CALIFORNIA UPDATE

September 4, 2026

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

Here's what you'll find in this week's edition:

- **DHCS To Hold Webinar On Ordering, Referring, And Prescribing (ORP) In Medi-Cal Rx**
- **APG Advocacy Leads To Relief On UHC Medicare Advantage Clinical Criteria Requirement**
- **APG Urges DHCS To Clarify And Standardize New Overpayment Requirements**
- **California Artificial Intelligence (AI) Health Care Proposals: Measures On The Governor's Desk**
- **APG California Policy & Advocacy 2026 Meeting Dates**
- **APG California Advocacy Member Resources**

DHCS To Hold Webinar On Ordering, Referring, And Prescribing (ORP) In Medi-Cal Rx

On **September 24**, from **10:30 a.m. to 12 p.m**. PDT, DHCS will host a second Town Hall webinar to present the planned approach and timeline for enforcement of Ordering, Referring, and Prescribing (ORP) enrollment requirements for claims across pharmacy (Medi-Cal Rx), behavioral health (Short-Doyle) and medical (CA-MMIS) billing systems.

Based upon stakeholder feedback received after the July 30 Town Hall webinar and August stakeholder meetings, DHCS has refined the multi-year, phased approach for application of provider enrollment status claim edits.

DHCS will share the timeline for implementation beginning in 2027, to comply with federal law requiring providers who order, refer, or prescribe services for Medi-Cal members to be enrolled in Medi-Cal and identified on claims using a valid Type 1 (Individual) National Provider Identifier (NPI).

APG Advocacy Leads To Relief On UHC Medicare Advantage Clinical Criteria Requirement

APG members received important relief this week from a UnitedHealthcare Medicare Advantage documentation requirement that had raised significant concerns among delegated physician organizations. APG had questioned whether physician organizations using nationally

recognized clinical criteria should be required to recreate extensive documentation already developed and maintained by their clinical guideline vendors.

Following concerns raised by APG and multiple delegated risk-bearing organizations, UHC announced on September 2 that, after executive leadership review of the CMS Final Rule and current guidance governing Internal Coverage Criteria (ICC), it will **no longer require physician organizations using third-party clinical criteria, such as MCG or Apollo, to submit separate coverage summaries at this time**. UHC characterized the change as a refinement of its oversight approach while continuing to support compliance with CMS utilization management requirements.

The development also follows direct engagement between MCG and CMS concerning questions raised about MCG's rationale summaries and transparency solution. MCG has informed APG members that CMS indicated it was not aware of concerns with MCG's transparency solution and was not opposed to rationale summaries applying across multiple guidelines where clinically appropriate. MCG has since provided CMS with examples for further review and expects a formal response from the agency.

The issue was initially brought to APG by **Phyllis Adams of Heritage Provider Network**, who identified the operational implications of UHC's requirement and requested APG's advocacy. APG subsequently convened members to evaluate the requirement and develop a coordinated response. APG also thanks **Mike Meyers, CEO of HICE**, for incorporating the issue into HICE's existing utilization management workgroup effort and facilitating engagement with MCG staff. APG particularly appreciates the contributions of **Phyllis Adams, Jonas Green, George Hong, Andrea Snyder, Darren McLachlan, Kara Bourne, Glenn Loomis, Debra Muscio, and David Joyner**, whose operational and clinical expertise helped inform the collective response.

APG appreciates UHC's willingness to reconsider its approach and will continue working with HICE, UHC, MCG, and APG members as CMS provides further guidance. APG's goal remains a **standardized, operationally practical, and vendor-neutral framework** that enables delegated physician organizations to demonstrate CMS compliance without unnecessary duplication of clinical information already developed and made publicly available through nationally recognized clinical criteria resources.

APG Urges DHCS To Clarify And Standardize New Overpayment Requirements

On September 3, APG submitted **comments** to the Department of Health Care Services (DHCS) concerning its **draft All Plan Letter** governing Medi-Cal managed care overpayments. The draft would require managed care plans to report every identified overpayment within 30 days, regardless of amount or cause, and require providers and delegated entities to return overpayments within 60 days. However, it does not define when an overpayment is considered "identified," creating uncertainty about when these deadlines begin.

APG urged DHCS to adopt a uniform statewide definition based on the False Claims Act knowledge standard and to allow up to 180 days for a timely, good-faith investigation of related payments. APG also requested a streamlined reporting process for low-dollar adjustments, a prospective January 1, 2027 implementation date, and safeguards against recovering disputed amounts before plans and providers receive supporting information and a meaningful opportunity for review.

The letter emphasizes that leaving the identification standard to individual plans would create yet another source of administrative friction in the delegated model. Most delegated physician organizations contract with multiple Medi-Cal managed care plans. Different plan-specific definitions, documentation requirements, escalation procedures, and reporting workflows would increase administrative costs and could produce inconsistent treatment of the same underlying facts. APG therefore called on DHCS to establish one clear and administrable standard that protects program integrity while producing more consistent and actionable information for the Department.

California Artificial Intelligence (AI) Health Care Proposals: Measures On The Governor's Desk

August 31st was the last day for the California legislature to send bills to the Governor's desk for the 2025-26 Legislative Session. As reported earlier, the regulation of artificial intelligence (AI) remained a top issue for the legislature and was heavily debated throughout the late hours of the end of session. APG has been engaged throughout the session to ensure that newly introduced AI policy measures support value-based care, enhance clinical workflows, and avoid unintended restrictions on providers.

There were several AI proposals introduced in the 2025-26 legislative session and they impacted a broad range of industries. However, several bills were specifically directed at the health care industry. Many of the proposals focused on how health care professionals may utilize AI in the clinical setting, and what types of disclosures are required for patients and health care professionals using these AI tools. These proposals were

primarily sponsored by the California Nurses Association. Ultimately, many of the more problematic provisions were removed or amended from the AI proposals. However, one measure (AB 1575 (Ortega)) did get to the Governor's desk and APG is requesting a VETO for this measure. Below is a summary of some of the key AI health care related proposals that were considered this year.

- **AB 1979 (Bonta)** AB 1979 was authored by the Chair of the Assembly Health Committee, Mia Bonta. An earlier version of AB 1979 sought to 1) add "health care chatbots" to the existing requirements of the California Medical Information Act; and 2) require health facilities, clinics, and physician's offices to ensure that no clinical decision by a provider is based solely on the output of a clinical decision support system (CDSS). This raised several concerns with APG and would have significantly limited the ability of providers to use AI in the clinical setting. Ultimately, a significant number of amendments were taken in the Senate Health Committee and APG was able to move to a NEUTRAL position. AB 1979 is currently awaiting action on the Governor's desk.

- **SB 503 (Weber)** SB 503 was authored by the Chair of the Senate Committee on Health and introduced in 2025. Initially SB 503 contained some potentially problematic provisions relating to ensuring that AI tools mitigate any potential biases in their use. Several amendments were made to SB 503 narrowing the measure's application and narrowing the definition of "biased impacts" and the notice requirements. APG joined some other industry stakeholders, like Kaiser Permanente, in moving to a Support position with these amendments. SB 503 is currently on the Governor's desk awaiting his signature.

- **AB 2575 (Ortega)** seeks to establish a series of problematic requirements on health facilities, physician's offices and group practices that utilize a CDSS. APG has been Opposed to AB 2575, along with other health care industry stakeholders, throughout most of the legislative session.

When AB 2575 was initially brought to the Senate Floor for consideration it failed to pass. In a series of last-minute amendments and waivers of the parliamentarian rules, AB 2575 was pushed off the Senate Floor with the bare minimum 21 votes required and is currently waiting for the Governor's signature. In its current form, AB 2575 seeks to prohibit an employer from retaliating or discriminating against an employee providing direct patient care if they override a CDSS while using their professional judgment and places several other administrative

requirements. APG, along with several other healthcare industry stakeholders are requesting a VETO of AB 2575.

Governor Newsom has until September 30 to act on legislation sent to his desk during the 2025-26 Legislative Session.

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 - ***Register***
- 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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