)**, joined by five APG member organizations that provided supporting letters emphasizing the clinical risks of requiring an approved prior authorization to remain valid for a prescribed course of treatment for up to one year. APG's letter argues that the bill fails to clarify which provider determines the course of treatment when multiple physicians share responsibility for a patient, could interfere with appropriate clinical reassessment, and creates an unresolved interaction with the prior authorization reforms now being implemented under SB 306.

APG extends its thanks to **MemorialCare Medical Foundation, Sutter Medical Group, Children First Medical Group IPA, Hill Physicians Medical Group, and Universal Healthcare IPA** for responding quickly and adding

the clinical voice of physician organizations to our advocacy. Their letters provided compelling examples involving cancer immunotherapy, changing drug therapies, pediatric care coordination, diagnostic imaging and invasive procedures, while reinforcing the need for physician organizations to retain the ability to reassess treatment as a patient's condition changes. Their participation substantially strengthens APG's message that prior authorization reform should reduce unnecessary administrative burdens without undermining coordinated clinical management and patient safety.

APG Opposes AB 1018's Overly Broad AI Requirements

APG has joined a broad coalition of health care organizations in opposing **AB 1018 (Bauer-Kahan)** unless it is amended. Although recent amendments recognize that HIPAA-regulated health care entities warrant different treatment, the bill would still require providers to disclose when an automated decision system has "facilitated" a consequential decision before that decision is finalized. In everyday clinical practice, however, physicians and nurses routinely combine laboratory results, imaging, clinical guidelines, risk scores, electronic alerts, patient preferences, and professional judgment. There often is no distinct point at which technology facilitates a decision and the clinician subsequently finalizes it.

The bill's expansive approach could sweep longstanding clinical decision-support tools into a substantial new compliance framework without producing a corresponding improvement in patient care. Providers would have to inventory covered systems, determine which clinical decisions trigger the law, prepare disclosures, and continually update them as technology changes. At a time when California faces serious health care workforce shortages, these requirements could discourage tools that improve patient outcomes, expand access, reduce administrative workload, and help clinicians use limited resources more effectively. APG believes AB 1018 should instead focus on genuinely high-risk automated systems that replace meaningful human decision-making—not routine tools that support physicians and other health professionals. Read our joint floor alert **here**.

DMHC Responds to APG Request for Flexibility in Federal Prior Authorization Implementation

APG has achieved an important step toward a more practical implementation of the federal CMS interoperability and prior authorization requirements for California's delegated physician organizations. Following APG's July 27 meeting with DMHC, DHCS, and HCAI—and our subsequent request to DMHC for clarification—the

Department has issued a **draft All Plan Letter** that would apply the same compliance requirements and guidance previously established by DHCS in APL 26-008 to California's commercial health plans. The draft specifically states that DMHC "adopts the same compliance requirements and guidance articulated under DHCS APL 26-008 for all plans."

This directly addresses the relief APG requested. During our discussions with the three departments, DHCS clarified that the federal requirements provide flexibility in implementing electronic prior authorization, including use of the HIPAA X12 278 transaction standard as an alternative to immediate implementation of the FHIR-based Prior Authorization API. APG subsequently asked DMHC to make that same flexibility clear for the commercial market. Our concern was that, without uniform guidance, individual health plans could impose differing API requirements on their delegated physician organizations, resulting in costly and duplicative technology investments and a fragmented implementation process.

The draft APL provides the regulatory alignment APG sought by expressly adopting DHCS's compliance framework rather than establishing a separate commercial-market standard. It also establishes a February 1, 2027 filing deadline for plans to demonstrate compliance with Health & Safety Code § 1374.196 as of
January 1, 2027.

This is a significant and timely response by DMHC to concerns raised by APG and our members. It preserves greater flexibility for delegated organizations and provides a more uniform path toward implementation while the California health care market continues its transition toward FHIR-based interoperability. APG appreciates DMHC's responsiveness and will continue working with the Department, DHCS, HCAI, health plans, and our members as implementation moves forward.

APG And Cal Schools VEBA Obtain Unanimous Floor Vote To Pass AB 2594

AB 2594 was passed by the Senate and Assembly on August 25th to extend the direct contracting pilot through December 31, 2030, which will allow more performance data to be gathered and reported in support of APG's long-standing effort to pioneer capitated-delegated payment models in the self-funded coverage market. The bill will move to the Governor's desk in a few days for review and, we hope, signature into law. APG's signature request letter can be read **here**.

OHCA Advances Spending Target Enforcement Framework

The Health Care Affordability Board took another major step toward implementing its spending target enforcement framework at its August 26 meeting, unanimously approving the proposed scope and range of spending target penalties and the factors OHCA will use to adjust them. Under the approved approach, an initial penalty would be based on the amount by which an entity's spending exceeded its target and could then be adjusted from **0 to 125 percent** based on specified factors. Importantly, enforcement remains a multi-step process involving additional data review, technical assistance and potentially a Performance Improvement Plan (PIP) before spending target penalties are imposed. Staff indicated that the earliest such penalties are likely around 2030 or 2031. OHCA plans to release draft enforcement regulations for informal comment in October, submit them to the Office of Administrative Law in November, and seek regulations effective by December 2026.

APG continued to emphasize that **attribution for enforcement purposes must be based on control**. Risk-bearing physician organizations may be attributed hospital, pharmaceutical, behavioral health and other expenditures that they do not financially or operationally control, while lacking access to the underlying health plan data necessary to validate those attributions. APG urged OHCA to develop adjustment factors for these circumstances, provide RBOs access to the underlying attribution data, and ensure that PIPs address only spending drivers an organization can actually influence. These concerns gained broader attention during the meeting, with Board members and other stakeholders emphasizing the need to distinguish controllable from uncontrollable costs; the Board also acknowledged the need for further discussion of data methodology and the unique challenges facing physician organizations. **APG is not giving up on these policy priorities. As OHCA moves toward draft enforcement regulations this fall, we will continue to advocate strenuously for an approach that better recognizes and supports California's delegated model, rewards organizations already operating under advanced value-based payment arrangements, and does not hold physician organizations responsible for costs they do not control.** OHCA's forthcoming October enforcement regulations will provide the next major opportunity to advance these protections.

DHCS Provides Important Clarifications on 2025 MLR Reporting
DHCS held a **stakeholder meeting** on August 27 to provide updates on its implementation of the 2025 Medi-Cal Medical Loss Ratio reporting requirements. APG emphasized that DHCS should make its subcontractor reporting templates publicly available when they are released to Medi-Cal managed care plans. Delegated physician organizations need adequate

lead time to convert financial information maintained under Generally Accepted Accounting Principles into the different classifications and reporting structure required by the templates.

APG also urged DHCS to standardize MCP data-reporting requirements, at least regionally, to avoid variations among plans in reporting content, deadlines, and standards. This administrative variation is burdensome and inefficient for subcontracted delegates—particularly those contracting with multiple MCPs—and undermines the consistency of the information collected. Greater standardization would reduce unnecessary administrative costs while producing more comparable and actionable data for DHCS.

APG also requested clarification of the reporting deadline. Federal regulations generally require third-party vendors performing claims-adjudication activities to provide the underlying MLR data to plans within 180 days after the end of the reporting year—June 29, 2026, for calendar year 2025 reporting. During the meeting, DHCS described some flexibility in applying that deadline. APG will seek further clarification regarding the scope of that flexibility and how it will apply to delegated entities.

Finally, APG asked how fraud, waste and abuse prevention activities performed by delegated physician organizations should be treated. Although general fraud-prevention expenses are excluded from HCQI treatment under the federal framework, DHCS explained that certain components may qualify when they independently satisfy the requirements for health care quality improvement activities. Those requirements flow through 42 C.F.R. § 438.8 and are further defined in 45 C.F.R. § 158.150. APG will continue working with DHCS to determine which clinically integrated program-integrity activities may be recognized as HCQI expenses and what documentation members will need to support their inclusion.

2026 APG California Policy & Advocacy Meeting Dates
*Members, please mark your calendars for APG's California Policy Forum and California Medi-Cal Forum meetings. You can download APG's 2026 events calendar **here**.*

California Policy Forum
2:00 - 3:00 pm

- December 3

California Medi- Cal Forum
4:00 - 5:00 pm

- October 13
- November 10
- December 8

APG California Advocacy Member Resources

- 2025 Legislative Implementation Guide
- **Tracked Health Care** Bills 2025-26: bills we're following in the California State Legislature

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For more news and resources, please visit APG's website or contact a member of APG's California advocacy team.

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