OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Advisory Committee Meeting

July 8, 2026

HCAi

Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Welcome and Call to Order

HCAI
Department of Health Care Access and Information

Agenda

1. **Welcome and Call to Order**

2. **Executive Updates**
   Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

3. **Cost-Reducing Strategies – Los Angeles General Medical Center Safer@Home Program**
   Margareta Brandt; Los Angeles General Medical Center: Dr. Brad Spellberg, Chief Medical Officer; Dr. Josh Banerjee, Associate Medical Director of Transitions of Care; Dr. Christopher Lynch, Medical Director, Safer@Home Program

4. **Non-Supervisory Organized Labor Adjustment Data Collection Regulations**
   Vishaal Pegany; CJ Howard, Assistant Deputy Director

5. **Spending Target Enforcement – Continued Spending Target Penalty Discussion**
   Vishaal Pegany; CJ Howard

6. ***Cost and Market Impact Review Program – Status Update on Regulatory Text***
   Heather Hoganson, Assistant Chief Counsel

7. **General Public Comment**

8. **Adjournment**

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Executive Updates

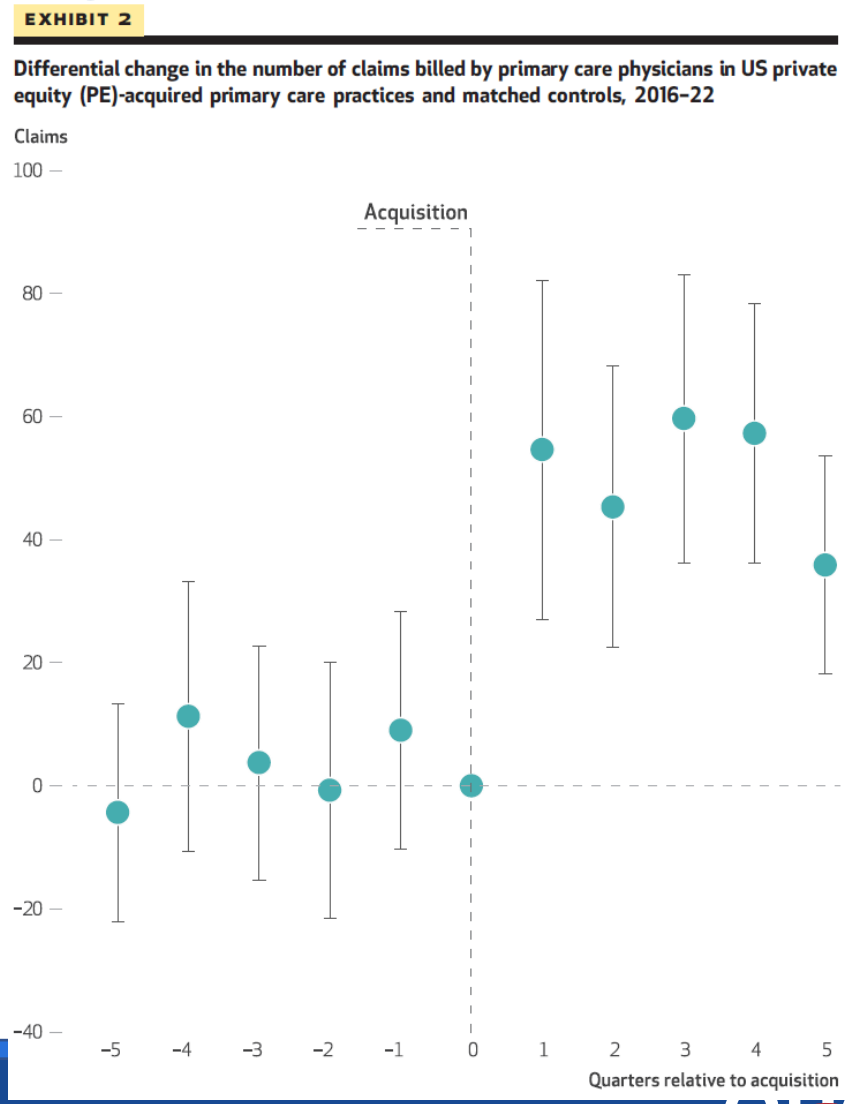
Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

HCAI
Department of Health Care Access and Information

Private Equity Acquisitions in Primary Care: Changes in Utilization, Spending, and Workforce

- An article published in Health Affairs assessed the effects of private equity (PE) acquisitions of primary care practices on primary care physician practice patterns and patient care in the traditional Medicare market from 2016 to 2022.
- After PE acquisition, compared to matched controls:
  - Claims billed increased by 50.6 claims per physician (30.5%)* and Medicare initial annual wellness visits increased by 21.0%*
  - Patients seen per physician increased by eight patients (11.1%)*
  - Medicare spending per physician increased by $846 (14.9%)*
  - Patients received more laboratory tests (11.1%)* and preventive/screening services (11.3%)*
  - Visits per patient decreased by 1.3%*
  - There were no significant changes to Medicare spending per patient on services billed by primary care physicians.

**Results were statistically significant.*



Singh Y, Dixit MN, Trivedi AN, Whaley CM (June 2026). Private Equity Acquisitions In Primary Care: Changes In Utilization, Spending, And Workforce. *Health Affairs* 45, No. 6 (2026):629-636. https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.01703

Private Equity Acquisitions in Primary Care: Changes in Utilization, Spending, and Workforce

- Additional workforce analysis found that PE acquisitions increased the total number of primary care physicians (16.9%)* and advanced practice providers (i.e., physician assistants and nurse practitioners) (40.1%)*.
- Limitations of this study include:
  - Incomplete inclusion of all PE acquisitions;
  - Restriction of study to traditional Medicare claims, reducing generalizability;
  - Unobserved differences between PE practices and controls;
  - Spending measures only captured services billed by primary care physicians, potentially underestimating impacts on total Medicare spending;
  - Workforce analysis limited to acquisitions before 2020 due to data availability; and
  - Short follow-up time (five quarters of follow-up).
- The authors concluded that PE investments have the potential to increase the use of primary care services, including preventive services and laboratory tests, and the number of patients seen by primary care providers, in part through greater reliance on advanced practice providers.

**Results were statistically significant.*

Singh Y, Dixit MN, Trivedi AN, Whaley CM (June 2026). Private Equity Acquisitions In Primary Care: Changes In Utilization, Spending, And Workforce. *Health Affairs* 45, No. 6 (2026):629-636. https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.01703

Primary Care as a Public Utility: The Case for a Common Fund

- A recent JAMA article outlines a proposal for **state-administered common fund** that consolidates existing primary care spending by public and private payers and pays primary care practices directly.
  - The fund would function as a multipayer-financed, state-administered, primary care resource pool.
- Sources of funding would include contributions from commercial and self-funded health plans (a percentage of premiums) and transfers from Medicaid.
- Initial contributions from public and private sources would match current primary care spending, with funding rising over time to meet state investment goals.
  - Health plan contributions to the fund would align with state primary care spending targets.
- States would determine primary care payment structure (FFS vs PMPM, level of cost sharing).
- Traditional insurance would remain unchanged for all non-primary care services.
- **Limitations** of this financing approach include vulnerability to state budget pressures, lack of impact on non-primary care sectors, and absence of a direct mechanism to strengthen the primary care workforce.

Song Z, Altman W, Crichlow R, Grumbach K. Primary Care as a Public Utility: The Case for a Common Fund. JAMA. Published online May 20, 2026. doi:10.1001/jama.2026.7194 Primary Care as a Public Utility: The Case for a Common Fund | Health Care Economics, Insurance, Payment | JAMA | JAMA Network

Primary Care as a Public Utility: The Case for a Common Fund

Policy Implementation

- **Compatibility with existing payment systems**: Common fund could operate alongside insurance and ACOs, minimizing system disruption while supporting primary care in line with state goals.
- **Transparency and accountability:** Designated funding and standardized reporting would help ensure that primary care investments flow directly to frontline primary care practices.
- **Precedent for funding mechanism:** Current state and federal assessments already fund Medicaid and the Patient-Centered Outcomes Research Trust Fund; similar pooled-fund mechanisms could support the common fund.
- **Alignment with current trends:** The Direct Primary Care (DPC) model, in which individuals or employers pay primary care practices directly outside of insurance, is growing nationally. A primary care common fund would be akin to a more universal DPC program.
- **State-level readiness:** Implementation of a public utility approach for primary care may be facilitated by existing state initiatives and stakeholder support.

Song Z, Altman W, Crichlow R, Grumbach K. Primary Care as a Public Utility: The Case for a Common Fund. JAMA. Published online May 20, 2026. doi:10.1001/jama.2026.7194 Primary Care as a Public Utility: The Case for a Common Fund | Health Care Economics, Insurance, Payment | JAMA | JAMA Network

States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?

- A recent Health Affairs Forefront article emphasizes that while cost growth targets and transparency can reveal the sources of spending growth for the eight states with targets, complementary polices are necessary to meaningfully bend the cost curve.
- Analysis of commercial claims in hospital services and retail prescription drugs together account for the majority of per person commercial spending and have seen the greatest increases in growth, making them the logical focal point for cost containment policy.
- Spending trends in these areas reflect the significant pricing power and limited regulatory constraints that hospitals and pharmaceutical manufacturers have, which transparency can elucidate but alone cannot address.
    - For hospitals, studies point to provider market consolidation and resulting weak insurer bargaining leverage as a primary contributor to price growth, alongside the strategic use of claim coding to maximize provider revenue.
    - For pharmaceutical manufacturers, pricing power is reinforced by structural factors, including government-granted patent exclusivity, which creates time-limited monopolies, and by the relative absence of any regulatory ceiling on launch prices.

Bailit, M., Angeles, A., Block, R. (2026, June 16). *States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?* Health Affairs Forefront. DOI: 10.1377/forefront.20260610.549590. https://www.healthaffairs.org/content/forefront/states-exceeding-their-health-care-cost-growth-targets-does-mean

States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?

- To constrain spending growth, a number of states (with and without targets) are using their cost data to move toward hospital- and pharmacy-focused approaches, especially in the commercial market.
- State hospital approaches to constrain spending growth include:
  - **Indiana**: Requires its five largest nonprofit hospital systems to reduce aggregate average inpatient and outpatient prices to below the statewide average by June 2029 or forfeit their tax-exempt status until compliance. Also requires these systems to offer direct-to-employer contracting with price caps at or below 260 percent of Medicare prices.
  - **New Mexico, Oregon, Washington**: Authorized hospital price caps in public employee health plans.
  - **Washington**: Established a maximum statewide aggregate reimbursement ceiling of 160 percent of Medicare for provider and facility services for its public option plan, Cascade Select.
  - **Vermont**: Enacted 2025 legislation to apply provider rate-setting authority to establish price caps for hospital services at a percentage of Medicare across the fully and self-insured commercial markets.
  - **Rhode Island, Delaware**: Generally limits average inpatient and outpatient average annual price increases within each insurer-provider contract to the Consumer Price Index plus one percent.
  - **California**: Established a hospital sector spending target equal to its statewide target, with an adjusted lower target for seven hospitals identified as high cost.
  - **Indiana, Maine**: Enacted facility fee bans.
  - **New York and others**: Considering site-neutral payment policies.

Bailit, M., Angeles, A., Block, R. (2026, June 16). *States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?* Health Affairs Forefront. DOI: 10.1377/forefront.20260610.549590. https://www.healthaffairs.org/content/forefront/states-exceeding-their-health-care-cost-growth-targets-does-mean

States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?

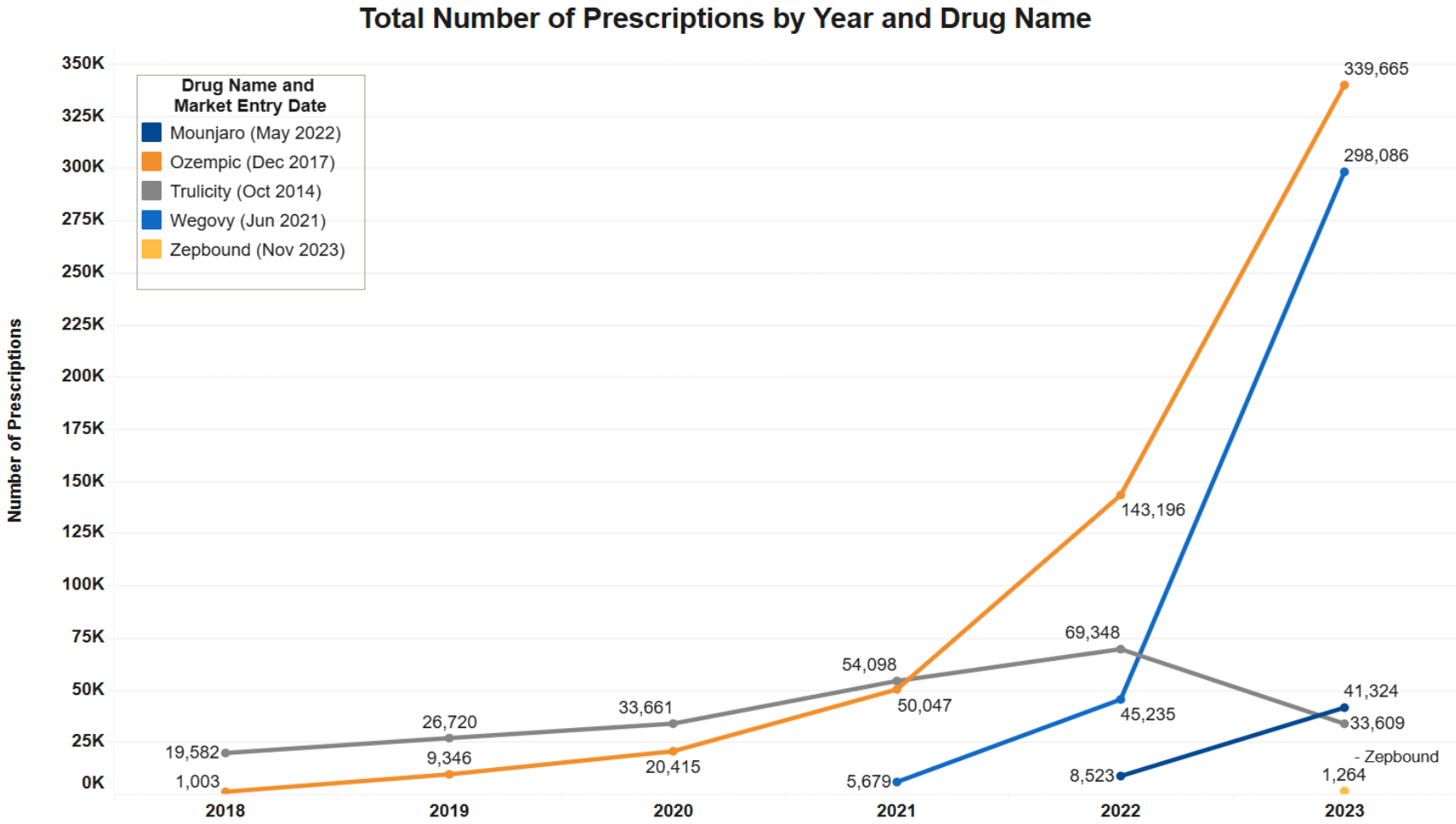
- State pharmaceutical approaches to constrain spending growth include:
  - **Colorado**: Conducts affordability reviews to determine if drugs are unaffordable for Colorado consumers and eligible for the application of upper payment limits.
  - **Maryland**: Authorized to set upper payment limits for all purchaser and payer reimbursements of prescription drugs (excluding Medicare Part C and Part D plans, 340B purchases, and federal purchases that the state is preempted from regulating by federal law). **Minnesota, Oregon, and Washington** have similar authority.
  - **Connecticut**: Caps price increases for off-patent and generic / biosimilar drugs at the rate of inflation.

- Among the authors' conclusions are that these state initiatives represent a fundamental shift in how states exercise authority over health care markets and that states with cost growth targets should treat the failure to meet targets as a mandate for stronger intervention.

Bailit, M., Angeles, A., Block, R. (2026, June 16). *States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?* Health Affairs Forefront. DOI: 10.1377/forefront.20260610.549590. https://www.healthaffairs.org/content/forefront/states-exceeding-their-health-care-cost-growth-targets-does-mean

New HCAI Data Brief: GLP-1 Use and Costs for Weight Loss

- An analysis of Healthcare Payments Data found:
  - GLP-1 utilization for weight loss has increased exponentially from 2018 to 2023
  - In 2023, the total overall cost for GLP-1s for Medi-Cal and Commercial plans was approximately $822 million
  - The total member cost per year varied by county, ranging from $3,051 in Lassen to $5,096 in Mendocino
- Data source: HPD pharmaceutical data from 2018-2023 for Medi-Cal and Commercial payers.
- Note: Patients diagnosed with diabetes were excluded from the analysis to focus on weight loss utilization.



HCAI. (2026, April). *Data Brief: GLP-1 Prescriptions for Weight Loss over Time, 2018-2023*. HCAI Website. https://hcai.ca.gov/visualizations/data-brief-glp-1-prescriptions-for-weight-loss-over-time-2018-2023/

Equity Adjustment Next Steps

- **OHCA will assess a payer-level equity adjustment's suitability for improving health equity in at least 2 years.**
  - We will monitor and assess new equity adjustment methodologies used by other programs.
  - OHCA will explore opportunities to conduct, or emphasize the need for, additional research into the inter-connected relationship between equity, quality, and cost.
- Assess whether and how to develop an equity adjustment for physician organizations and hospitals.
  - OHCA will conduct more literature research and engage expert consultants about an equity adjustment for physician organizations and hospitals.

Quality Adjustment Recommendation and Next Steps

- **Our recommendation is to wait apply a quality adjustment to the spending targets.**
  - This recommendation applies to entities that deliver high-cost care not commensurate with improvements in quality and entities that deliver low-cost, high-quality care.
- OHCA will continue to monitor cost and quality data and reassess quality adjustment factors in at least 2 years.
- We will monitor how sibling departments are assessing and benchmarking quality performance.

Slide Formatting



Indicates items that the Advisory Committee provides input or recommendations on based on statute and other areas as requested by the Board or OHCA.

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Public Comment

HCAI
Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Informational Items

HCAI
Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Cost-Reducing Strategies – Los Angeles General Medical Center Safer@Home Program

Margareta Brandt, Assistant Deputy Director

Dr. Brad Spellberg, Chief Medical Officer

Dr. Josh Banerjee, Associate Medical Director of Transitions of Care

Dr. Christopher Lynch, Medical Director

HCAi

Department of Health Care Access and Information

Los Angeles General
Medical Center

An All-Virtual Acute, Home Care Model

Christopher Lynch, MD- *Medical Director of Safer@Home*

Josh Banerjee, MD- *Associate Medical Director of Transitions of Care*

Brad Spellberg, MD - *Chief Medical Officer*



SAFER @ OME

OVERVIEW



- **Virtual care, at home, for patients who would otherwise be in the hospital**
- **Patients monitored via remote pulse oximetry and thermometer**
- **Daily phone visit check-ins with video support**
- **All medications oral or inhaled in lieu of IV**
- **First implemented during COVID to enable home care for COVID pneumonia requiring oxygen**

Los Angeles General
Medical Center

SAFER @HOME

ORIGIN

Los Angeles General Medical Center

- Ultimately, we cared for >4,000 patients with COVID pneumonia at home during the pandemic
- If not for Safer@Home, LA General would have reached the triage stage during winter of ‘20-’21
- Post COVID, LA General decided to expand the program to other common, acute illnesses



SAFER @ OME

ORIGIN

Los Angeles General Medical Center

- Historically “IV antibiotics” or “IV medications” has been a valid reason to admit people to hospital
- Similarly, new onset pneumonia severe enough to require oxygen
- But modern clinical trials have demonstrated that IV therapy is not more effective than oral
- And we found that oxygen up to 6 liters/hour could be safely given at home during COVID



WHY SAFER @HOME

Los Angeles General Medical Center

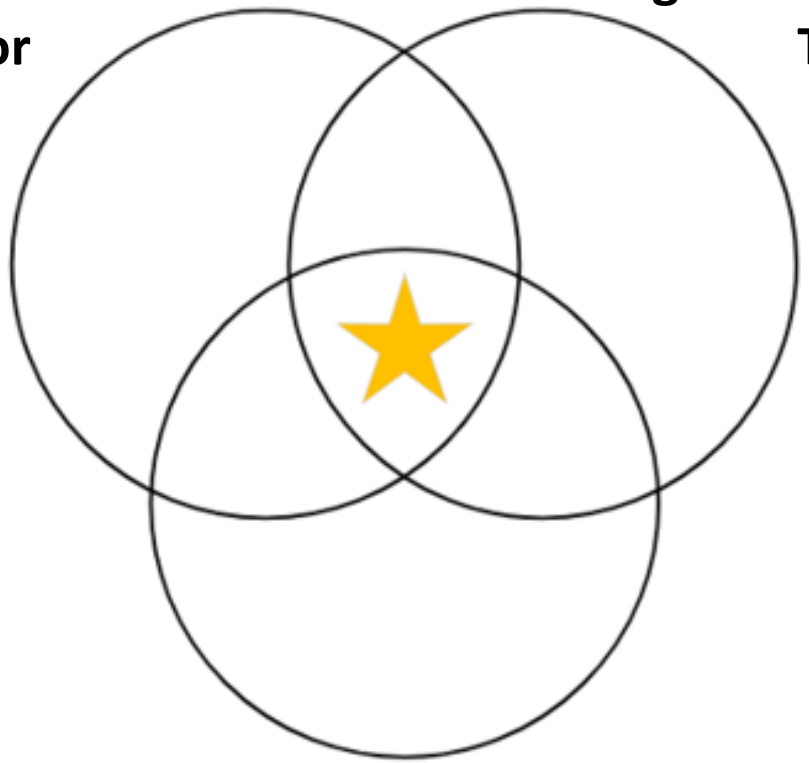
- Hospitalizations can cause harm events and can be disruptive to patients' lives.
- Access to care is critical and hospital overcrowding can compromise quality of care.
- Recent innovations in care practices suggest we do not need to hospitalize patients for as many indications as previously thought.
- We should care for as many patients at home whenever it is safe to do.
- "Hospital at Home" models are not feasible due to expansive patient catchment area in LA County and limited staffing.
- LA General's community partners expressed a strong desire to expand patient-centered, out-of-hospital care



Population and Key Principles for Enrollment

Patient Requires Admission or Continued Enrollment

High Probability of Treatment Response



Low Probability of Rapid Decompensation



SAFER @OME OVERVIEW



Current eligible diagnoses:

- Acute gallstones
- Alcohol withdrawal
- Asthma/COPD exacerbation
- Bone infections
- Cellulitis (skin infection)
- Complicated Urinary/Kidney Infections
- Diabetic foot infections
- Heart failure exacerbations
- Multiple sclerosis exacerbations
- Pneumonia (viral or bacterial)

- Other as needed

Los Angeles General Medical Center

Safer@Home **Process**

1

Care team calls the on-call Safer@Home Attending (12 hours per day coverage)

2

Reviews criteria for the program

3

If accepted, teaching and DME provided to the patient by Discharge Lounge nursing

4

Daily video visits with nurse using disease-specific script, with hospitalist back up

5

If face-to-face eval needed, Med Uber transportation provided to Urgent Care

Strategies to Address Barriers to Implementation

- Provider Adoption
  - Departmental, Chiefs/Chairs, and Resident Grand Rounds Presentations
  - ED Physician and Nurse Champions (part of S@H Leadership Team)
  - ED and Medical Unit Huddles
  - S@H Attending on-call 7a-7p
  - Job aids for residents and fellows

- Evolution of strategies based on provider feedback
  - Make enrollment process more efficient
  - Need for 24/7 (overnight) process for ED providers
  - Need for antibiotic decision support
  - Creation of more standardized pathways (e.g., Heart Failure Exacerbation)
  - Easy access to most current and more detailed program information

Enrollment Order Sets with Antibiotic Decision Support

	$	Component	Status	Dose ...	Details
Safer at Home - Diabetic Foot Infection (Planned Pending)					
		Safer at Home - Infected Diabetic Foot Ulcer (For questions, please contact Safer at Home Attending listed on Amion)			
		Referral Information:			
☑		Enroll into Safer at Home			T;N, DM Foot Ulcer Infection (cellulitis, OM)
☑		Communication Order (DO NOT USE FOR MEDICATIONS)			T;N >>If patient is currently in the ED or ED OBS, patient must be discharged AND transported to ED OBS. Discuss and coordinate with...
		DME Orders (All patients enrolled into Safer at Home to receive pulse oximeter and thermometer. Order additional DME as needed):			
☑		DME Respiratory Oximetry Device			Device for Home use, Not applicable for this Order, T;N, Safer at Home
☑		DME Miscellaneous Equipment			T;N, Safer at Home: DME Thermometer
☑		DME Phone for Safer at Home			T;N, Safer at Home
		Prescriptions:			
		RECOMMENDED EMPIRIC ORAL ANTIBIOTIC (for patients >18 years old) · If susceptibilities available, used targeted therapy (in consultation with ID if necessary). · Duration of therapy: - 5-6 days if exam is consistent with cellulitis. - 4 weeks if concern for osteomyelitis but further workup needed (i.e. MRI as outpatient; antibiotic treatment can be extended in outpatient setting if needed). - 6 weeks if findings consistent with osteomyelitis (i.e. XR findings consistent or able to probe to bone). · If renal dysfunction present, adjust dose and discuss with pharmacy as needed. >> If no abscess present, the patient has not previously grown MRSA or Pseudomonas from prior cultures, and the wound is not gangrenous: · Amoxicillin-clavulanic acid 875mg BID. If renal dysfunction, discuss with pharmacy regarding renal dosing. >> If an abscess is present (even if drained), or the patient has previously grown MRSA: · TMP-SMX 2 DS BID + metronidazole 500 mg BID (when using TMP-SMX, be mindful of need for renal dose adjustment. If renal dysfunction, consider alternative medication or discuss with pharmacy regarding renal dosing). · Clindamycin 600mg TID - be aware of GI side effects and compliance. · Doxycycline 100 mg BID + metronidazole 500 mg BID. >> If the patient has previously grown Pseudomonas (not resistant to ciprofloxacin/levofloxacin) or the wound is gangrenous: · Levofloxacin 750 mg daily + metronidazole 500 bid mg once daily. If renal dysfunction, discuss with pharmacy regarding renal dosing for levofloxacin.			
☐		amoxicillin-clavulanate (amoxicillin-clavulanate 875 ...			1 tabs, Oral, Q12H, # 56 tabs, Safer at Home Patient Dosing per ID recommendations.
☐		sulfamethoxazole-trimethoprim (sulfamethoxazole-tri...			2 tabs, Oral, BID, # 112 tabs, Safer at Home Patient Dosing per ID recommendations.
☐		metroNIDAZOLE (metroNIDAZOLE 500 mg oral tablet)			2 tabs, Oral, Q24H, # 28 tabs, Safer at Home Patient Dosing per ID recommendations.
☐		clindamycin (clindamycin 300 mg oral capsule)			2 caps, Oral, Q8H, # 168 caps, Safer at Home Patient Dosing per ID recommendations.
☐		doxycycline (doxycycline monohydrate 100 mg oral c...			= 1 caps, Oral, BID, # 56 caps, Safer at Home Patient Dosing per ID recommendations.
☐		levoFLOXacin (levoFLOXacin 750 mg oral tablet)			1 tabs, Oral, Q24H, # 28 tabs, Safer at Home Patient Dosing per ID recommendations.

Staff Facing Website



lacounty.sharepoint.com/sites/dhs-saferathome

Link can also be found on Home Page next to UpToDate under "Los Angeles General Quick Links"

SAFER@HOME

Safer@Home

- Home
- What is Safer@Home?
- Inpatient Referring Provid...
- ED/OBS Referring Provid...
- Nursing (Primary RNs)
- Referral Criteria
- Home Monitoring Equip...
- Site contents
- Recycle bin
- Edit

New | Page details | Preview | Analytics

Click the applicable tiles below for more information.













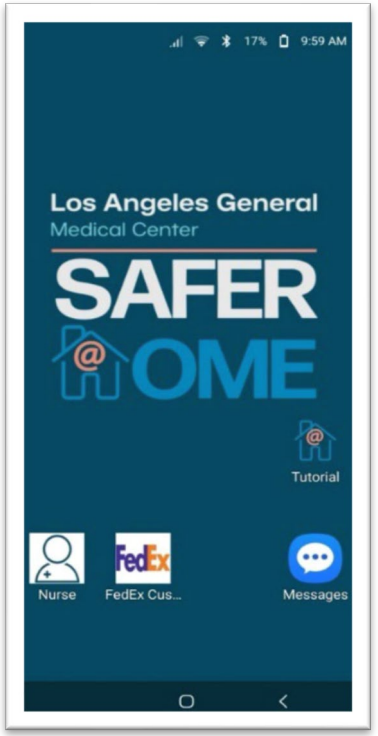
Patient Barriers



There is a digital divide in our patient population that makes it difficult for them to fully take advantage of the S@H program. Lack of access to reliable technology perpetuates further disparity in healthcare.

Improve Access Via

Voice **Messaging** **Video**



SAFER @ OME

RESULTS

Year 1 of the Program

Patient Characteristic	Safer At Home Cohort	Comparison Cohort	P Value
Total	876	1590	
Care Setting at Discharge--no. (%)			
Hospital (Inpatient)	396 (45.2%)	1590 (100%)	
Emergency Department / Observation / Urgent Care (Outpatient)	480 (54.8%)	0 (0%)	
Patient Age--avg. (SD)	54.0 (14.5)	52.3 (19.6)	0.15
Patient Sex			0.14
Female	335 (38.2%)	688 (43.3%)	
Male	541 (61.8%)	901 (56.7%)	
Patient Race/Ethnicity--no.(%)			0.071
White	10 (2.6%)	59 (3.7%)	
Hispanic	326 (83.2%)	1235 (77.7%)	
Black	14 (3.6%)	108 (6.8%)	
Asian	19 (4.9%)	75 (4.7%)	
Other	26 (6.6%)	113 (7.1%)	
Patient Case Mix Index--avg.(SD)	1.27 (0.66)	1.26 (0.59)	0.72
Patient Expected Mortality--avg.(SD)	0.016 (0.47)	0.019 (0.059)	0.45

Los Angeles General
Medical Center

RESULTS

Year 1 of the Program

Patient Outcome	Safer At Home Cohort	Comparison Cohort	P- Value
Hospital Length of Stay Days avg.(SD)	1.33 (2.00)	5.34 (10.44)	<0.0001
Number of 30-Day Urgent Care Visit Per Patient--avg. (SD)*	0.61 (0.96)	0.083 (0.51)	<0.0001
Number of 30-Day Emergency Department Visit Per Patient--avg. (SD)*	0.19 (0.50)	0.21 (0.85)	<0.0001
30-Day Hospital Readmission--no. (%)	174 (19.9%)	266 (16.9%)	0.062
30-Day Mortality--no. (%)	4 (0.5%)	16 (1.0%)	0.13

Los Angeles General
Medical Center

SAFER @OME

RESULTS

- In year 1, **876** patients enrolled = 2.3 pts/day
- In year 2, **1,171** patients enrolled = 3.2 pts/day
- In year 3, **1,230** patients in 11.5 mos = 3.5 pts/day
- Year 1 detailed financial analysis would generate an additional 50% of savings with higher enrollment now achieved

Los Angeles General
Medical Center

Los Angeles General
Medical Center

Exceptional Care. Healthy Communities.

Safer@Home Analysis

Year 1 Financial Analysis

- LA General has a very high rate of Medicaid/uninsured
- $4 million revenue lost; mostly Medicare/Commercial
- $10 million costs avoided; mostly Medicaid; $0.7 million in fixed costs
- Net $5.6 million saved; Net savings for Medicaid/uninsured Net losses for Medicare/Commercial

Table 1. Net Hospital Financial Outcomes: Cost Avoidance vs. Lost Revenue and Fixed Costs

Total Inpatient Days Saved Insurance (N, %)	Total Inpatient Days Saved	Total Lost Revenue	Total Variable Costs Avoided	Total Fixed Costs of the Program*	Net Revenue Lost + Cost Saved	Net Revenue/ Cost Per Case
Base Case Analysis						
Medicare: 121 (13.8%)		-$1,876,585	$1,469,533	-$94,279	-$501,331	-$4,143
Medicaid: 676 (77.2%)		-$1,670,311	$7,861,619	-$526,714	$5,664,594	$8,380
Commercial: 11 (1.3%)		-$444,152	$166,734	-$8,571	-$285,989	-$25,999
Tricare/VA: 3 (0.3%)		-$34,256	$48,040	-$2,337	$11,447	$3,816
Uninsured: 65 (7.4%)		-	$761,348	-$50,646	$710,702	$10,934
Total	**-3504**	**-$4,025,305**	**$10,307,274**	**-$682,547**	**$5,599,422**	**$6,392**

Reimbursement at around 55–65% of normal DRG payment would be cost neutral to society/payors, while enabling cost savings at hospitals with normal payor mixes

Los Angeles General
Medical Center

Questions?



Thank You



OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Non-Supervisory Organized Labor Adjustment Data Collection Regulations

Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

HCAI

Department of Health Care Access and Information

Statute

127502 (c)(7)

The health care cost targets shall… Be adjusted for a provider or fully integrated delivery system's cost target, as appropriate upon a showing that **nonsupervisory employee organized labor costs are projected to grow faster than the rate of any applicable cost targets**.

127502 (d)(7)

The methodology shall **require the board to adjust cost targets** for a provider or a fully integrated delivery system as appropriate **to account for actual or projected nonsupervisory employee organized labor costs**, including increased expenditures related to compensation. For an adjustment to be effectuated, the provider, the fully integrated delivery system, or other associated party **shall submit a request with supporting documentation in a format prescribed by the office**. To validate the basis for the requested adjustment, the office may request or accept further information, such as any single labor agreement that is final and reflects the actual or projected increased nonsupervisory employee organized labor costs. *The office may audit the submitted data and supporting information as necessary.*

127502 (m)(1)-(4)

(1) The board shall hold a public meeting to discuss the development and adoption of recommendations for statewide cost targets, or specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities. The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting. The meetings shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code) consistent with paragraph (2) of subdivision (e) of Section 127501.10.

(2) The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. **The board shall discuss recommendations** at a public meeting for proposed targets **on or before March 1 of the year prior to the applicable target year**.

(3) The board shall receive and consider public comments for 45 days after the board meeting.

(4) The **board shall adopt final targets on or before June 1**, at a board meeting.

Draft NOLA Regulations

- OHCA posted draft Nonsupervisory Organized Labor Adjustment (NOLA) data collection regulations for public comment on June 23.
- Regulations define who may request a spending target adjustment and the information to be included with the request. The regulations also incorporate a File Specifications Document by reference.
- The File Specifications Document details the format and contents of a data file to support the request for adjustment.
- Public comments are due to OHCA@hcai.ca.gov by Monday, July 13.

Proposed NOLA Data Collection



Proposed Data Collection Elements

- Current and projected productive hours and average hourly wage
- Current and projected payroll, benefits, and professional development expenses
- Current and projected total operating costs



Possible Calculations

- Cost of each labor contract as a percentage of total operating costs for both baseline and performance years
- Cost share of all other operating expenses (i.e., those not related to nonsupervisory employee labor costs)
- Projected growth attributable to labor costs

Potential Approach for Setting Preliminary Adjusted Targets

Using data submitted by the requestor, OHCA could calculate an adjusted spending growth target for Board consideration.

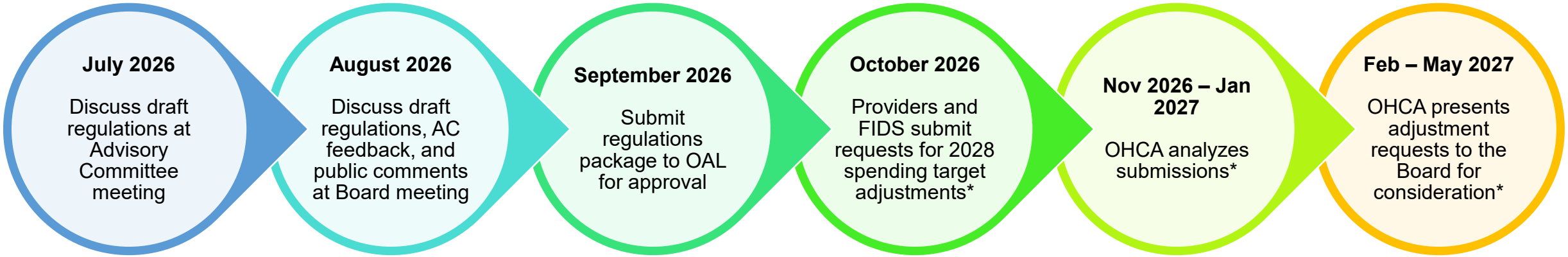
	Submitted by requestor		Calculated by OHCA		
Expense Category	**Current Costs**	**Projected Costs**	**Projected Growth Rate**	**Cost Share of Total Operating Expenses**	**Weighted Growth**
Labor Group A	$21M	$22M	5%	22%	1.1%
Labor Group B	$9M	$10M	7%	10%	0.7%
All other operating expenses	$66M	$68M	3.5%*	68%	2.4%
				Proposed Adjusted Spending Target	4.2%

Calculation for proposed adjusted spending target:

(0.22 x 0.05) + (0.10 x 0.07) + (0.68 x 0.035) = 0.011 + 0.007 + 0.024 = 0.042 x 100 = 4.2%

*Assumes all other operating expenses increase at statewide spending growth target rate, or 3.5%.

Projected Timeline for NOLA Regulations



Note: Dates are subject to change.
*If regulations are approved by the Office of Administrative Law.

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Public Comment

HCAI
Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Spending Target Enforcement – Continued Spending Target Penalty Discussion

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

HCAI
Department of Health Care Access and Information

Review: Progressive Enforcement

- Per Health & Safety Code section 127502.5(a), OHCA enforces spending targets through progressive enforcement actions, including:
  - Technical assistance (TA)
  - Public testimony (PT)
  - Performance improvement plans (PIPs)
  - Administrative penalties
- OHCA began discussions about progressive enforcement with the Health Care Affordability Advisory Committee in September 2025 and has continued this discussion with Board. The topics presented to the Board thus far include:
  - January 2026: Waiver of Enforcement, TA, PT, PIPs
  - March 2026: OHCA's proposed approach to monitoring and evaluating PIPs
  - April 2026: PIPs + introduction to administrative penalties
  - May to June 2026: continued discussions on OHCA's proposed approach to administrative penalties
- OHCA is aiming for a Health Care Affordability Board vote to approve penalty scope, range, and justification factors in late summer.

Health & Safety Code § 127502.5

Statute

Board

Approves Scope, Range, and Justification Factors

127501.11. (b) The board shall approve all of the following: …
(2) The scope and range of administrative penalties and the penalty justification factors for assessing penalties.

Review and Provide Input on Administrative Penalties

127501.11. (c) The director shall present to the board for discussion all of the following: …
(5) Review and input on administrative penalties to inform any adjustments to the scope and range of administrative penalties and the penalty justification for assessing penalties.

Closed Sessions

127501.10. (e) (2) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code), except that the board may hold closed sessions when considering matters related to the office assessing administrative penalties, requiring performance improvement plans under Section 127502.5, and discussing nonpublic information and documents received by the office and board under this chapter.

Statute

OHCA

Authority to Assess Penalties

127501. (c) The office shall do all of the following: …
(6) Oversee the state's progress towards meeting the health care cost target by providing technical assistance, requiring public testimony, requiring submission of and monitoring compliance with performance improvement plans, and assessing administrative penalties through enforcement actions, including escalating administrative penalties for noncompliance.

127502.5. (a) Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions: …

- (4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.
- (d)(5) If, after the implementation of one or more performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan, the director may assess escalating administrative penalties that exceed the penalties imposed under paragraphs (1) and (2) of this subdivision and paragraph (4) of subdivision (a).

Statute

OHCA

Limitations on Penalty Assessments

127502.5. (d)(1) If the director determines that a health care entity is not compliant with an **approved performance improvement plan and does not meet the cost target**, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target. An entity that has fully complied with an approved performance improvement plan by the deadline established by the office **shall not be assessed administrative penalties.** However, the director may require a modification to the performance improvement plan until the cost target is met.

Penalty Adjustment Considerations

127502.5. (d)(6) The director shall consider all of the following to determine the penalty:

(A) The nature, number, and gravity of the offenses.

(B) 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.

(C) The market impact of the entity.

Statute

OHCA

Consultation and Coordination Requirements

127502.5. (b) Prior to taking any enforcement action, the office shall do all of the following: …
(4) The director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, prior to taking any of the enforcement actions specified in this section with respect to a payer regulated by the respective department to ensure any technical assistance, performance improvement plans, or other measures authorized by this section are consistent with laws applicable to regulating health care service plans, health insurers, or a Medi-Cal managed care plan contracted with the State Department of Health Care Services.

127502.5. (d) (3) Prior to assessing an administrative penalty against a health care entity, the director **may** consider related provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement.
(4) To the extent that an administrative penalty is related to a Medi-Cal expenditure, including federal financial participation, the office shall coordinate with the State Department of Health Care Services to ensure appropriate treatment and return of any federal funds pursuant to Subpart F commencing with Section 433.300 of Part 433 of Title 42 of the Code of Federal Regulations.

Statute

OHCA
Procedural Penalties Health and Safety Code section 127502.5 (h)(1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following: (A) Willfully failing to report complete and accurate data. (B) Repeatedly neglecting to file a performance improvement plan with the office. (C) Repeatedly failing to file an acceptable performance improvement plan with the office. (D) Repeatedly failing to implement the performance improvement plan. (E) Knowingly failing to provide information required by this section to the office. (F) Knowingly falsifying information required by this section.

When Can Penalties be Assessed?

Statute provides for various instances where financial penalties may be assessed:

1. When an entity is not compliant with an approved PIP and does not meet the spending target. (127502.5 (d)(1))
2. After the implementation of one or more performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan, the director may assess escalating administrative penalties that exceed the commensurate penalties. (127502.5 (d)(5))
3. When a health care entity has (127502.5 (h)(1)):
    - Willfully failed to report complete and accurate data. (Data Submission Penalties)
    - Repeatedly neglected to file a performance improvement plan with the office.
    - Repeatedly failed to file an acceptable performance improvement plan with the office.
    - Repeatedly failed to implement the performance improvement plan.
    - Knowingly failed to provide information required by this section to the office.
    - Knowingly falsified information required by this section.

Considerations for Spending Target Penalty Structure

- The penalty needs to provide an incentive to implement a PIP so entities will comply with applicable targets.
- Statute indicates the penalty should be initially commensurate with an entity's failure to meet its applicable target.
- Statute directs and enables OHCA to consider a number of penalty adjustment factors to determine the final assessed penalty amount, including but not limited to the nature and gravity of the offense and the entity's fiscal condition and market impact.
- The range should give OHCA the flexibility to lower or increase the penalty from the initially commensurate penalty amount.
- Escalating penalties must be large enough to deter future noncompliance.
- Entities have multiple opportunities to comply with applicable targets, including through PIP implementation, before penalties are assessed.

Spending Target Penalties (Scope)

OHCA recommends the following approach to calculating spending target penalties.

Step 1: Initially Commensurate

- Calculate penalties that are initially commensurate with the degree to which the entity exceeded the spending target.
- "Initially Commensurate" is the difference between an entity's actual spending growth and what the growth would have been had the entity met the target.
- If 2023 were an enforceable year, "initially commensurate" penalties would have ranged from $4M - $350M.[1]

Step 2: Penalty Justification Factors

- Consider a variety of penalty justification factors that could result in an increased or decreased final penalty amount.
- Penalty justification factors listed in statute include nature, number, and gravity of offenses, the fiscal condition and market impact of the entity, and consideration of provision of nonfederal share.
- Other potential adjustment factors include input from other state agencies, other factors approved by the Board, and escalating amounts for repeated failure to meet targets.

[1]Example penalty amounts based on commercial market excess growth over 3.5% from 2022 to 2023, at the aggregate parent company level for health plans.

Spending Target Penalties (Range)

OHCA recommends a percentage-based range of up to 125% of the initially commensurate excess growth. Below are example penalties calculated at the maximum of the range.

Example Commensurate Penalties	Non-Exhaustive Examples of Penalty Range		
100%	**115%**	**125%**	**150%**
$4M	$4.6M	$5M	$6M
$100M	$115M	$125M	$150M
$350M	$402.5M	$437.5M	$525M

Example penalty amounts based on commercial market excess growth over 3.5% from 2022 to 2023, at the aggregate parent company level for health plans.

Spending Target Penalties (Justification Factors)

OHCA recommends penalty justification factors as described in statute (127502.5.(d)), outlined below.

- The nature, number, and gravity of the offenses.
- 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.
- The market impact of the entity.
- Consideration of provision of nonfederal share.

Spending Target Penalties (Justification Factors)

Penalty Justification Factor	Non-exhaustive potential examples of what each factor could include on a case-by-case basis
The nature, number, and gravity of the offenses.	• Excess growth beyond the state average or that was an extreme outlier • Conduct that resulted in harm to public, patients, access to care, affordability, market competition, etc. • A history of exceeding the target • Excess growth due to investments in primary care
The fiscal condition of the health care entity…	• Bankruptcies or other legal proceedings • Whether the proposed penalty negatively impacts the entity's financial standing with other state and federal regulators • If the entity's revenue, profit, assets, etc. significantly increased, especially in comparison with other years, while exceeding the target
The market impact of the entity.	• If the entity's share of total covered lives statewide is significant or greater than the average • The entity's impact on spending in its county or Covered California region • If the entity plays a unique or essential role in providing care to underserved populations

Health and Safety Code section 127502.5

Spending Target Penalties Implementation

- OHCA would enforce each performance year individually and discretely.
- OHCA would assess a penalty against the performance year that prompted enforcement.
- OHCA could assess penalties against an entity for missing PIP milestones.

Example Spending Target Enforcement Timeline

	2026	2027	2028	2029	2030	2031	2032
2025-2026	Exceeds Target	Data Reported in September	**PIP Development January-June** **~2.5 Year PIP Begins in July**	**PIP Implementation**	**PIP Ends ~December** **Entity noncompliant with PIP *AND* does not meet Target**	**Penalty Assessed Against 2026 Spending Year (Fall/Winter)**	
2026-2027		Exceeds Target	Data Reported in September	**PIP Development January-June** **~1.5 Year PIP Begins in July**	**PIP Ends ~December** **Entity noncompliant with PIP *AND* does not meet Target**	**Penalty Assessed Against 2027 Spending Year (Fall/Winter)**	
2027-2028			Exceeds Target	Data Reported in September	**PIP Development January-June** **~1.5 Year PIP Begins in July**	**PIP Ends ~December** **Entity noncompliant with PIP *AND* does not meet Target**	**Penalty Assessed Against 2028 Spending Year (Fall/Winter)**

Health and Safety Code section 127502.5

Review of Board Discussion: Spending Target Penalties

- Board members shared concerns about entities being able to grow from a higher baseline when they exceed a prior year's spending target.
  - OHCA clarified that health care entities will be subject to enforcement for each year they exceed the spending target.
- Board members recommended that PIPs require milestones so that OHCA could better monitor for PIP compliance and assess penalties for noncompliance with PIP milestones.
  - OHCA clarified that PIPs could require milestones and that OHCA could assess penalties for missed PIP milestones.
- Board members shared concern about OHCA's ability to bring entities into compliance with the spending target when entities comply with their PIP but still exceed the target.
  - OHCA noted that the statute prohibits spending target penalties for entities that comply with the PIP and exceed the spending target. This means that PIPs must be sufficiently designed to address causes of excess spending.
- Board members discussed the meaning of the statute's penalty justification factors, with particular focus on "market impact."
  - OHCA clarified that existing statute language would allow OHCA to consider a wide variety of factors and that the Board could add factors later, if the need arises.
- Board members shared concerns that a range maximum of 125% may not be high enough and that the exact minimum should be stated.
  - OHCA clarified that the Board could adjust the range in the future, if the need arises.

Discussion: Spending Target Penalties

1. A penalty structure that calculates penalties that are initially commensurate and then makes adjustments based on a variety of factors.
2. Penalty justification factors would be those listed in HSC section 127502.5.(d) as listed below:
   - The nature, number, and gravity of the offenses.
   - 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.
   - The market impact of the entity.
   - Consideration of provision of nonfederal share.
3. A spending target penalty range of up to 125% of the initially commensurate excess spending growth

Procedural Penalties – Pursuant to HSC § 127502.5 (h)(1)

Considerations

- Procedural penalties need to allow OHCA to respond to non-compliance with enforcement actions, including public testimony and performance improvement plans (PIP).
- Procedural penalties should encourage entities to participate in the enforcement process.
- Procedural penalties can be issued in addition to spending target penalties depending on the entity's compliance with the enforcement process.

Procedural Penalties – Pursuant to HSC § 127502.5(h)(1)

Administrative Penalty	Recommendation	
	Per Day Penalty	Flat Penalty
(A) Willfully failing to report complete and accurate data.	For annual THCE data submission, the Board voted on combination of per day and flat penalties.	
(B) Repeatedly neglecting to file a performance improvement plan with the office.	X	
(C) Repeatedly failing to file an acceptable performance improvement plan with the office	X	
(D) Repeatedly failing to implement the performance improvement plan.		X
(E) Knowingly failing to provide information required by this section to the office.	X	
(F) Knowingly falsifying information required by this section.		X

Health and Safety Code section 127502.5

Procedural Penalties – Pursuant to HSC §§ 127502.5 (h)(1)(B), (C), and (E)

Recommendation

A penalty of up to $10,000 per day for:

- (h)(1)(B) Repeatedly neglecting to file a performance improvement plan with the office.
- (h)(1)(C) Repeatedly failing to file an acceptable performance improvement plan with the office.
- (h)(1)(E) Knowingly failing to provide information required by this section to the office.
- "Repeatedly" means not filing a PIP or failing to file an acceptable PIP more than once.

- Depending on the entity's compliance with the enforcement process, spending target penalties may still be issued in addition to procedural penalties identified above.
- A per day penalty prompts entities to take action to prevent penalties from continuously accruing.
- $10,000 per day aligns with other programs:
  - The California Public Utilities Commission's $5,000-$20,000 per day financial penalty for failure to submit supply and pricing information.
  - The California Department of Health Care Services has an up to $25,000 per day financial penalty for Medi-Cal Managed Care Plans that fail to implement corrective action plans. These penalties increase to $50,000 per day for second offenses and $100,000 per day for subsequent offenses.

Procedural Penalties – Per HSC §§ 127502.5 (h)(1)(D) and (F)

Recommendation

A one-time flat penalty of up to $500,000 for:

- HSC section 127502.5 (h)(1)(D) Repeatedly failing to implement the performance improvement plan.
  - "Repeatedly" means failing to implement a PIP more than once, which could mean failing to implement more than one component of a single PIP or failing to implement multiple PIPs over an extended period.
- (h)(1)(F) Knowingly falsifying information required by this section.

- Depending on the entity's compliance with the enforcement process, spending target penalties may still be issued in addition to procedural penalties identified above.
- A flat penalty is appropriate for these violations because OHCA is no longer compelling an action – the entity has already failed to implement the PIP or has already falsified information.
- A flat penalty of up to $500,000 aligns with Massachusetts' approach for entities that do not implement their PIP.

Review of Board Discussion: Procedural Penalties

- A Board member shared that a flat penalty of $500,000 for falsifying information may not be high enough.
  - OHCA responded that it would consider the feedback.
- Board members asked that language for the procedural penalty for failing to implement a PIP (127502.5 (h)(1)(D)) clarify that the penalty targets health care entities that do not attempt to implement the PIP rather than those that attempt but fail to achieve the PIP's goals.
  - OHCA responded that it would consider the feedback.
- A Board member asked for clarification on whether or not OHCA could proceed to assessing a spending target penalty if an entity is refusing to participate in the enforcement process.
  - OHCA responded that it would follow up on this question at a future Board meeting.

Discussion: Procedural Penalties

Does the Advisory Committee have any initial feedback on the proposed procedural penalties framework?

- **Up to $10,000 per day for violations under 127502.5 § (h)(1)(B), (C), and (E):**
  - (h)(1)(B) Repeatedly neglecting to file a performance improvement plan with the office.
  - (h)(1)(C) Repeatedly failing to file an acceptable performance improvement plan with the office.
  - (h)(1)(E) Knowingly failing to provide information required by this section to the office.
- **One-time flat penalty of up to $500,000 for violations under HSC §§ 127502.5 (h)(1)(D) and (F):**
  - (h)(1)(D) Repeatedly failing to implement the performance improvement plan.
  - (h)(1)(F) Knowingly falsifying information required by this section.

Next Steps

- Board vote for spending target penalty scope, range, and justification factors for Health and Safety Code sections 127502.5(a) and (d).
- Board vote for procedural penalties scope, range, and justification factors for Health and Safety Code section 127502.5 (h)(1).
- OHCA staff will draft regulations for spending target enforcement.

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Public Comment

HCAI
Department of Health Care Access and Information

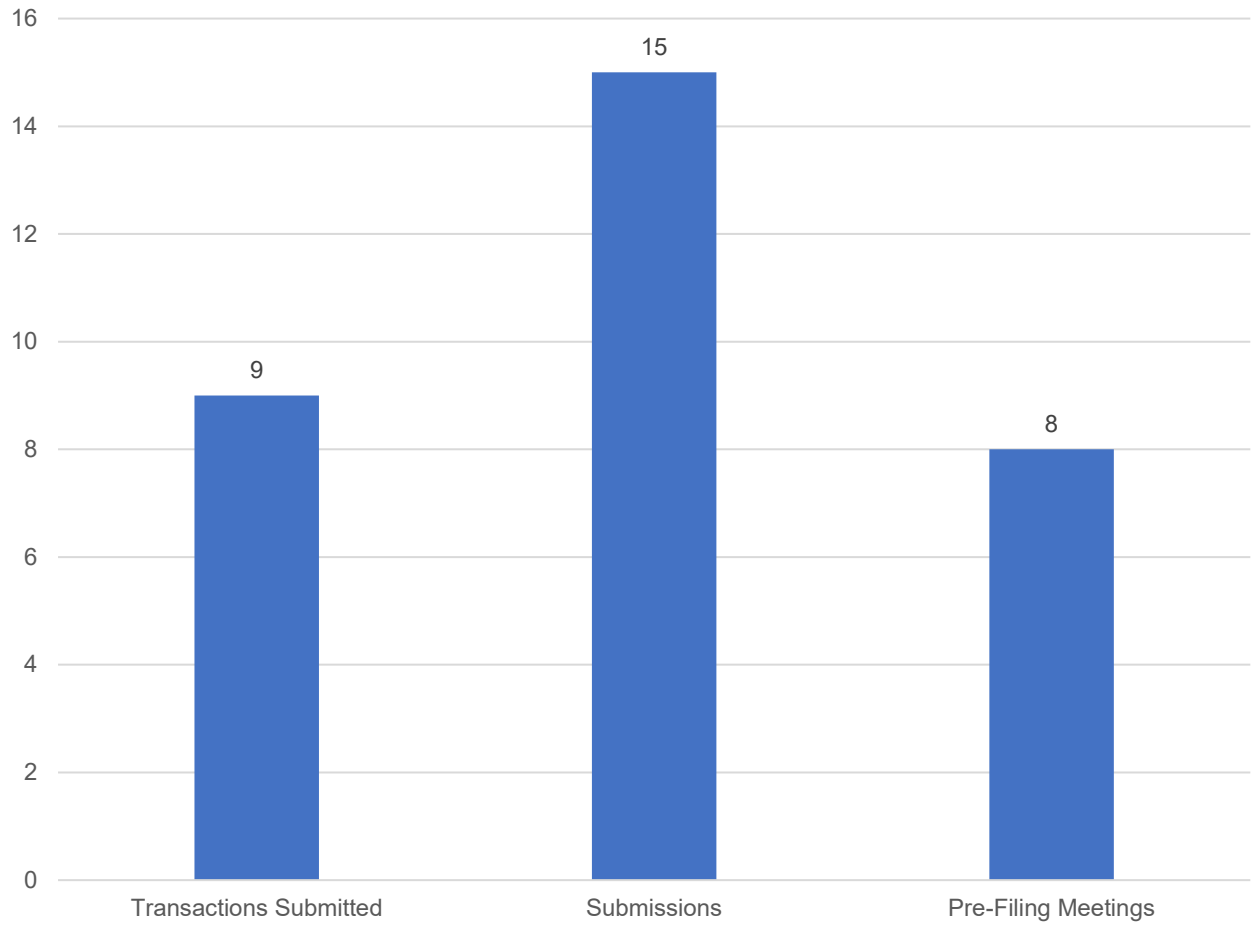
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Cost and Market Impact Review Program – Status Update

Heather Hoganson, Assistant Chief Counsel

HCAI
Department of Health Care Access and Information

CMIR Program January 2026 to June 2026



January 2026 to June 2026

- 9 transactions
- 15 different MCN submissions (number of submitters per transaction varies)
- 8 Pre-Filing Meetings

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

CMIR Program Submissions January 2026 to June 2026

Type of Transaction	Number	Percentage
Skilled Nursing Facilities (SNFs)	1	6.67%
Laboratories	5	33.33%
Physician Organizations	2	13.33%
Hospitals	3	20.00%
MSOs	1	6.67%
Others	3	20.00%
Total	**15**	**100%**

CMIR Program: January 2026 to Present

Since the January Advisory Meeting:

- 9 Transaction Reviews Commenced

  (15 Different Submissions)
- 11 Transaction Reviews Completed/Waived
- 4 Transaction Reviews Open
- 1 CMIR Completed
- 8 Pre-Filing Meetings

CMIRs Completed Since January 2026

Submitters	Transaction Summary	Submission Complete	Status
Res-Care, Inc.	National Mentor Holdings, Inc. will acquire subsidiaries, equities, and assets from ResCare, an operator of intermediate care facilities for individuals with intellectual and developmental disabilities.	April 21, 2025	CMIR Complete (April 8, 2026)

CMIRs Currently in Review

Submitters	Transaction Summary	Submission Complete	Status
Covenant Care California, LLC; Covenant Care Mission, Inc.; Covenant Care Long Beach, Inc.; Covenant Care Morgan Hill, LLC; Covenant Care Capitola, LLC; Covenant Care Encinitas, LLC; Covenant Care La Jolla, LLC; Covenant Care Courtyard, LLC; and Covenant Care Lodi, LLC.	Submitters will transfer the assets and operations of its respective skilled nursing facilities to subsidiaries of: International Equity Partners, Spyglass Healthcare, Links Healthcare Group, and The Ensign Group. OHCA is conducting a CMIR over three acquisitions by The Ensign Group.	April 24, 2025	In CMIR Review

Transaction Reviews Completed since January 2026

Submitters	Transaction Summary	Submission Complete	Status
CareMeridian, LLC	CareMeridian, LLC, a rehabilitation services provider, will acquire all assets of Sierra Summit Head Injury Care Homes.	December 5, 2025	CMIR Waived (January 16, 2026)
Physician Health Network Medical Corporation	Current shareholders are selling their equity interest in Physician Health Network Medical Corporation to David Ulick, M.D., and Eva L. Vargas, RN/BSN, through a Stock Purchase Agreement.	December 1, 2025	CMIR Waived (January 16, 2026)
Euclid Endoscopy Center, L.P. and AmSurg Holdings, LLC	AmSurg Holdings, LLC, a subsidiary of Ambulatory TopCo, LLC (AmSurg), will acquire 51% of issued and outstanding membership interests in Euclid Endoscopy Center, L.P. (Euclid). Euclid will convert from a limited partnership to a limited liability company.	December 16, 2025	CMIR Waived (June 25, 2026)

Transaction Reviews Completed Since January 2026

Submitters	Transaction Summary	Submission Complete	Status
Imperial Care LLC and El Centro Regional Medical Center	Imperial Care LLC (licensee of El Centro Post-Acute Care), a skilled nursing facility located in El Centro, CA. The transaction will result in the transfer of the skilled nursing facility's operations to El Centro Regional Medical Center and sublease of the skilled nursing facility's real property to El Centro Regional Medical Center.	December 22, 2025	CMIR Waived (February 5, 2026)
Abbott Laboratories and Exact Sciences Corporation	Pursuant to an Agreement and Plan of Merger, Abbott Laboratories (Abbot) is acquiring Exact Sciences Corporation through a merger with Abbott's subsidiary.	February 4, 2026	CMIR Waived (March 19, 2026)

Transaction Reviews Completed Since January 2026

Submitters	Transaction Summary	Submission Complete	Status
Sharp HealthCare and Tri-City Healthcare District dba Tri-City Medical Center	Tri-City Healthcare District plans to transfer substantially all of Tri-City Medical Center's assets and the District's liabilities to Sharp HealthCare and its wholly-controlled subsidiary Tri-City Medical Center Corporation. The transaction will be subject to voter approval in June 2026.	February 25, 2026	CMIR Waived (April 13, 2026)

Transaction Reviews Completed Since January 2026

Submitters	Transaction Summary	Submission Complete	Status
Inform Diagnostics, Inc. and Fulgent Therapeutics, LLC	Inform Diagnostics, Inc. and Fulgent Therapeutics, LLC will acquire equity interests of Dermatopathology Experts, LLC and all assets related to the diagnostic and therapeutic services of Bako Pathology Holdings Corp. and its subsidiaries.	January 7, 2026	CMIR Waived (February 23, 2026)
UC San Diego Health and Palomar Health	The transaction will result in the formation of a Joint Powers Authority between Palomar Health and The Regents of the University of California, on behalf of UC San Diego Health	January 14, 2026	CMIR Waived (**JPA Formation**) (March 24, 2026)
Vitalant and San Diego Blood Bank	Vitalant, an Arizona-based non-profit specializing in providing blood supplies to health systems and hospitals, will acquire San Diego Blood Bank, also a non-profit specializing in blood-related services, and will serve as its sole member.	February 13, 2026	CMIR Waived (March 3, 2026)

Transaction Reviews Completed Since January 2026

Submitters	Transaction Summary	Submission Complete	Status
Centene Corporation (“Centene”), Madison Health Group (“Madison”), Magellan Health Service of California, Inc. – Employer Services (“MHSC”), Magellan Federal, Inc. (“Magellan Federal”), Magellan Healthcare Provider Group, Inc. (“MHPG”), and Magellan Life Insurance Company (“Magellan Life”)	Centene will divest itself of several health care entity subsidiaries pursuant to a Stock Purchase Agreement with Madison. The transaction will ultimately result in MHSC, Magellan Federal, MHPG, and Magellan Life becoming wholly indirectly-owned subsidiaries of Madison.	March 19, 2026	CMIR Waived (May 4, 2026)

Transaction Reviews Completed Since January 2026

Submitters	Transaction Summary	Submission Complete	Status
Vibra Hospital of San Diego, LLC And California Rehabilitation Institute, LLC	Stallion Intermediate Corporation will acquire Select Medical Holdings Corporation which owns two hospitals and two management services organizations in California. Stallion Intermediate Corporation is wholly owned by Stallion Group Parent, LP and indirectly owned by WCAS Fund XIV, L.P., a fund affiliated with Welsh, Carson, Anderson & Stowe.	April 24, 2026	CMIR Waived (June 19, 2026)

Transaction Reviews Completed Since January 2026

Submitters	Transaction Summary	Submission Complete	Status
Genesis Healthcare Partners, P.C.	Golden Gate Urology Inc. will transfer certain clinical assets to Genesis Healthcare Partners, P.C. and certain non-clinical assets to Unio Health Partners, LLC or one of its affiliates. Golden Gate's physicians will enter into employment agreements with Genesis, and its shareholder-physicians will acquire Genesis equity.	May 14, 2026	CMIR Waived (June 26, 2026)

Material Change Notices Currently in Review

Submitters	Transaction Summary	Submission Complete	Status
Long Beach NSC – Commons Clinic Medical Network, Commons Clinic MSO	Commons Clinic MSO CA, LLC (CCMSO) and Commons Clinic Medical Network, PC (CCMN) will acquire the ambulatory surgery center, Long Beach NSC, LLC, from AmSurg Holdings, LLC.	May 18, 2026	In Review
NAHS Holding, Inc., MOJUMU, Inc., and Argent Trust Company (solely as Trustee of the NAHS employee stock ownership plan trust)	MOJUMU, Inc., will acquire 100% equity ownership of NAHS Holding, Inc., from the NAHS employee stock ownership plan trust through a stock purchase agreement.	June 4, 2026	In Review

Revising CMIR Regulations Due to AB 1415

- Legislation added **Noticing Entities** required to submit transactions for review:
  - Private Equity
  - Hedge Funds
  - Management Services Organizations
  - New entities created for the transaction
  - Entities that control a provider

- Updating regulations with cross-references and renumbering
- Revising Information for Public Notice
- Updating Confidentiality Process

AB 1415 (Chapter 641, Statutes of 2025) was signed by the Governor on October 11, 2025.

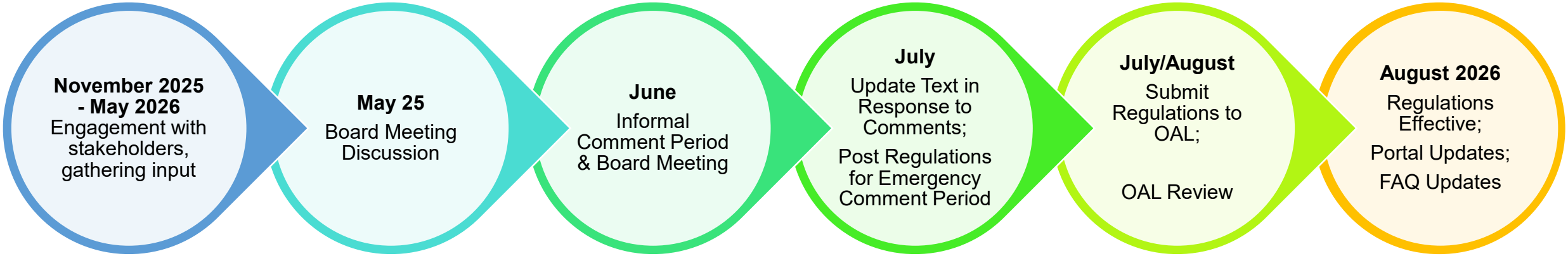
Regulatory Considerations

- **Creating Thresholds & Circumstances for filing by noticing entities**
  - 22 CCR 97435 (b) describes the thresholds for health care entities, which currently reflect revenue and geographic parameters.
  - 22 CCR 97435 (c) lists circumstances under which a transaction requires a filing – adding private equity/hedge fund, MSOs, and real estate
- Adding financial risk due to real estate terms as a reason for CMIR
- Adding a remand procedure if new information might negate the reason to be in a CMIR
- Adding a potential reason for Expedited Review (Urgent Situation)

CMIR Regulations Status Update

- Proposed regulations were discussed at the Health Care Affordability Board meeting in May 2026.
- OHCA published draft regulations on May 22, 2026.
- Public comments were accepted from May 22 to June 11, 2026.
- OHCA received 12 comment letters.

Projected Timeline for Revising CMIR Regulations Due to AB 1415



Note: Dates are subject to change.

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

General Public Comment

Written public comment can be emailed to:
ohca@hcai.ca.gov
To ensure that written public comment is included in the posted board materials, e-mail your comments at least 4 business days prior to the meeting.

HCAI
Department of Health Care Access and Information

Next Advisory Committee Meeting:

October 14, 2026
10am

Location:
2020 West El Camino Ave, Conference Room 900, Sacramento, CA 95833

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Adjournment

HCAI

Department of Health Care Access and Information