

TEXT OF PROPOSED EMERGENCY REGULATIONS

Legend: Proposed additions to the current text published in the California Code of Regulations are illustrated in green underline (added text). Deleted text is illustrated in red strikethrough (~~deletions~~).

Note to Reader: These draft regulations assume that OAL will approve the previously submitted emergency regulations regarding requests to adjust the spending target based on nonsupervisory organized labor costs (NOLA Regulations) with revisions to Section 97445 and 97449. For more information, please see the NOLA Regulations and the Advance Notification of Proposed Emergency Regulatory Action (dated 9/23/2026), available at: [Laws & Regulations - HCAI](#)

California Code of Regulations, Title 22. Social Security

Division 7. Health Planning and Facility Construction

Chapter 11.5. Promotion of Competitive Health Care Markets; Health Care Affordability

Article 2. Health Care Spending Targets.

§ 97445. Definitions.

As used in this Article, the following definitions apply:

(a) "Accountable health care entity" refers to a payer, a fully integrated delivery system, a physician organization, and a hospital health facility.

(~~a~~b) "Affiliated," as used in section 97449(d) of these regulations, refers to a situation in which an entity controls, is controlled by, or is under common control with another entity.

(~~b~~c) "Board" shall mean the Health Care Affordability Board.

(~~e~~d) "Control" (including the terms "controlling," "controlled by," and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an entity, whether through the ownership of voting shares, debt, by contract, or otherwise.

(~~d~~e) "Department" shall mean the Department of Health Care Access and Information.

(~~e~~f) "Directly contracted plan" means a payer or fully integrated delivery system that is directly contracted with a group purchaser, individual subscriber, or a public agency, to arrange for the provision of health care services to members.

(~~f~~g) "Director" shall mean the director of the Department of Health Care Access and Information.

(~~g~~h) "Fully integrated delivery system" shall have the meaning set forth in section 127500.2(h) of the Health and Safety Code ("the Code").

(i) "Hospital Health Facility" shall include all entities listed in section 97446(a).

(~~h~~i) "Health insurer" means a health insurer licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.

(~~k~~l) "Health plan" means a health care service plan or a specialized mental health care service plan as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). "Health plan" does not include a health care service plan that holds only a restricted or limited license under 28 CCR § 1300.49(a).

(~~j~~l) "Office" shall mean the Office of Health Care Affordability established by section 127501 of the Code.

(~~k~~m) "Payer" shall have the meaning set forth in section 127500.2(~~e~~q) of the Code.

(n) "Performance Improvement Plan" as used in section 127502.5 of the Code, means an action plan to bring an entity into compliance with an applicable spending target.

(o) "Performance Improvement Plan Submission Guide" means the Office of Health Care Affordability: Performance Improvement Plan Submission Guide, dated October 08, 2026, and hereby incorporated by reference. The Performance Improvement Plan Submission Guide is available on, and may be downloaded from the Department's website, hcai.ca.gov.

(~~p~~q) "Plan-to-plan contract" means a contractual arrangement between a payer or fully integrated delivery system and another payer or fully integrated delivery system, in which the subcontracted plan makes network providers available to the directly contracted plan's members, and the subcontracted plan may be responsible for other directly contracted plan functions. Plan-to-plan contracts do not include contractual arrangements between a payer or fully integrated delivery system and a physician organization.

(~~m~~q) "Physician organization" shall have the meaning set forth in section 127500.2(~~p~~r) of the Code.

(~~m~~q) "Provider" shall have the meaning set forth in section 127500.2(~~q~~t) of the Code.

(~~r~~t) "Registered submitter" means a payer or fully integrated delivery system or approved voluntary submitter that has registered to submit data through the Data Portal.

(es) “Reporting year” means the service year for which data files are being reported.

(pt) “Required submitter” means a payer or fully integrated delivery system that meets any of the criteria in section 97449(a).

(u) “Spending Target Performance Measurement Manual” means the Office of Health Care Affordability: Spending Target Performance Measurement Manual, dated October 08, 2026, and hereby incorporated by reference. The Spending Target Performance Measurement Manual is available on, and may be downloaded from, the Department’s website, hcai.ca.gov.

(qv) “Subcontracted Plan” means a payer or fully integrated delivery system that has a plan-to-plan contract allowing a directly contracted plan's members access to the subcontracted plan's network providers.

(fw) “System” or “THCE System” means the Total Health Care Expenditures Data System.

(sx) “THCE Data Portal” or “Data Portal” means the secure data submission mechanism through which health care entities register to submit data and data files are submitted to the System. The Data Portal is available via the Department's website, hcai.ca.gov.

(ty) “THCE Data Submission Guide” or the “Guide” means the Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 3.0), dated April 2026, and hereby incorporated by reference. The Guide is available on, and may be downloaded from, the Department's website.

(z) “Total medical expenses” or “TME” means total health care expenditures excluding administrative cost and profits.

(aa) “Total non-medical expenses” or “TNME” shall have the meaning set forth in section 127500.2(a) of the Code.

(ubb) “OHCA Attribution Addendum” means the Office of Health Care Affordability: Attribution Addendum, dated April 2026, and hereby incorporated by reference. The OHCA Attribution Addendum is available on, and may be downloaded from, the Department's website.

(vcc) “OHCA Behavioral Health Addendum” means the Office of Health Care Affordability: Behavioral Health Addendum, dated April 2026, and hereby incorporated by reference. The OHCA Behavioral Health Addendum is available on, and may be downloaded from, the Department's website.

(wdd) “OHCA Medi-Cal Payments Addendum” means the Office of Health Care Affordability: Medi-Cal Payments Addendum, dated April 2026, and hereby

incorporated by reference. The OHCA Medi-Cal Payments Addendum is available on, and may be downloaded from, the Department's website.

(~~ee~~) "OHCA Primary Care Addendum" means the Office of Health Care Affordability: Primary Care Addendum, dated April 2026, and hereby incorporated by reference. The OHCA Primary Care Addendum is available on, and may be downloaded from, the Department's website.

(~~yff~~) "Voluntary submitter" means a payer or fully integrated delivery system that is not subject to the requirements of this Article that chooses to voluntarily submit data to the Office and has been approved by the Office to register to submit data through the Data Portal.

(gg) "Year-over-year spending growth per-member-per-year" means, in the context of payer or fully integrated delivery system performance measurement, the spending growth per payer or fully integrated delivery system member for a reporting year when compared to the prior reporting year as calculated pursuant to the Spending Target Performance Measurement Manual.

(hh) "Attributed year-over-year spending growth per-member-per-year" means, in the context of physician organization performance measurement, the attributed spending growth a payer or fully integrated delivery system attributed to a physician organization member for a reporting year when compared to the prior reporting year as calculated pursuant to the Spending Target Performance Measurement Manual.

(ii) "Year-over-year combined payer-specific spending growth" means, in the context of hospital health facility performance measurement, a weighted combined growth measure for each payer type as calculated pursuant to the Spending Target Performance Measurement Manual.

Note

Authority: Sections 127501, 127501.2~~and~~, 127501.4 and 127502.5, Health and Safety Code.

Reference: Sections 127500.2, 127501.4, 127502.5, 127504 and 127505, Health and Safety Code

§ 97449. Total Health Care Expenditures Data Submission.

In order for the Office to measure total health care expenditures and per capita total health care expenditures, the reporting requirements for payers and fully integrated delivery systems to submit data and other information are as follows:

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- (b) A payer or fully integrated delivery system that meets any of the criteria in subsection (a) ("required submitter") shall submit data for all required market categories as outlined in the Guide incorporated in section 97445(~~ty~~), to the extent consistent with federal law.

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Note:

Authority cited: Sections 127501, 127501.2 and 127501.4, Health and Safety Code.

Reference: Sections 127500.2, 127500.5 and 127501.4, Health and Safety Code.

§ 97452. Spending Target Enforcement.

- (a) An accountable health care entity's failure to comply with an applicable spending target established by the Health Care Affordability Board pursuant to section 127502 of the Code is a violation of the Act. The Director shall enforce the failure to comply with an applicable spending target pursuant to section 127502.5(a) of the Code.

- (1) A payer or fully integrated delivery system fails to comply with an applicable spending target when the year-over-year spending growth per-member-per-year of either total medical expense or total non-medical expense, calculated by market, exceeds the applicable spending target. The Office shall calculate the year-over-year spending growth per-member-per-year pursuant to the Spending Target Performance Measurement Manual.
 - (2) A physician organization fails to comply with an applicable spending target when the attributed year-over-year spending growth per-member-per-year of total medical expense, calculated by market, exceeds the applicable spending target. The Office shall calculate the year-over-year spending growth per-member-per-year pursuant to the Spending Target Performance Measurement Manual.
 - (3) A hospital health facility fails to comply with an applicable spending target when the year-over-year combined payer-specific spending growth, calculated by market, exceeds the applicable spending target. The Office shall calculate the year-over-year combined payer-specific spending growth pursuant to the Spending Target Performance Measurement Manual.
- (b) Pursuant to section 127502.5(b) of the Code, the Office shall provide an accountable health care entity with a written notice of preliminary determination stating that OHCA determined the entity exceeded a spending target.

- (1) The notice shall be sent to the electronic mail address the accountable health care entity used to register in the Data Portal or electronic mail address of the primary contact person the hospital health facility designated for SIERA pursuant to California Code of Regulations, title 22, section 97041.1, subdivision (a). If an accountable health care entity is not registered in the Data Portal or SIERA, the notice shall be sent to the entity's agent for service of process.
- (2) A notice of preliminary determination shall include, at a minimum, the following:
 - (A) The name and address of the accountable health care entity.
 - (B) Identification of the applicable spending target.
 - (C) If the accountable health care entity is a payer or fully integrated delivery system, the entity's year-over-year spending growth per-member-per-year. If the accountable health care entity is a physician organization, the entity's attributed year-over-year spending growth per-member-per-year. If the accountable health care entity is a hospital health facility, the entity's year-over-year combined payer-specific spending growth.
 - (D) A statement of the extent to which the entity exceeded the applicable spending target ("excess spending growth"), and
 - (E) A statement that the accountable health care entity has 45 calendar days to respond and provide additional data and information related to factors that explain all or a portion of the excess spending growth.
- (3) The accountable health care entity shall have 45 calendar days from the date of the notice of preliminary determination to respond and provide additional data and information related to factors that explain all or a portion of the excess spending growth.
 - (A) Request for an Extension. At least 14 calendar days before the deadline to respond to the notice of preliminary determination, an entity may request an extension of up to 15 calendar days. An accountable health care entity shall submit a request for an extension of time electronically to SpendingTarget@hcai.ca.gov
 - (B) The request for an extension shall include, at a minimum, the following:
 - (i) the name, title, and contact information of the individual authorized to make the request on behalf of the accountable health care entity.
 - (ii) the date requested to submit the response.
 - (iii) a detailed explanation of the reasons for the request for extension, including, but not limited to, any issues preventing the required submitter from submitting a response.
 - (C) The Office has sole discretion to grant or deny requests for extensions of time. The Office shall review the request and grant an extension request if OHCA determines circumstances prevent timely submission of a response

to the notice of preliminary determination, including but not limited to, a natural disaster, a catastrophic event, a declared state of emergency, unforeseen disruptions to personnel, unforeseen disruptions to business operations, unforeseen disruptions to information technology systems, or another extraordinary event that directly impacts the submission of a response to the notice of preliminary determination.

- (4) The accountable health care entity's response to the notice of preliminary determination shall demonstrate the impact of relevant factors that contributed to the entity's excess annual spending growth, including but not limited to the following, as applicable:
- (A) The impact of unique population characteristics or changes in the distribution of social risk of the entity's population on the entity's excess spending growth.
 - (B) The impact of high-cost patient outliers on the entity's excess spending growth.
 - (C) The impact of high-cost drugs on the entity's excess spending growth after accounting for all rebates, discounts, fees, administrative payments, chargebacks, price concessions, and any other remuneration or financial consideration received directly or indirectly, whether received from a manufacturer, wholesaler, distributor, pharmacy benefit manager, or other entity.
 - (D) The impact of investments in primary and preventive care on the entity's excess spending growth.
 - (E) The impact of changes in state or federal law on the entity's excess spending growth.
 - (F) The impact of acts of God or catastrophic events on the entity's excess spending growth.
 - (G) The impact of non-supervisory organized labor costs on the entity's excess spending growth.
 - (H) Any other information the entity determines is relevant to its spending growth.
- (5) An accountable health care entity that disputes the Office's calculation of excess spending growth shall include in its response the entity's calculation of excess spending growth in accordance with the Spending Target Performance Measurement Manual, and a summary of the material facts supporting that calculation.
- (6) The Office may request supplemental documentation, analysis, or data regarding factors that explain all or a portion of the accountable health care entity's excess spending growth. Failure to provide the information may result in the Office determining the entity's explanation of all or a portion of the

excess spending growth is unsupported and that the Office's calculation shall stand.

- (c) The Office may modify the preliminary determination of excess spending growth if the accountable health care entity's response under subsection (b)(3) shows, by clear and convincing evidence, that the Office's calculation of excess spending growth is incorrect. A modification does not preclude the Office from proceeding with progressive enforcement if the entity's spending growth remains above the spending target.
- (d) In determining whether an accountable health care entity is subject to enforcement and the appropriate enforcement action, the Director may consider the accountable health care entity's response under subsection (b)(4) through (b)(6), the considerations stated in section 127502.5(a) of the Code, and one or more additional factors, including but not limited to the following, as applicable:
 - (1) The entity's historical spending growth.
 - (2) The entity's impact on consumer access and affordability.
 - (3) The entity's baseline costs.
 - (4) The amount of the entity's excess spending growth.
 - (5) The entity's actions that impair or impede enforcement of spending targets, including the conduct listed under section 127502.5 (h)(1) of the Code.
- (e) The Office shall notify an accountable health care entity in writing of the Office's final determination of excess spending growth and the type of enforcement action, if any. The Office shall publish the entity's excess spending growth on the Department's website pursuant to section 127502.5(c)(1).
- (f) Nothing in this section shall be construed to limit the Director's authority to directly assess administrative penalties against an accountable health care entity pursuant to sections 127502.5(h)(1) or 127502.5(a)(4) of the Safety Code.

Note:

Authority: Sections 127501, 127501.2, and 127502.5, Health and Safety Code

Reference: Sections 127501, 127501.2, 127501.4 and 127502.5, Health and Safety Code.

§ 97453. Technical Assistance

- (a) If the Director requires technical assistance for an accountable health care entity pursuant to section 97452, the Office shall notify the entity.
 - (1) The notice shall be sent to the electronic mail address the accountable health care entity used to register in the Data Portal or electronic mail address of the primary contact person the hospital health facility designated for SIERA pursuant to California Code of Regulations, title 22, section 97041.1, subdivision (a). If an accountable health care entity is not registered in the Data Portal or SIERA, the notice shall be sent to the entity's agent for service of process
 - (2) The notice shall include, at a minimum, the following:
 - (A) The name and address of the accountable health care entity.
 - (B) Identify the applicable spending target.
 - (C) State the excess spending growth, and
 - (D) Technical assistance information.
- (b) Technical assistance information includes, but is not limited to, the following, as applicable:
 - (1) resources and guidance to support the accountable health care entity in understanding applicable spending targets,
 - (2) research studies or academic literature relevant to drivers of excess spending growth,
 - (3) cost-reducing strategies.
- (c) Subject to section 127502.5(c)(4) of the Code, the Office may post the following on the Department's website:
 - (1) Technical assistance template letters without specific information about an accountable health care entity.
- (d) No later than 45 calendar days from the date of the notice containing technical assistance information, the accountable health care entity shall confirm receipt of the technical assistance information by sending an electronic email to SpendingTarget@hcai.ca.gov.
- (e) The accountable health care entity shall consider the technical assistance information in good faith, exercise judgement in determining if any elements of the technical assistance would be suitable to the entity's particular circumstances and make reasonable efforts to implement technical assistance.
- (f) Technical assistance provided by the Office shall not be construed as a representation, assurance, or guarantee that an entity will achieve compliance with an applicable spending target. The accountable health care entity's adherence to technical assistance shall neither create a presumption of compliance with applicable spending targets nor limit the authority of the Director to take additional enforcement actions.

Note:

Authority: Sections 127501, 127501.2, and 127502.5, Health and Safety Code

Reference: Sections 127501, 127501.2, 127501.4 and 127502.5, Health and Safety Code.

§ 97454. Public Testimony

- (a) If the Director requires public testimony for an accountable health care entity pursuant to section 97452, the Office shall notify the entity.
 - (1) The notice shall be sent to the electronic mail address the accountable health care entity used to register in the Data Portal or electronic mail address of the primary contact person the hospital health facility designated for SIERA pursuant to California Code of Regulations, title 22, section 97041.1, subdivision (a). If an accountable health care entity is not registered in the Data Portal or SIERA, the notice shall be sent to the entity's agent for service of process.
 - (2) A notice of public testimony shall include, at a minimum, the following:
 - (A) The name and address of the accountable health care entity;
 - (B) Identify the applicable spending target;
 - (C) State the excess spending growth;
 - (D) the purpose of the public testimony;
 - (E) the issues to be addressed;
 - (F) whether the testimony shall be provided orally, in writing, or both; and
 - (G) any applicable deadlines, meeting dates, or other procedural requirements consistent with this section.
 - (3) The testimony shall address the matters identified in the Office's notice, including but not limited to the following, as applicable:
 - (A) drivers of the entity's excess spending growth;
 - (B) corrective actions taken or proposed by the entity; and
 - (C) any past barriers to the entity's compliance with applicable spending targets.
- (b) Public testimony may be oral. If the Director requires oral public testimony, the Office shall notify the accountable health care entity of the time and place of the public meeting at least 30 calendar days prior to the public meeting.
 - (1) At least 20 calendar days prior to the meeting, the accountable health care entity shall identify one or two representatives authorized to testify on behalf of the entity and provide their names, job titles, and contact information to the Office.

- (2) If oral public testimony is presented before the Health Care Affordability Board, the testimony shall occur during a public meeting conducted in accordance with the Bagley-Keene Open Meeting Act (Government Code section 11120 et seq.). The Health Care Affordability Board, the Director, Department Executives, or their designee(s), may ask the accountable health care entity questions during oral public testimony.
- (c) Public testimony may be written. If the Director requires written public testimony, the Office shall specify the deadline for submitting the written testimony, which shall be at least 30 calendar days after the date on the notice of public testimony.
- (1) The written testimony shall respond to each issue identified in the Office's notice of public testimony and may include supporting documentation.
- (2) The written testimony shall be signed by an officer of the accountable health care entity and include an attestation signed under penalty of perjury affirming the information provided is true and correct, to the best of the attestor's personal knowledge.
- (d) If the Director determines that both written and oral public testimony are appropriate, the written testimony may serve as the accountable health care entity's primary submission, and the oral testimony may be limited to summarizing the written testimony, responding to questions, or providing updates on matters addressed in the written testimony.
- (e) An accountable health care entity shall participate in public testimony in good faith and exercise due diligence in preparing testimony. The Director may consider the entity's public testimony, responsiveness, and cooperation in determining whether additional enforcement action is appropriate.
- (f) Subject to section 127502.5(c)(4) of the Code, public testimony shall be shared with the Health Care Affordability Board and may be used in the annual report.
- (g) An accountable health care entity's participation in public testimony shall neither create a presumption of compliance with applicable spending targets nor limit the authority of the Director to take additional enforcement actions.

Note:

Authority: Sections 127501, 127501.2, and 127502.5, Health and Safety Code

Reference: Sections 127501, 127501.2, 127501.4 and 127502.5, Health and Safety Code.

§ 97455. Spending Target Performance Improvement Plan and Spending Target Penalties

- (a) If the Director requires an accountable health care entity to implement a proposed performance improvement plan, the Office shall notify the entity. The accountable health care entity shall submit a proposed performance improvement plan to the Office in accordance with this section and the Performance Improvement Plan Submission Guide incorporated by reference in section 97445.
- (1) The notice shall be sent to the electronic mail address of the accountable health care entity used to register in the Data Portal or electronic mail address of the primary contact person the hospital health facility designated for SIERA pursuant to California Code of Regulations, title 22, section 97041.1, subdivision (a). If an accountable health care entity is not registered in the Data Portal or SIERA, the notice shall be sent to the entity's agent for service of process.
- (2) The notice shall include, at a minimum, the following:
- (A) Name and address of the accountable health care entity;
 - (B) Applicable spending target;
 - (C) Excess spending growth;
 - (D) Submission deadline for the proposed performance of improvement plan;
 - (E) A reference to section 97455; and
 - (F) Either a copy of the Performance Improvement Plan Submission Guide or a uniform resource locator (URL) for the Performance Improvement Plan Submission Guide.
- (b) Submission. An accountable health care entity shall submit a proposed performance improvement plan within 45 calendar days of the date of the Office's notice requiring submission of a proposed performance improvement plan.
- (1) Form and Manner. An accountable health care entity shall submit a proposed performance improvement plan electronically in the manner prescribed by the Office in the Performance Improvement Plan Submission Guide. The proposed performance improvement plan shall be in a text-based machine-readable format. The Office may approve alternative submission methods, as necessary, for good cause shown.
- (2) Request for an Extension. An entity may request an extension of time in accordance with the Performance Improvement Plan Submission Guide.
- (A) Extension Discretion. The Office has sole discretion to grant or deny requests for extensions of time. The Office shall review the request and grant an extension request if it determines circumstances that prevent timely submission of a performance improvement plan, including but not limited to, a natural disaster, a catastrophic event, a declared state of

emergency, unforeseen disruptions to personnel, unforeseen disruptions to business operations, unforeseen disruptions to information technology systems, or another extraordinary event that directly impacts the submission of a performance improvement plan.

- (c) Performance Improvement Plan Contents. The contents of the proposed performance improvement plan shall be in accordance with the Performance Improvement Plan Submission Guide.
- (d) Completeness Review and Approval Process. The Office shall provide written acknowledgment of receipt to the accountable health care entity within five business days of receiving the submission of a proposed performance improvement plan.
 - (1) The notice shall be sent to the electronic mail address of the person that the accountable health care entity identified as the primary point of contact for the performance improvement plan.
 - (2) The Office shall evaluate the submission of a proposed performance improvement plan for submission deficiencies and completeness. The Office shall assess whether the accountable health care entity complied with the submission requirements in subsection (b) and whether the proposed performance improvement plan contains the contents required by the Performance Improvement Plan Submission Guide.
 - (3) If the Office deems the submission of the proposed performance improvement plan incomplete or otherwise deficient, the Office shall notify the accountable health care entity. The Office may require an accountable health care entity to submit additional information, clarification, or revisions to a proposed performance improvement plan as necessary to: evaluate how the proposed performance improvement plan will reduce spending to comply with the applicable spending target, ensure the Office can monitor implementation of the performance improvement plan, and assess compliance with the Act and regulations issued pursuant to the Act. The accountable health care entity shall have at least five business days to respond to any request issued pursuant to this subsection.
 - (A) The notice shall be sent to the electronic mail address of the person that the accountable health care entity identified as the primary point of contact for the performance improvement plan.
 - (4) After the Office deems the submission complete, the Office shall post the proposed performance improvement plan on the Department's website, subject to section 127502.5(c)(4) of the Code. The Office shall accept public comments for a period of 10 business days.
 - (5) Prior to approving or rejecting a proposed performance improvement plan, the Office shall obtain input from the Board in a closed session authorized by law.

- (6) The Director shall assess whether to approve or reject a complete performance improvement plan by considering one or more factors, including but not limited to the following, as applicable:
- (A) The likelihood that the performance improvement plan will achieve compliance with the applicable spending target;
 - (B) The clarity and evaluability of the goals and activities;
 - (C) The sufficiency of the assessment plan, progress reports, and final report to measure goals, progress, milestones and outcomes;
 - (D) The likelihood that the performance improvement plan will positively impact affordability for consumers and purchasers;
 - (E) The extent to which the performance improvement plan identifies and addresses drivers of excess spending growth;
 - (F) The adequacy of measures to mitigate adverse impacts on access, quality, equity, and workforce stability; and
 - (G) The feasibility of the implementation timeline, including whether it can be completed within the statutory maximum period.
- (7) Neither the Office's acknowledgment of receipt, review of a proposed performance improvement plan for completeness, request for additional information, nor failure to require revisions shall constitute approval of any aspect of the performance improvement plan or a waiver or limitation of the Director's authority under section 127502.5 of the Code.
- (8) If the Director approves a proposed performance improvement plan, the Office shall notify the accountable health care entity. The notice shall be sent to the electronic mail address of the person that the accountable health care entity identified as the primary point of contact for the performance improvement plan.
- (9) After the Director approves a proposed performance improvement plan, the Office shall post the approved performance improvement plan on the Department's website, subject to the restrictions of subsection (i) of this section and section 127502.5(c)(4) of the Code.
- (e) Progress Reports. An accountable health care entity subject to an approved performance improvement plan shall submit periodic progress reports in accordance with the Performance Improvement Plan Submission Guide.
- (1) Request for an Extension. An entity may request an extension of time in accordance with the Performance Improvement Plan Submission Guide.
- (A) The Office has sole discretion to grant or deny requests for extensions of time. The Office shall review the request and grant an extension request if it determines circumstances that prevent timely submission of a progress report, including but not limited to, a natural disaster, a catastrophic event, a declared state of emergency, unforeseen disruptions to personnel, unforeseen disruptions to business operations, unforeseen disruptions to

information technology systems, or another extraordinary event that directly impacts the submission of a progress report.

- (2) Neither the submission or acceptance of a progress report or final report, nor the Office's review of a progress report or final report, shall constitute: an approval of implementation performance; a determination that the accountable health care entity is in compliance with the performance improvement plan; or a waiver or limitation of the Director's authority to require modifications or take progressive enforcement action.
- (3) Progress reports do not create a presumption that the performance improvement plan will achieve compliance with the applicable spending target or that the entity will be deemed in compliance with the performance improvement plan based solely on partial or interim progress.
- (f) Final Report. An accountable health care entity subject to an approved performance improvement plan shall submit a final report in accordance with the Performance Improvement Plan Submission Guide and shall contain sufficient information to enable the Office to evaluate the entity's performance improvement plan.
- (1) Request for an Extension. An entity may request an extension of time in accordance with the Performance Improvement Plan Submission Guide.
 - (A) The Office has sole discretion to grant or deny requests for extensions of time. The Office shall review the request and grant an extension request if it determines circumstances that prevent timely submission of a final report, including but not limited to, a natural disaster, a catastrophic event, a declared state of emergency, unforeseen disruptions to personnel, unforeseen disruptions to business operations, unforeseen disruptions to information technology systems, or another extraordinary event that directly impacts the submission of a final report.
- (g) Compliance. After receiving the final report, or if no final report is submitted, following the deadline for submission of the final report, the Office shall notify the accountable health care entity in writing of the Director's compliance determination of an approved performance improvement plan.
 - (1) The notice shall be sent to the electronic mail address of the person that the accountable health care entity identified as the primary point of contact for the performance improvement plan.
 - (2) The notice shall include, at a minimum, the following:
 - (A) Name and address of the accountable health care entity;
 - (B) Applicable spending target;
 - (C) Excess spending growth;
 - (D) The compliance determination; and
 - (E) The basis for the determination.

- (3) In determining whether an accountable health care entity has satisfied the terms and conditions of an approved performance improvement plan, the Director shall consider, as applicable, one or more of the following factors:
- (A) The extent to which the entity achieved the performance improvement goals;
 - (B) The extent to which the entity implemented the performance improvement strategies and activities;
 - (C) The extent to which the entity completed milestones within applicable timeframes;
 - (D) The extent to which the entity submitted timely and complete progress reports within applicable timeframes;
 - (E) The extent to which the entity submitted a timely and complete final report within applicable timeframes;
 - (F) The adequacy of measures implemented to mitigate adverse impacts on access, quality, equity and workforce stability;
 - (G) The adequacy of measures implemented to ensure achieved goals or efficiencies will be sustained in future years;
 - (H) The adequacy of the entity's reported outcomes when compared with the total health expenditure data the Office has on file for the entity's most recent reporting year; and
 - (I) The supporting documentation the entity submitted in the final report to demonstrate compliance with an approved performance improvement plan; and
 - (J) Any other information the Office determines is relevant to assessing the entity's compliance with the approved performance improvement plan.
- (4) The Director may request additional information, clarification, or documentation to evaluate the final report and determine compliance with the approved performance improvement plan.
- (h) Administrative Penalty: An accountable health care entity may be subject to an administrative penalty if the accountable health care entity does not comply with the approved performance improvement plan and does not meet the spending target identified in the performance improvement plan. The spending target of the performance improvement plan shall be either the spending target that triggered the enforcement action or a spending target established by the Board that is no less than the spending target that triggered enforcement.
- (1) No sooner than thirty (30) calendar days after the date of the Office's notice of an administrative penalty, the Director shall issue a final order for the administrative penalty unless the accountable health care entity timely contests the violation and penalty pursuant to section 97459.

- (2) The Office shall provide the health care entity with written notice of the basis for an administrative penalty. The notice shall be sent to the electronic mail address of the person that the accountable health care entity identified as the primary point of contact for the performance improvement plan.
- (3) A notice of administrative penalty shall include, at a minimum, the following:
- (A) The amount of the administrative penalty.
 - (B) A description of the acts or omissions that give rise to the administrative penalty, including identifying the specific statute, regulation, or law that an accountable health care entity violated.
 - (C) A statement that the health care entity may contest the administrative penalty in accordance with section 97459.
- (4) The range of the administrative penalty shall be up to 125% of the initially commensurate amount of excess spending growth identified by the Office. The initially commensurate amount of excess spending growth shall be calculated in accordance with the Spending Target Performance Measurement Manual.
- (5) In determining the final amount of an administrative penalty, the Director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, and may adjust the amount of an administrative penalty by considering the penalty justification factors pursuant to Section 97457.
- (i) Confidentiality. A performance improvement plan, progress report, final report and related materials shall be considered a public record unless the accountable health care entity properly designates documents and information as nonpublic and Office accepts the designation in accordance with this subsection.
- (1) For purposes of this section only, “nonpublic” means information that:
- (A) Is confidentially maintained and not shared by the holder of the information with the public; and
 - (B) Does not include information that is lawfully made available to the public from any federal, state, or local government record or disclosure, media source, or any other publicly available source.
- (2) An accountable health care entity may submit a written request for confidential treatment of information or documents submitted to the Office. The entity shall file a nonpublic (confidential) and public (nonconfidential) version of any materials for which the entity requests confidentiality. The nonpublic version shall be unredacted and shall be maintained as confidential by the Department pending a determination of confidentiality. The public version, which may be made available to the public by the Department, shall have the confidential portions removed or redacted.

- (3) An accountable health care entity claiming confidentiality shall include a justification that provides a detailed statement of the grounds enumerated in (A) through (D), below, on which confidentiality is claimed, a statement of the specific time for which confidential treatment of the information is necessary, and a statement that the information has been confidentially maintained by the entity. The detailed statement in support of the request for confidentiality shall indicate whether any of the following applies:
- (A) The information or documents are proprietary or of a confidential business nature, including trade secrets (as defined in California Civil Code section 3426.1(d)), such that release would be damaging or prejudicial to the business,
 - (B) Another state or federal agency deems the information or documents confidential and the duration of time,
 - (C) A law or statute requires the information to be kept confidential, or
 - (D) The information is such that the public interest is served in withholding the information.
- (4) Requests for confidentiality of publicly available information or documents will be denied. In accordance with 127502.5(c)(2) of the Code, the Office shall publicly post the identity of an accountable health care entity implementing a performance improvement plan and the detailed summary of the entity's compliance with the requirements of the performance improvement plan during the duration of the performance improvement plan.
- (5) The Office shall notify an accountable health care entity in writing of a confidentiality determination, subject to the exceptions in section 127502.5(c)(4) of the Code. If a request for confidentiality is denied, the accountable health care entity may request to withdraw or replace any information or documents with public versions.
- (j) PIP and Penalty Website Posting: Subject to section 127502.5(c)(4) of the Code, the Office shall post the following on the Department's website:
- (1) A list of accountable health care entities required to implement a performance improvement plan;
 - (2) An accountable health care entity's proposal for a performance improvement plan, excluding information deemed confidential pursuant to Section 97455(i);
 - (3) An accountable health care entity's approved performance improvement plan, excluding information deemed confidential pursuant to Section 97455(i);
 - (4) A detailed summary of an accountable health care entity's compliance with an approved performance improvement plan, excluding information deemed confidential pursuant to Section 97455(i); and
 - (5) A list of accountable health care entities assessed an administrative penalty.

Note:

Authority: Sections 127501, 127501.2, and 127502.5, Health and Safety Code

Reference: Sections 127501, 127501.2, 127501.4 and 127502.5, Health and Safety Code.

§ 97456. Procedural Penalties for Impeding or Impairing the Spending Target Enforcement Process

(a) As used in this section, the following definitions apply:

(1) For purposes of subsection (c)(1), “repeatedly neglects to file” means a subsequent failure to comply with the same requirement after the Office has provided written notice of an initial failure and a reasonable opportunity to cure that failure.

(2) For purposes of subsection (c)(2), “repeatedly fails to file an acceptable plans” means that, after the Office has provided written notice of an initial failure and a reasonable opportunity to cure that failure, the accountable health care entity submits a proposed performance improvement plan that fails to satisfy the submission and content requirements of section 97455(b) and (c) and is deemed incomplete or otherwise deficient pursuant to section 97455(d)(2).

(3) For purposes of subsection (c)(3), “repeatedly fails to implement” means two or more failures to perform the terms or conditions of the approved performance improvement plan.

(b) The Director may assess an administrative penalty against an accountable health care entity that impedes or impairs the spending target enforcement process. No sooner than thirty (30) calendar days after the date of the Office’s notice of administrative penalty, the Director shall issue a final order for an administrative penalty unless the accountable health care entity timely contests the violation and penalty pursuant to section 97459.

(1) The Office shall provide the required submitter with written notice of the basis for an administrative penalty. The notice shall be sent to the electronic mail address the accountable health care entity used to register in the Data Portal or electronic mail address of the primary contact person the hospital health facility designated for SIERA pursuant to California Code of Regulations, title 22, section 97041.1, subdivision (a). If an accountable health care entity is not registered in the Data Portal or SIERA, the notice shall be sent to the entity’s agent for service of process

(2) A notice of administrative penalty shall include, at a minimum, the following:

(A) The amount of the administrative penalty,

(B) A description of the acts or omissions that give rise to the administrative penalty, including identifying the specific statute, regulation, or law that an accountable health care entity violated,

- (C) A statement that the health care entity may contest the administrative penalty in accordance with section 97459.
- (c) An accountable health care entity impairs or impedes the spending target enforcement process if the accountable health care entity does any of the following:
- (1) Repeatedly neglects to file a performance improvement plan with the Office.
 - (2) Repeatedly fails to file an acceptable performance improvement plan with the Office.
 - (3) Repeatedly fails to implement a performance improvement plan approved by the Office.
 - (4) Knowingly fails to provide information to the Office that is required by section 127502.5 of the Code.
 - (5) Knowingly falsify information provided to the Office that is required by section 127502.5 of the Code.
- (d) The amount of an administrative penalty for a violation of this section shall be according to the following:
- (1) For a violation of subsection (c)(1) and (c)(2), the accountable health care entity shall be subject to a penalty of up to ten thousand dollars (\$10,000) for each calendar day after the date the performance improvement plan is due to the Office.
 - (2) Per violation of subsection (c)(3), up to five-hundred thousand dollars (\$500,000).
 - (3) For a violation of subsection (c)(4) up to ten thousand dollars (\$10,000) for each calendar day that information is unsubmitted or incomplete.
 - (4) Per violation of subsection (c)(5), up to five-hundred thousand dollars (\$500,000).
- (e) In determining the final amount of an administrative penalty, the Director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, and may adjust the amount of an administrative penalty by considering the penalty justification factors pursuant to Section 97457.

Note:

Authority: Sections 127501, 127501.2, and 127502.5, Health and Safety Code

Reference: Sections 127501, 127501.2, 127501.4 and 127502.5, Health and Safety Code.

§ 97457. Penalty Justification Factors

- (a) Consistent with the scope and range of administrative penalties approved by the Health Care Affordability Board, the Director shall determine the appropriate amount of an administrative penalty based on consideration of one or more of the following factors, as applicable:
- (1) The nature, number, and gravity of the offenses.
 - (2) The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.
 - (3) The market impact of the entity.
 - (4) The related provision of nonfederal share associated with Medi-Cal.

Note:

Authority: Sections 127501, 127501.2, and 127502.5, Health and Safety Code

Reference: Sections 127501, 127501.2, 127501.4 and 127502.5, Health and Safety Code.

§ 97459. Appeal of an Administrative Penalty

- (a) An ~~required submitter~~ accountable health care entity may contest an administrative penalty issued pursuant to this Article by submitting a notice of appeal, including any exhibits, in portable document format (PDF) to ~~OHCA~~SpendingTarget@hcai.ca.gov, that complies with the requirements of this section within 30 calendar days from the date of the notice of administrative penalty.
- (b) A notice of appeal shall include, at a minimum, the following:
- (1) The legal name and address of the ~~required submitter~~ accountable health care entity,
 - (2) The name, title, and contact information of an authorized representative,
 - (3) A statement setting forth the material facts and relevant law that is the basis of the appeal, including, but not limited to, any documents supporting that the ~~required submitter~~ accountable health care entity did not violate applicable laws,
 - (4) A copy of the notice of the administrative penalty,
 - (5) A statement of whether the ~~required submitter~~ accountable health care entity consents to electronic service, including the electronic mail address for accepting service, if applicable, and
 - (6) An attestation signed under penalty of perjury affirming the information provided in the notice of appeal is true and correct, to the best of the attestor's personal knowledge and, if the attestor did not personally know the information, the attestor exercised due diligence to confirm the information with someone who knows the information personally.

- (c) Within 60 days of receipt of the notice of appeal, the Office shall either withdraw the notice of administrative penalty or notify the ~~required-submitter~~ accountable health care entity that the Office will file an Accusation with the California Office of Administrative Hearings based on review of the appeal documents. A hearing shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Venue for filing purposes shall be Sacramento. Hearings shall be videoconference unless by mutual agreement of the parties. The standard of proof shall be preponderance of the evidence.
- (d) Informal Resolution Process. The Office and ~~required-submitter~~ accountable health care entity may schedule one or more teleconferences to resolve the appeal informally. If the parties reach an agreement that is mutually acceptable, the agreement shall be in writing and signed by both parties. The agreement signed by the parties shall become a final order from the Director that resolves the appeal. If a hearing has been scheduled, the Office shall notify the Office of Administrative Hearings of the resolution and the appeal shall be taken off calendar in accordance with section 1028, subdivision (j) of Title 1 of the California Code of Regulations.

Note:

Authority: Sections 127501, 127501.2, and 127502.5, Health and Safety Code.

Reference: Sections 127501, 127501.2, 127501.4 and 127502.5, Health and Safety Code.