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Health Care Affordability Board
June 2026 Board Meeting
Public Comment on Draft CMIR Regulations

The following attached letters were sent to the Office of Health Care Affordability (OHCA) regarding OHCA's implementation of Assembly Bill 1415 (Chapter 641, Statutes of 2025) for the Cost and Market Impact Review (CMIR) regulations (Material Change Transactions and Pre-Transaction Review, Article 1 of Chapter 11.5 of Division 7 of Title 22, California Code of Regulations), for which public comment was invited from May 22 through June 11, 2026.

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June 11, 2026

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

Heather Cline Hoganson, Assistant Chief Counsel
Office of Health Care Affordability

Health Care Access and Information Department
2020 W. El Camino Ave, Ste. 1200 Sacramento, CA

Re: AB 1415 Updates to Regulation for Material Change Transactions and Pre-Transaction Review

Dear Ms. Landsberg, Mr. Pegany and Ms. Hoganson,

Health Access of California, the statewide health care consumer advocacy coalition, committed to quality, affordable health care for all Californians, provides comments on the proposed amendments to **California Code of Regulations, Title 22, Division 7, Chapter 11.5, Article. 1.** As sponsors of AB 1415 (Bonta, Chapter 641 of 2025), Health Access California appreciates the efforts made by OHCA to implement the bill's requirements, and improve transparency for transactions involving private equity groups, hedge funds, and management services organizations. As private equities footprint in health care grows, and health care transactions become increasingly complex, clear and comprehensive regulations are imperative to transparency in our health care system.

Health Access especially appreciates the following additions the Office has incorporated into the proposed regulation, including:

- 97435 (c)(11) Inclusion of real estate leaseback arrangements as material change transactions that will be subject to review. These

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arrangements can significantly affect financial stability, access to care and operations and the requirement for disclosure of copies of any sale lease-back agreements in 97438 (c)(3). This is aligned with the law.

- Sale lease back arrangements are a common private equity tactic in skilled nursing facilities where the firm will sell the real estate underlying the nursing home to another organization. This can lead to declines in quality and staffing. For example, when a private equity group bought HCR Manor Care in 2007, in the years that followed the sale-lease back, annual health code violations rose 26% in four years, and the next year, the company filed for bankruptcy.[i]
- This tactic is also used by private equity-backed hospitals. Here are California examples:
  - Pipeline Health – backed by three private equity and investment firms - sold the hospital real estate of four Los Angeles hospitals to Medical Properties Trust in 2021, a REIT in a $215 million sale-leaseback transaction. Pipeline Health declared Chapter 11 Bankruptcy the following year. ii
  - In July of 2019, Prospect sold the real estate of its California, Connecticut and Pennsylvania hospitals in a sale-leaseback transaction with Medical Properties Trust for $1.55 billion. This left Prospect with few assets, and Prospect filed for bankruptcy in 2025.[iii]
  - Outside of California, the use of sale-leasebacks played a role of Steward Health Care's eventual bankruptcy. Steward sold its Massachusetts properties to MPT for $1.25 billion in 2016, including a 10-year escalator clause leading to annual rent increases, with each hospital responsible for paying rent, insurance and taxes. As a result, Steward experienced increasing operating costs and worsening budgetary pressures due to the increasing lease payments. Steward fell behind on accounts payable to vendors who repossessed needed medical

equipment. The loss of this equipment was linked to adverse patient outcomes, including a patient dying.[iv]

  - These examples illustrate the negative impacts of REITs for consumers, why they were included in AB 1415 and we support their inclusion in the regulation.

- 97438 (b)(8)(D) Including CMS Star rating and other quality measures will help provide a holistic view of the potential impact of the transaction on quality for consumers. Looking at quality measures is consistent with OHCA's mission: such measures should also include equity measures and if available, stratification of measures by race, ethnicity, language, disability, sexual orientation and gender identity (RELD-SOGI).
- 97438 (b)(8)(G) Including anticipating cost savings, quality investments, price reductions and serve expansions as a result of the transaction. Research shows that health care mergers and acquisitions result in price increases without improvements in quality. Hospitals often say that these mergers result in efficiencies and better coordination and quality for the consumer. Requiring this disclosure of potential impacts would ensure that communities can hold hospitals and other health care entities accountable for their promises to benefit their care. Ideally, such anticipated improvements would be quantified and part of the transaction agreements. This is similar to what the Attorney General now requires for nonprofit health facility transactions.
- 97437(a)(2) The improvements to the confidentiality section of the regulations., The law is clear that only information that is not already available publicly may be treated as confidential. We think this is an important distinction, so that information that is useful in the understanding of the impact of the transaction, and is already made available to the public through federal, state, or local government record or disclosure, media source or other publicly available sources is not incorrectly labeled as confidential. This is consistent with AB 1415 and the underlying OHCA statute.

- 97438 (b)(10)(A) The 5% or more ownership threshold to disclose potential post-transaction changes is appropriate because ownerships of this size can still hold significant influence over complex organizations, with impacts on prices, quality and access to care for consumers.
- 97435 (c)(9) The entirety of section (9) describes the potential impacts of a private equity, hedge fund, and management services organization involvement in health care on consumers. We appreciate the threshold of including transactions that result in any of the impacts and types of control described in (B)(i)-(viii). If a private equity group or hedge fund obtains control of a doctors' group through a management service organization, and has the ability to expand or reduce services, change arrangements, charge the physician group fees and make financial decisions for the health care entity, then that would have a significant impact on consumers' health care and warrants the noticing entity or health care entity filing with OHCA. Private equity groups often engage in financial tactics with health care entities they would use for other businesses to maximize profit that result in higher prices, dangerous health care outcomes, reduced access to care and worse financial outcomes for the health care entity:
  - Higher Prices: Research shows that private equity acquisitions of physician practices lead to price increases ranging from 16% in oncology and 4% in primary care and dermatology; and that in regions where private equity dominate physician specialties, prices increases are 3 times higher than comparable markets.[v]
  - Dangerous Health Outcomes: Private equity ownership in skilled nursing facilities was shown to increase death rates for patients with Medicare coverage by 10%; and was associated with a 25% increase in hospital-acquired conditions, avoidable injuries, and central line-associated infections in private equity-owned hospitals.[vi][vii]
  - Reduced Access: When attempting maximize profits, private equity firms will flip the asset by selling their newly purchased health care organization to another buyer like CVS or Amazon, for a much higher price. To make the asset more attractive, the firm boosts their profits

by cutting costs, raising prices and increasing profitable services provided and cutting unprofitable services – even if needed in the community.[viii]

    - Worse Financial Outcomes for the Health Care Entity: Private equity acquisitions often lead to worse financial outcomes for the health care provider being acquired; in 2023, at least 80% of large health care companies that filed for bankruptcy were private equity-owned, with that trend continuing in 2024. Steward Healthcare's bankruptcy is one giant example of this trend that including the private equity owner leaving the system with $800 million profit, and the system in financial distress, worsening quality of care, 5 hospital closures, 2,400 worker layoffs and loss of critical health care services in Massachusetts in Florida and Ohio.[ix]

- 97435 (c)(11) requiring filing when the transaction results in the sale or transfer of real estate where a health care entity provider services to another entity not involved in the transaction, and the surviving health care entity will be required to pay rent for the real estate. If this is the plan for the health care entity being acquired, it's important this is captured in the notice. If the health care entity's real estate, its biggest asset is being sold to another entity – that can have an impact on patient care and the financial stability of the health care entity.

Areas for Improvement

While Health Access supports many elements of the proposed regulations, we are recommending that the Office alters the definition of MSO to avoid gaps in transparency over these transactions and entities, captures withdrawals of financing and adjust phrasing for clarity.

Improving Transparency over Management Services Organizations (MSO's) Transactions that Impact Consumers' Care

Definition of MSO 97431 (K)

The proposed definition of management services organization would not fully capture the range of MSO structures that impact consumers' care and the health

care market, and the proposed regulation inappropriately narrows the scope of transactions intended for review under AB 1415. The definition in the law of management services organization (HSC Section 127500.2 (o)) already narrows the scope of MSOs captured to those whose functions for the services they provide to health care entities, would impact the health care prices and quality for consumers. The existing law does so by requiring only MSOs that do provider rate negotiation, revenue cycle management, or both on behalf of health care entities as noticing entities and for research under OHCA. The proposed regulation significantly narrows this definition by MSOs to file including in the threshold of one condition they must meet under (k) that they are owned by a hospital and **have two or more** physician organizations as clients or affiliates, or must be affiliated with two of the following: a health plan, **two or more physician organizations**, or a hospital.

The Proposed Text States:

(k) "Management services organization" shall mean entities, as described in section 127500.2(o) of the Code that are additionally at least one of the following:

> *(1) Owned by a hospital and have ~~two~~* ***one*** *or more physician organizations as clients or affiliates;*
>
> *(2) Employ the physician-owner of, or otherwise have an agreement with the physician-owner that defines the services to be provided and compensation for such services with, one or more physician organizations;*
>
> *(3) Share directors, officers, investors, or other natural persons with the ability to exercise control with respect to a health care entity; or*
>
> *(4) Affiliated with at least ~~two~~* ***one*** *of the following:*
>
> > *(A) A health plan;*
> >
> > *(B) ~~Two~~* ***One*** *or more physician organizations; or*
> >
> > *(C) A hospital.*

We recommend:

- Revising 97431 (k)(1) to refer to **one or more** physician organizations, replacing the two or more physician organization requirement. Many MSO's, especially captive MSOs may only be tied to a single organization, and the arrangement can allow the MSO to have significant influence over clinical or financial decisions. Private equity groups that supply capital to physician organizations, will do so through captive MSO as a vehicle to buy out the shares of the medical practice and assume control over it without triggering corporate practice of medicine bans. Large private equity-backed providers will use this tactic to functionally acquire and run medical practices. That's why it is important that MSOs that meet the laws definition and are affiliated with one or more physician organization are captured in these regulations.[x]
- Revising 97431 (K)(4) to affiliation with any of the following listed entities. Requiring affiliation with two or more entities can exclude MSO's that have substantial influence through a single affiliation. We suggest "Any affiliated entities" to capture more entities that AB 1415 is designed to address.
- Remove references of two or more physician organizations, and update to one or more physician organizations. This is referenced throughout the regulation and should be updated so that single affiliations are not excluded.

Use of "And/Or"

The proposed regulation uses the phrase "and/or" throughout. This phrasing can create uncertainty about whether requirements apply in addition to, separately, or both, and may lead to inconsistent interpretation or enforcement.

We recommend:

- Revising "and/or" to "or". We believe this would increase clarity throughout the proposed regulation.

Capturing When Private Equity Withdraws from a Health Care Entity - Material Change Transactions 97435 (c)(9)(B)

Health Access strongly supports the addition of private equity activities that indicate that it might have control operationally or have influence over decision making. These examples reflect what we see when private equity affects the affordability, quality, and access to care for consumers. We believe there is one additional scenario that the Office may want to capture.

We recommend:

Additionally, capturing scenarios in which private equity groups withdraw their funds and control from a health care entity, jeopardizing financial stability of the health care entity. For example, where an investor exits and extracts their financial backing, they may load the health care entity with debt. This financial instability will impact the consumers when the health care entity tries to recoup cost through increasing prices, cutting unprofitable services, increasing high-priced services, decreases in quality of care. Steward Health's financial collapse is one example of the impacts of private equity financing leaving a multi-state health system in financial distress, while taking their profits as described in detail above.

Conclusion

In Conclusion, Health Access California appreciates the Office's continued work to implement AB 1415 and strengthen transparency over transactions involving private equity and hedge funds in health care that have a history of negatively affecting consumers' prices, quality and access to care, and the financial stability of health care entities. We also appreciate your consideration of our recommendations for improvement of the regulations to ensure transactions that impact consumers' care are appropriately captured consistent with the law.

Sincerely,

K. Walters White

Katrina Walters-White
Regulatory Advocate

[i] “Private Equity in Health Care: Prevalence, Impact and Policy Options for California and the U.S.” (California Health Care Foundation, 2024)
[ii] How Private Equity Raided Safety-Net Hospitals – Pipeline Health (Private Equity Stakeholder Project, 2023)
[iii] Steward Health Care’s Bankruptcy: One Year Later (Private Equity Stakeholder Project, 2025)
[iv] Steward Health Care: A Cautionary Tale (Health Management, Policy and Innovation, 2024)
[v] “Monetizing Medicine: Private Equity and Competition in Physician Practice Markets.” (American Antitrust Institute, 2024)
[vi] “Private Equity’s Role in Health Care.” (The Commonwealth Fund, 2023)
[vii] Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition.” (JAMA Network, 2023)
[viii] “Private Equity’s Role in Health Care.” (The Commonwealth Fund, 2023)
[ix] “Steward Health Care’s bankruptcy: one year later.” (Private Equity Stakeholder Project, 2025)
[x] The Corporate Backdoor to Medicine: How MSOs are Reshaping Physician Practices (Milbank Memorial Fund, 2025)

June 11, 2026

Vishaal Pegany, Deputy Director
Office of Health Care Affordability
Department of Health Care Access and Information
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Submitted Electronically to: cmir@hcai.ca.gov

Re: Informal Comments on Proposed Emergency Regulations – Material Change Transactions and Cost and Market Impact Review (22 CCR §§ 97431–97442)

Dear Deputy Director Pegany:

America's Physician Groups (APG) appreciates the opportunity to provide comments on the Office of Health Care Affordability's proposed emergency regulations governing Material Change Transactions and Cost and Market Impact Review (CMIR).

APG represents physician organizations and medical groups that provide care to millions of Californians through coordinated, value-based care arrangements. Many APG members operate under California's longstanding delegated model, in which physician organizations assume responsibility for care coordination, utilization management, quality improvement, network management, and financial accountability under arrangements overseen by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), Medicare Advantage organizations, and contracted health plans.

Background: California's Delegated Care Model Requires Distinct Regulatory Consideration

California's health care delivery system includes a longstanding and nationally recognized delegated care model that differs substantially from traditional fee-for-service and hospital-centric delivery systems. Under this model, physician organizations and independent practice associations frequently assume delegated responsibility for care coordination, utilization management, quality improvement, network management, and financial accountability on behalf of health plans. These arrangements are designed to promote value-based care, improve quality outcomes, and align provider incentives with affordability goals.

As a result, physician organizations routinely enter into administrative, management, contracting, and operational arrangements that facilitate the delivery of coordinated care but do not necessarily increase market concentration, reduce competition, or adversely affect affordability. In many cases, these arrangements are expressly encouraged by state and federal policymakers because they support population health management, accountability for outcomes, and alternative payment models.

APG is concerned that several provisions of the proposed regulations may unintentionally subject routine transactions within California's delegated care framework to the same level of scrutiny applied to large-scale mergers, acquisitions, and consolidation transactions. While APG supports OHCA's responsibility to evaluate transactions that may materially affect affordability, access, quality, or competition, the regulations should distinguish between transactions that merely support the operation of delegated physician organizations and transactions that meaningfully alter market structure or competitive dynamics.

Accordingly, APG respectfully requests that OHCA consider modifications to the proposed regulations that recognize the unique characteristics of California's delegated model and avoid creating unnecessary regulatory burdens on physician organizations that are already subject to extensive oversight by the Department of Managed Health Care, the Department of Health Care Services, Medicare Advantage organizations, and contracted health plans. California's delegated physician organizations have long operated under capitated and value-based payment arrangements that hold providers accountable for the total cost and quality of care delivered to their patient populations. Long before the enactment of SB 184, these organizations were effectively functioning under cost-growth accountability structures similar in concept to the statewide affordability targets now being implemented by OHCA. By placing physician organizations at financial risk for the total cost of care, the delegated model creates strong incentives to coordinate care, improve quality, reduce avoidable utilization, invest in prevention and chronic disease management, and eliminate unnecessary spending. As a result, delegated physician organizations have historically contributed to California's ability to moderate health care cost growth while maintaining high levels of quality and patient access. These incentives directly support the affordability objectives underlying SB 184 and the mission of the Office of Health Care Affordability. APG therefore encourages OHCA to ensure that the final regulations distinguish between transactions that may increase market concentration or health care costs and those that strengthen, support, or expand physician-led, risk-bearing delivery systems that are already aligned with the state's affordability goals.

APG respectfully offers the following comments.

I. Clarify the Definition of Management Services Organization

Applicable Sections:
22 CCR § 97431(k)
22 CCR § 97435(c)(10)

The proposed definition of "Management Services Organization" is substantially broader than the traditional understanding of an MSO and appears capable of encompassing a wide range of physician-group administrative support entities that do not exercise meaningful control over clinical operations.

In particular, proposed § 97431(k)(2), (3), and (4) would capture entities that merely employ physician owners, share investors or directors with health care entities, or maintain affiliations with physician

organizations, hospitals, or health plans. Similarly, proposed § 97435(c)(10) would require notice for a broad range of management services relationships that may arise during ordinary physician group operations.

California's delegated care model frequently relies upon administrative organizations that provide contracting support, care management services, information technology infrastructure, credentialing assistance, data analytics, and related operational functions. These relationships are common and often necessary for independent physician organizations to participate successfully in value-based care arrangements.

Recommendation: APG recommends that OHCA narrow the definition of MSO to focus on entities that exercise actual operational control over clinical services, governance, or financial decision-making, rather than entities that merely provide administrative support functions.

II. Clarify That Routine Delegated Care Arrangements Do Not Constitute Material Change Transactions

Applicable Sections:
22 CCR § 97431(p)
22 CCR § 97435(c)(4)
22 CCR § 97435(c)(10)

The proposed definition of "transaction" and the provisions addressing transfers of control, responsibility, or governance could be interpreted to encompass routine delegated contracting arrangements between health plans, physician organizations, and administrative entities.

Under California's delegated model, physician organizations routinely assume responsibilities relating to utilization management, care coordination, quality improvement, credentialing, network administration, and other delegated functions without any corresponding transfer of market power, ownership, or competitive significance.

Recommendation: APG recommends that OHCA expressly clarify that the delegation or redelegation of administrative and care management functions, standing alone, does not constitute a reportable material change transaction unless accompanied by a transfer of ownership, market control, or governance authority sufficient to affect competition, affordability, or access to care.

III. Narrow the Ten-Year Transaction Aggregation Provisions

Applicable Sections:
22 CCR § 97435(c)(7)
22 CCR § 97435(c)(8)

The proposal would aggregate related transactions occurring over a ten-year period for purposes of determining whether filing thresholds have been met.

APG is concerned that a ten-year lookback period is excessively long and may inadvertently capture ordinary physician recruitment efforts, practice acquisitions, and growth strategies that occurred years before the current transaction. The practical effect may be to transform otherwise routine transactions

into reportable events based upon historical activity that no longer bears a meaningful relationship to current market conditions.

Recommendation: APG recommends shortening the aggregation period to three years or, alternatively, limiting aggregation to transactions involving substantially identical parties, markets, and services.

IV. Reconsider Application of CMIR Requirements to Sale-Leaseback Transactions

Applicable Sections:
22 CCR § 97435(c)(11)
22 CCR § 97441(a)(1)(G)

The proposed regulations would subject many sale-leaseback transactions involving health care real estate to CMIR review and further identify transactions involving REITs as a factor supporting a full CMIR review.

Physician organizations frequently utilize real estate transactions to obtain capital needed for infrastructure investments, technology upgrades, practice expansion, and care delivery improvements. Many such transactions have no effect on market concentration, patient access, pricing, quality, or competition.

Recommendation: APG recommends that OHCA establish either an exemption or expedited review process for real estate transactions that do not alter provider ownership, clinical operations, service availability, or competitive market dynamics.

V. Avoid Duplicative Reporting Requirements for Affiliated Management Services Organizations

Applicable Sections:
22 CCR § 97431(k)
22 CCR § 97435(c)(10)
22 CCR § 97438(b)
22 CCR § 97438(c)

California's delegated care model frequently utilizes affiliated management services organizations (MSOs) to provide administrative, operational, contracting, technology, care management, and support services to physician organizations and risk-bearing organizations. In many cases, the financial activity of these affiliated entities is already reflected in the consolidated financial reporting, annual surveys, financial statements, and other oversight mechanisms applicable to the affiliated risk-bearing organization and routinely reviewed by the Department of Managed Health Care.

As a result, APG is concerned that the proposed regulations may require separate CMIR filings and extensive duplicative disclosures regarding entities whose revenues, expenses, governance structures, and operational activities are already reported to regulators through existing oversight processes. Requiring separate submissions from affiliated MSOs would increase administrative burden and compliance costs without necessarily providing OHCA with meaningful new information regarding affordability, competition, quality, or access to care.

This concern is particularly relevant in California's delegated model, where physician organizations, risk-bearing organizations, and affiliated MSOs often function as integrated components of a single care delivery system while maintaining separate legal structures for regulatory and operational purposes. In many instances, the revenues and expenses of affiliated MSOs are already incorporated into the financial reporting of the affiliated risk-bearing organization, making separate reporting largely duplicative.

Recommendation: APG recommends that OHCA recognize existing regulatory reporting mechanisms applicable to affiliated risk-bearing organizations and permit submitters to satisfy applicable CMIR reporting requirements through incorporation by reference of information previously reported to DMHC or other state regulators. Where an affiliated MSO's financial and operational information is already reflected in the reporting of a regulated risk-bearing organization, OHCA should avoid requiring duplicative submissions and should establish streamlined filing procedures that leverage existing regulatory data sources whenever practicable.

VI. Protect Confidential Business Information and Reduce Burdensome Disclosure Requirements

Applicable Sections:
22 CCR § 97437
22 CCR § 97438(b)
22 CCR § 97438(c)

The proposed regulations significantly expand the volume and sensitivity of information required to be submitted.

Required disclosures include extensive financial information, valuation analyses, governance documents, ownership information, labor-related information, strategic planning materials, and investor-related documents.

While APG appreciates OHCA's efforts to establish confidentiality protections, many physician organizations remain concerned that competitively sensitive information may become subject to public disclosure.

Recommendation: APG recommends that OHCA expand the categories of documents deemed confidential, including internal strategic planning documents, governance analyses, investor presentations, compensation analyses, business valuation materials, contracting strategy documents, and proprietary operational information.

VII. Reconsider the Scope of Ownership and Investor Disclosure Requirements

Applicable Sections:
22 CCR § 97438(b)(10)
22 CCR § 97438(c)(7)
22 CCR § 97435(c)(9)

The proposed regulations require disclosure of extensive ownership information, including all entities and individuals possessing five percent or greater ownership interests.

APG is concerned that the proposed threshold may impose substantial reporting burdens while producing information of limited relevance to the affordability and competition objectives of the CMIR process.

Recommendation: APG recommends that OHCA consider increasing the ownership reporting threshold or limiting required disclosures to investors possessing governance rights, operational control rights, or material decision-making authority.

VIII. Avoid Duplicative Oversight of Already-Regulated Risk-Bearing Organizations

Applicable Sections:
22 CCR § 97435
22 CCR § 97438
22 CCR § 97441

Many APG members are already subject to extensive regulatory oversight by the Department of Managed Health Care, Medi-Cal managed care plans, Medicare Advantage organizations, and the Department of Health Care Services.

These entities routinely submit financial reports, quality data, network information, governance disclosures, operational reports, medical loss ratio data, financial solvency reports, and delegated oversight documentation to multiple regulators. In many cases, affiliated MSOs are already captured within the financial, operational, and governance reporting submitted by regulated risk-bearing organizations, further reducing the need for separate and duplicative reporting obligations under the CMIR process.

Recommendation: APG recommends that OHCA establish streamlined filing requirements, abbreviated review pathways, or presumptive exemptions for transactions involving entities already subject to comprehensive state regulatory oversight. Such an approach would reduce duplicative reporting burdens while preserving OHCA's ability to review transactions that may genuinely affect affordability, access, competition, or quality.

IX. Reconsider Asset-Based Filing Thresholds for Physician Organizations

Applicable Section:
22 CCR § 97435(c)(3)

The proposed regulation would trigger review when a transaction involves the sale, transfer, lease, exchange, option, encumbrance, or other disposition of 25 percent or more of a submitter's California assets.

For many physician organizations operating under delegated arrangements, tangible assets represent only a small portion of the organization's overall operations. Physician groups often maintain relatively modest physical assets while managing substantial patient populations and financial accountability arrangements. As a result, routine transactions involving office space, technology infrastructure, equipment, or administrative assets could unintentionally exceed the 25 percent threshold despite

having no meaningful impact on market concentration, competition, affordability, quality, or access to care.

Recommendation: APG recommends that OHCA establish a higher threshold for physician organizations and delegated entities or require a showing that the transaction materially affects health care delivery, market concentration, affordability, or competitive dynamics before triggering CMIR review.

Conclusion

APG appreciates OHCA's willingness to engage stakeholders during development of these important regulations. California's physician organizations play a central role in delivering coordinated, value-based care to millions of Californians, including approximately six million Medi-Cal beneficiaries served through delegated and risk-bearing arrangements. The delegated care model has been one of California's most successful mechanisms for aligning provider accountability with affordability, quality, and population health objectives. As OHCA finalizes these regulations, APG respectfully urges the Office to ensure that the CMIR framework distinguishes between transactions that may threaten affordability or competition and those that support physician-led, risk-bearing delivery systems that are already advancing the goals embodied in SB 184.

In evaluating these regulations, APG respectfully urges OHCA to recognize that physician organizations operating under delegated and capitated payment arrangements are not merely subjects of affordability policy, but have been among California's most significant contributors to health care affordability for decades. The final regulations should preserve and encourage these models while focusing regulatory scrutiny on transactions that present a genuine risk to competition, affordability, access, or quality.

We appreciate your consideration of these comments and look forward to continued collaboration with OHCA as these regulations are finalized.

Sincerely,

William J. Barcellona, Esq., MHA
Executive Vice President, Government Affairs
America's Physician Groups

CC: Elizabeth Landsberg, Director, HCAI+

June 11, 2026

VIA E-MAIL (OHCA@HCAI.CA.GOV)
Ms. Megan Brubaker
HCAI, Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95814

RE: Comments on Proposed Regulations for Material Change Transactions and Pre-Transaction Review Process

Dear Ms. Brubaker:

The California Independent Physician Practice Association ("CIPPA") appreciates the ongoing efforts of the Office of Health Care Affordability ("OHCA" or "Office") to address the harmful effects of health care consolidation that undermine the quality, affordability and accessibility of health care in the State. CIPPA submits these comments in response to OHCA's proposed emergency regulations (the "Proposed Regulations")[1] implementing the amendments to the Health Care Quality and Affordability Act ("HCQAA") that became law through Assembly Bill 1415 in 2025. The Proposed Regulations, when finalized, will govern the notice and review process for "material change" transactions involving a new class of "Noticing Entities," which include Management Services Organizations ("MSOs"), Private Equity Groups, and Hedge Funds.[2]

We are deeply concerned that certain aspects of the Proposed Regulations exceed the authority the Legislature granted OHCA under the HCQAA and run counter to the Legislature's stated purpose in the HCQAA of "promot[ing] competitive health care markets."[3] As we explain below, certain proposed regulations, if not modified, will inhibit transactions that promote competition and will drive even more health care services into the higher cost and rapidly consolidating hospital setting.

We have divided our comments into three parts. In Part I, we explain the limited scope of rulemaking authority delegated to OHCA under the HCQAA. In Part II, we identify specific provisions in the Proposed Regulations that violate the plain text of the HCQAA by (A) requiring notice of transactions with independent physician practices below statutory thresholds, (B) modifying the definition of MSO, (C) bringing transactions between Noticing Entities and MSOs ("Non-Health Care Entity Transactions") into the scope of cost and market impact review

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[1] Office of Health Care Affordability, Proposed Emergency Text for Informal Comment, Promotion of Competitive Health Care Markets; Health Care Affordability (CMIR), *available online at* https://hcai.ca.gov/wp-content/uploads/2026/05/CMIR-Regulations-May-2026-Proposed-Text-for-Informal-Comment.pdf (May 15, 2026).
[2] "Noticing Entities" is defined to include (1) "private equity groups;" (2) "hedge funds;" (3) "management services organization;" (4) "newly created business entit[ies] created for the purpose of entering into agreements or transactions with a health care entity;" and (5) "entit[ies] that own[], operate[], or control[] a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license." Cal. Health & Saf. Code § 127507(h).
[3] Cal. Health & Saf. Code § 127507(a).

("CMIR"), and (D) creating new pre-close waiting periods for Non-Health Care Entity Transactions. In Part III, we identify limited changes that need to be made to the Proposed Regulations so that OHCA adheres to the Legislature's directive in AB 1415 that OHCA eliminate duplicative reporting.

Our comments focus on aspects of the Proposed Regulations that need to be modified to ensure that OHCA acts consistent with the text and purpose of the HCQAA and does not inadvertently harm competition in the health care market. We place in bold typeface the specific changes we ask OHCA to make to the Proposed Regulations and include our suggested revisions to the Proposed Regulations as Attachment A to this letter.

California Independent Physician Practice Association

CIPPA is an advocacy organization whose mission is to promote and protect the high quality, cost-efficient care furnished in the independent practice setting. CIPPA's members are medical practices from across California that provide care to millions of Californians. Physicians in CIPPA member practices are not employed by hospitals, hospital systems, health care service plans, or health insurers. They care for patients in independent physician practices and specialize in fields such as dermatology, gastroenterology, oncology, ophthalmology, retinal surgery, urology, and women's health. CIPPA member practices provide treatment for serious injuries, conditions, illnesses and diseases, including various forms of cancer, in cities and towns, including in underserved communities, throughout California. CIPPA submitted comments in response to OHCA's initial draft regulations issued on July 27, 2023, and to OHCA's revised proposed regulations issued on October 9, 2023.[4]

I. OHCA's Rulemaking Authority Under the HCQAA Is Limited.

As amended by AB 1415, the HCQAA only requires Health Care Entities and Noticing Entities to provide notice of certain material change transactions. A Health Care Entity must provide notice to OHCA of transactions in which the Health Care Entity sells or transfers a material amount of the Health Care Entity's assets or ownership interests to one or more entities.[5] Noticing Entities must also provide notice to OHCA of Noticing Entity transactions with Health Care Entities and MSOs that similarly result in the sale or transfer of a material amount of the assets or ownership interests of a Health Care Entity or MSO.[6]

The Legislature did not give OHCA the authority to expand the type of agreements or transactions that trigger a notice obligation under section 127507. Instead, the Legislature tasked OHCA with establishing standards of materiality that will trigger a notice obligation for agreements and transactions that fall into one of the two statutorily-created categories set forth in section 127507(c)(1) and (2). The Legislature also charged OHCA with streamlining the reporting of

[4] Letter from CIPPA to Ms. Megan Brubaker, HCAI-OHCA (Aug. 30, 2023), *available at* https://hcai.ca.gov/wp-content/uploads/2023/10/Merged-Regs-Public-Comment.pdf; Letter from CIPPA to Ms. Megan Brubaker, HCAI-OHCA (Oct. 17, 2023), *available at* https://hcai.ca.gov/wp-content/uploads/2023/11/Consolidated-October-Comment-Letters.pdf.
[5] Cal. Health & Saf. Code § 127507(c)(1).
[6] Id. § 127507(c)(2).

transactions under section 127507(c)(2) by "adopt[ing] regulations to eliminate duplicative reporting if a noticing entity or health care entity is required to submit notice to the office under more than one provision in subdivision (c)."

It is against this backdrop that we turn to the specific proposed regulations that are at odds with the statutory constraints under which OHCA operates.

II. Certain of the Proposed Regulations Violate the Plain Text of the HCQAA.

A. The Proposed Regulations Require Notice of Transactions with Independent Physician Practices Below Statutory Thresholds.

In 2022, and again in 2025, the Legislature decided that transactions involving independent physician practices would only require notice if the practice satisfied the definition of "Physician Organization," which the HCQAA defines in relevant part as:

> (5) A medical group practice, a professional medical corporation, a medical partnership, or any lawfully organized group of physicians and surgeons that provides, delivers, furnishes, or otherwise arranges for health care services and is comprised of ***25 or more physicians***.
>
> (6) Notwithstanding paragraph (5), an organization of less than 25 physicians, but that ***is a high-cost outlier*** whose costs for the same services provided are substantially higher compared to the statewide average, as identified through data sources that include, but are not limited to, data from state and federal agencies, other relevant supplemental data, such as financial data on providers that is submitted to state agencies, or data reported to HCAI under the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671). […][7]

Thus, medical group practices are deemed to be "Physician Organizations," which, in turn, are "Health Care Entities" subject to the HCQAA's transaction reporting requirements, if—and only if—the medical group practice has 25 or more physicians (or is deemed to be a high-cost outlier).[8]

The Legislature set the 25-physician threshold to limit the costs of complying with the transaction notice requirement for smaller independent physician practices that pursue transactions to remain viable. The physician headcount of the practice serves as one of several gating mechanisms for determining whether a transaction constitutes a material change.

The Proposed Regulations seek to amend the definition of "Health Care Entity" under section 97431(g) in the following way (OHCA's proposed change is in bold and underline):

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[7] Id. § 127500.2(r).
[8] *See* id. § 127500.2(k), (t) ("(k) 'health care entity' means a payer, provider, or a fully integrated system…(t) 'provider' means… (1) a physician organization").

(g) "Health care entity" shall: …

> (4**5**) Exclude physician organizations with less than 25 physicians, unless determined to be a high-cost outlier, as described in 127500.2(p)(6) of the Code. Any **noticing and/or** health care entity entering into a transaction with a physician organization of less than 25 physicians remains subject to the notice filing requirements of section 97435.[9]

OHCA's proposed addition to the second sentence of subsection (g)(5) contradicts the text of the HCQAA. Unless it is a high-cost outlier, a medical practice with fewer than 25 physicians is not a Physician Organization and, therefore, is not a Health Care Entity. As a result, a Noticing Entity cannot remain "subject to the notice filing requirements of 97435," as OHCA is proposing, because the Legislature stated in section 127507(c)(2)(A) that a Noticing Entity is only obligated to submit written notice of agreements or transactions between the Noticing Entity and "a health care entity or management services organization, or an entity that owns or controls the health care entity or management services organization."[10] A medical practice with fewer than 25 physicians is not a "health care entity" as defined in the HCQAA and, therefore, does not fall into any of those statutorily-defined categories.[11]

Even unamended, the legality of the second sentence of the revised section 97431(g)(5) is tenuous. Under the HCQAA, a Health Care Entity is only required to provide notice of its transactions with Physician Organizations of fewer than 25 physicians if the Health Care Entity independently triggered the notice requirement through the sale of its assets or ownership interests. But under no circumstance does notice have to be provided if the transaction involves a Noticing Entity and a medical practice that has fewer than 25 physicians.

Because OHCA's proposed change to 22 CCR 97431(g)(5) contradicts the plain text of the HCQAA, we urge OHCA to eliminate that proposed change to the regulations.

The Proposed Regulations also run afoul of the HCQAA's plain text by proposing in a new section 97435(c)(10) that certain transactions involving MSOs would trigger a notice obligation, even though the Legislature was very specific about what types of transactions involving MSOs would be captured by the notice-and-review process. The HCQAA notice obligation, as applied to MSOs and other "Noticing Entities," is spelled out in section 127507(c)(2)(A) and (B) of the statute. Section 127507(c)(2)(A) states that a Noticing Entity shall provide OHCA with written notice of agreements or transactions between the Noticing Entity and a Health Care Entity or MSO, or an entity that owns or controls the Health Care Entity or MSO that do either of the following: "[s]ell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of the health care entity's or management services organization's assets to one or more entities" or "[t]ransfer control, responsibility, or governance of a material amount of the assets or operations

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[9] Note, the reference to section 127500.2(p)(6) is outdated and should be corrected to 127500.2(r)(6).
[10] Cal. Health & Saf. Code § 127507(c)(2)(A).
[11] Id. § 127500.2(r)(5).

of the health care entity or management services organization to one or more entities."[12] Section 127507(c)(2)(B) requires MSOs to provide notice of their transactions if they are the subject of a qualifying transaction under paragraph (A) with any other entity.

OHCA has gone beyond the statutorily-defined types of transactions that trigger notice obligations by proposing in a new section 97435(c)(10) other circumstances that would trigger notice (identified in bold):

> (10) The transaction involves a management services organization and does one of the following:
>
> > **(A) Results in a management services organization providing management and administrative support services for a health care entity satisfying subsection (b)(1);**
> >
> > **(B) Results in a management services organization providing management and administrative support services for two or more providers;**
> >
> > (C) Involves a transfer of control, responsibility, or governance, in whole or in part, of the management services organization, as defined in subsection (e), or a change in 25% or more of the management services organization's ownership.

The problem with these proposed provision is that, unlike the other criteria in 97435(c), the newly-proposed paragraph (10) attaches to transactions that are outside the scope of the statutorily-defined agreements or transactions that trigger notice obligations in section 127507(c)(2). Practically, this means that a Physician Organization merely entering into an agreement with an MSO could be obligated to file a notice, even if there is no sale of assets to the MSO. This would represent a significant expansion of the notice requirements as compared to the statutorily-prescribed universe of transactions that trigger notice to OHCA. Accordingly, **CIPPA respectfully requests that OHCA strike subparagraphs (A) and (B) of section 97435(c)(10) of the Proposed Regulations**.

B. The Proposed Regulations Materially Change the Definition of Management Services Organization.

Section 97431(k) of the Proposed Regulations impermissibly changes the scope of entities required to file notice under the HCQAA by adding that MSOs, as defined under section 127500.2(o), must also satisfy one of four additional criteria. These criteria treat stakeholders differently, contrary to the intent and text of AB 1415. For example, an MSO owned by a hospital must also have two Physician Organizations as customers under paragraph (1), whereas an MSO that employs, as part of the MSO, a physician-owner of the Physician Organization or that shares investors or leaders in the Physician Organization must be affiliated only with one Physician Organization under

[12] Id. § 127507(c)(1), (2).

paragraphs (2) and (3). The definition of MSO under section 127500.2(o) does not contemplate such different treatment for MSOs affiliated with hospitals versus Physician Organizations. Additionally, the proposed criteria make it challenging to interpret the scope of entities that would satisfy the definition of being an MSO. Paragraph (3) is so broad that it would likely obviate the other threshold requirements, and paragraph (2) is ambiguous and challenging to interpret. To correct for both the impermissible change to the definition of MSO that contradicts the HCQAA and for the issues identified in paragraphs (2) and (3), **we propose OHCA adopt the following change to the definition of "management services organization"** (with edits in bold strikethrough for deletions and underline for additions):

> (k) "Management services organization" shall mean entities, as described in section 127500.2(o) of the Code that are additionally at least one of the following:
>
> > (1) Owned by a hospital and have two or more physician organizations as clients or affiliates;
> >
> > (2) Employ **or otherwise contract with** the physician-owner**(s)** of~~**, or otherwise have an agreement with the physician-owner that defines the services to be provided and compensation for such services with, one**~~ **two** or more physician organizations; **or**
> >
> > ~~**(3) Share directors, officers, investors, or other natural persons with the ability to exercise control with respect to a health care entity; or**~~
> >
> > (~~**4**~~**3**) Affiliated with at least two of the following:
> >
> > > (A) A health plan;
> > >
> > > (B) Two or more physician organizations; or
> > >
> > > (C) A hospital.

C. The Proposed Regulations Bring Non-Health Care Entity Transactions into the Scope of CMIR Review Contrary to Statute.

In AB 1415, the Legislature created a new class of entities—Noticing Entities—required to file notices of their material change transactions, but the Legislature did not amend the law to permit OHCA to conduct CMIRs of transactions in which Health Care Entities are not the subject of the transaction. Contrary to the statutorily-defined parameters of CMIRs, OHCA has proposed a change to the definition of "transaction" in section 97431(u) that would subject Non-Health Care Entity Transactions to the CMIR process.

OHCA's proposed change to section 97431(u) contradicts the plain words and purpose of the HCQAA. There is a clear distinction in the HCQAA between the initial obligation to submit a notice of a transaction—which Noticing Entities must now submit for transactions with statutorily-

defined Health Care Entities and MSOs—and the follow-on CMIR process that includes its own statutorily-defined parameters. The Legislature did not expand the scope of CMIR in AB 1415, so OHCA is not permitted to do so via regulation.

We start with the statutory text. AB 1415 did not change the provision in the HCQAA that authorizes OHCA to conduct CMIRs. That statutory provision, section 127501(c)(12), directs OHCA to:

> (12) Review and evaluate consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations ***involving health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities***.[13]

OHCA is not permitted under the HCQAA to place in the CMIR process a transaction between and among Noticing Entities, Private Equity Groups, Hedge Funds, and/or MSOs that does not include one or more Health Care Entities as subjects of the transaction. The Legislature could have amended section 127501(c)(12) to include one or more of these other types of entities—just as it amended section 127501(c)(15) to add MSOs—but it did not do so. This makes sense when considering OHCA's role in "analyzing the health care market."[14] The defining characteristic of Non-Health Care Entity Transactions is that they do not involve Health Care Entities. OHCA was not given the statutory authority to impose notice obligations and conduct reviews of all health care-related transactions.

Nor did the Legislature amend section 127507.2 of the HCQAA, which describes the CMIR process and review criteria, to include review of transactions that do not involve a statutorily-defined "health care entity." When OHCA determines a transaction is likely to have a significant impact on competition, "the office shall conduct a cost and market impact review that examines factors relating to a ***health care entity's*** business and its relative market position."[15] The Health Care Entity that triggers this heightened review is not just any entity; it is the Health Care Entity that is the subject of the transaction. This is clear from the statutory timeline that requires OHCA, within 60 days of receiving a material change transaction notice, to notify "***the noticing health care entity***" whether OHCA will "conduct a cost and market impact review or provide a written waiver."[16]

The Legislature did not delegate authority to OHCA to conduct CMIRs of Non-Health Care Entity Transactions, yet, the Proposed Regulations bring Non-Health Care Entity Transactions into the scope of CMIR. In determining whether to conduct a CMIR, OHCA evaluates eleven different factors, each of which relates to a potentially harmful outcome arising out of "the *transaction.*"[17]

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[13] Id. § 127501(c)(12) (emphasis added).
[14] Id. § 127501(b).
[15] Id. § 127507.2(a)(1) (emphasis added).
[16] Id. § 127507.2(a)(3)(A) (emphasis added).
[17] *See, e.g.,* 22 CCR 97441(a)(1)(A) ("*The transaction* may result in a negative impact on the availability or accessibility of health care services…") (emphasis added).

The Proposed Regulations seek to amend the definition of "transaction" under section 97431(u) to include all "agreements and transactions set forth in subdivisions…(c)(2)(A), and (c)(2)(B) of section 127507 of the Code." The broad reference to subdivisions (c)(2)(A) and (c)(2)(B) would include Non-Health Care Entity Transactions, contrary to the HCQAA.

As such, **OHCA should remove the reference to subdivisions (c)(2)(A) and (c)(2)(B) of the HCQAA from the definition of Transaction**. Furthermore, to avoid ambiguity and ensure consistency with the statute, **OHCA should promulgate regulations clarifying that OHCA will not conduct a CMIR of transactions in which a Health Care Entity is not required to file notice.**[18]

D. The Proposed Regulations Create a 90-Day Waiting Period for Non-Health Care Entity Transactions Without Statutory Authority.

In adding Noticing Entities to the HCQAA, AB 1415 did not create a 90-day waiting period for Non-Health Care Entity Transactions. Section 127507(c)(3) of the HCQAA, requiring "at least 90 days" prior written notice of material change transactions, applies only to transactions under section 127507(c)(1) and was not amended to cover transactions involving Noticing Entities under paragraph (c)(2).[19] Thus, under the HCQAA, there is no time period that Noticing Entities must wait between filing a notice with OHCA and closing the transaction. Although transactions between Noticing Entities and Health Care Entities would be prevented from closing for 90 days because of the waiting period requirement for noticing Health Care Entities, Non-Health Care Entity Transactions must only provide pre-close notice to OHCA to satisfy their statutory notice requirement. OHCA's lack of authority to subject Non-Health Care Entity Transactions to CMIR further supports this conclusion because the pre-close waiting period serves no purpose if OHCA cannot delay the transaction from closing. Accordingly, **OHCA should amend section 97435(a) to exclude Non-Health Care Entity Transactions from the 90-day pre-close notice requirement** as follows (with proposed additions in bold and underline):

> (a) A health care entity or noticing entity that meets the criteria of subsection (b) shall provide the Office with notice of a material change transaction as described in subsection (c) **<u>prior to the closing date of the transaction. Health care entities that are required to provide the Office with such notice must file the notice</u>** at least 90 days before the closing date of the transaction. For purposes of section 127507(c)(3) of the Code, the phrase "entering into the agreement or transaction" refers to the closing date.

III. The Proposed Regulations Do Not Satisfy OHCA's Statutory Obligation to Eliminate Duplicative Reporting.

AB 1415 directs OHCA to eliminate duplicative reporting by requiring OHCA to "adopt regulations to eliminate duplicative reporting if a noticing entity or health care entity is required

[18] See CIPPA's proposed amendment to add a new section 97441(c) in Attachment A.

[19] Cal. Health & Saf. Code § 127507(c)(3).

to submit notice to the office under more than one provision in subdivision (c)."[20] The Legislature included this directive in response to stakeholders' concerns that AB 1415 would unnecessarily increase transaction costs by requiring duplicative reporting regarding the same transaction.

The only provision that appears intended to fulfill that statutory mandate is the following amendment that OHCA proposed to section 97438:

> (b) Form and Contents of Public Notice. A submitter ~~health care entity submitting a notice ("submitter")~~ shall indicate which threshold(s) and circumstance(s) are met, pursuant to section 97435(b) and (c), respectively, and either note where in another entity's submission for the same transaction the following information is found or provide the following information to the Office for public posting on the Office's website.

Permitting parties to incorporate-by-reference information submitted by other parties to the transaction does not go far enough to "eliminate duplicative reporting" as the Legislature charged. The parties must still file two notices regarding the same transaction and prepare responses to the same questions. Multiple filings for a single transaction serve no additional, informational purpose for the Office and waste both private and public resources. To merely permit parties to cross-reference information submitted by another submitter disregards the Legislature's charge that OHCA "eliminate duplicative reporting." Accordingly, **instead of making the proposed amendments to section 97438(b) to permit cross-references to another entity's submission,[21] OHCA should permit multiple parties to a transaction to submit a consolidated filing by adding the following paragraph to section 97435(b):**

> **(5) If a single transaction or series of transactions requires notice to be filed under this subsection (b) by more than one Submitter, a single notice may be filed by all Submitters involved in the transaction or series of transactions; provided that all individual requirements for each Submitter must be met before the single notice can be deemed complete.**

IV. Summary of Requests for Action

To summarize, CIPPA asks that OHCA take the following actions as it finalizes the regulations that will govern the Material Change Transaction Review Process, as amended by AB 1415 (2025):

- Eliminate the proposed change to section 97431(g)(5) of the Proposed Regulations, which contradicts the plain text of the HCQAA by eliminating the 25-physician threshold for Physician Organizations in their transactions with Noticing Entities.

- Delete subparagraphs (A) and (B) of section 97435(c)(10) of the Proposed Regulations, which improperly expand the notice requirements to include MSO

[20] Id. § 127507(c)(2)(C).
[21] See CIPPA's proposed amendment to remove this provision from section 97438(b) in Attachment A.

agreements and transactions that do not involve a sale or transfer of a Health Care Entity's or MSO's assets or ownership interests.

- Remove the reference to "subdivisions (c)(2)(A) and (c)(2)(B)" from the definition of "Transaction" in section 97431(u) of the Proposed Regulations, so that Non-Health Care Entity Transactions are not subject to CMIR review in contravention of the plain text and intent of the HCQAA.

- To accurately reflect the statutory limitations on OHCA's authority to conduct CMIRs, promulgate regulations clarifying that OHCA will not conduct a CMIR of transactions in which a Health Care Entity is not required to file notice.

- Amend section 97435(a) of the Proposed Regulations to exclude Non-Health Care Entity Transactions from the 90-day pre-close notice requirement, consistent with the Legislature's decision not to create a pre-close waiting period for notices filed pursuant to section 127507(c)(2).

- Amend the definition of Management Services Organization under section 97431(k) by striking paragraph (3) and amending paragraph (2) to say: "Employ <u>or otherwise contract with </u>the physician-owner<u>(s)</u> of <u>two </u>or more physician organizations," so that OHCA does not establish different rules for MSO affiliations in the hospital and independent practice settings.

- Instead of the proposed revisions to section 97438(b) of the Proposed Regulations, permit multiple parties to a transaction to submit a consolidated filing to eliminate duplicative reporting as mandated by the Legislature under section 127507(c)(2)(C) of the HCQAA. OHCA can satisfy its statutory obligation by adding the following paragraph to section 97435(b)(5): "If a single transaction or series of transactions requires notice to be filed under this subsection (b) by more than one Submitter, a single notice may be filed by all Submitters involved in the transaction or series of transactions; provided that all individual requirements for each Submitter must be met before the single notice can be deemed complete."

- Correct what we believe is a typo in the proposed regulations by fixing the cross-references to subsections (c)(10) and (c)(11) under section 97435(b)(4) by updating them to (c)(9) and (c)(10), respectively.[22]

[22] OHCA sets forth the circumstances that require filing of a material change transaction notice in section 97435(c) of the regulations. OHCA has expanded that subsection to add paragraph (9) relating to transactions involving a private equity group or hedge fund and paragraph (10) relating to transactions involving an MSO. In newly-proposed 97435(b)(4), OHCA seeks to cross reference the new 97435(c)(9) and (10) but accidentally refers to those provisions as (c)(10) and (c)(11). Section 97435(b)(4)(A) should be revised to reference (c)(9) and 97435(b)(4)(B) should be revised to reference (c)(10).

CIPPA thanks OHCA for the opportunity to comment on the Proposed Regulations. We urge OHCA to modify the Proposed Regulations as requested above—and as collected in Attachment A—so that the material change transaction review process does not chill or otherwise undermine the ability of independent medical group practices to pursue transactions that enable them to continue functioning as a lower cost, competitive counterbalance to hospitals and health systems.

* * * * * * * * * *

We look forward to continuing to work with OHCA as it refines the Proposed Regulations. Please reach out to CIPPA's government affairs advocates, Jon Ross ((916) 448-2162; jross@ka-pow.com) or John Doherty ((916) 207-7852; jd@jd-lawgroup.com), if we can be of further help.

Sincerely,

Ed Cohen, M.D.
President & Chairman of the Board

ATTACHMENT A

Provision	**Proposed Edit**	**Rationale**
Section 97431(g)(5)	(g) "Health care entity" shall: … (5) Exclude physician organizations with less than 25 physicians, unless determined to be a high-cost outlier, as described in 127500.2(~~p~~r)(6) of the Code. Any ~~noticing and/or~~ health care entity entering into a transaction with a physician organization of less than 25 physicians remains subject to the notice filing requirements of section 97435.	Extending the filing requirements to include transactions between Noticing Entities and Physician Organizations with fewer than 25 physicians exceeds OHCA's statutory authority by eliminating the 25 physician threshold from the statutory definition of Physician Organization. *See Part II.A. of CIPPA's Comment Letter.*
Section 97431(k)	(k) "Management services organization" shall mean entities, as described in section 127500.2(o) of the Code that are additionally at least one of the following: (1) Owned by a hospital and have two or more physician organizations as clients or affiliates; (2) Employ or otherwise contract with the physician-owner(s) of~~, or otherwise have an agreement with the physician-owner that defines the services to be provided and compensation for such services with, one~~ two or more physician organizations; ~~(3) Share directors, officers, investors, or other natural persons with the ability to exercise control with respect to a health care entity;~~ or (4) Affiliated with at least two of the following:	The proposed definition of Management Services Organization is ambiguous and materially changes the stakeholders subject to the material change transaction filing requirement, contrary to the intent and text of AB 1415. *See Part II.B. of CIPPA's Comment Letter.*

	(A) A health plan; (B) Two or more physician organizations; or (C) A hospital.	
Section 97431(u)	(u) "Transaction" shall mean the agreements and transactions set forth in subdivision~~s~~ (c)(1)~~, (c)(2)(A), and (c)(2)(B)~~ of section 127507 of the Code~~,~~ and ~~includes~~ mergers, acquisitions, affiliations, and agreements impacting the provision of health care services in California that involve a transfer (including a sale, lease, exchange, option, encumbrance, conveyance, or disposition) of assets or a transfer of control, responsibility, or governance of the assets or operations, in whole or in part, of any health care entity and/or management services organization to one or more entities. Being a subject of a transaction means the transaction will result in the transfer, as used in this subsection, of a health care entity's assets, control, responsibility, governance, or operations, in whole or in part to one or more entities.	The incorporation-by-reference of section 127507(c)(2)(A) and (B) into the definition of "transaction" brings transactions between and among Noticing Entities and Management Services Organizations into the scope of CMIR review, contrary to statute. *See Part II.C. of CIPPA's Comment Letter.*
Section 97435(a)	(a) A health care entity or noticing entity that meets the criteria of subsection (b) shall provide the Office with notice of a material change transaction as described in subsection (c) prior to the closing date of the transaction. Health care entities that are required to provide the Office with such notice must file the notice at least 90 days before the closing date of the transaction. For purposes of section 127507(c)(3) of the Code, the phrase "entering into the agreement or transaction" refers to the closing date.	The HCQAA does not create a 90-day waiting period for Noticing Entities, but does for Health Care Entities. Accordingly the proposed regulations should be amended to reflect this statutory timeline. *See Part II.D. of CIPPA's Comment Letter*

Section 97435(b)(4)	(4) A noticing entity meeting one of the following: (A) A private equity group or hedge fund that is a party to a transaction identified in subsection (c)(~~10~~9) with a management services organization or health care entity satisfying subsection (b)(1), (2), or (3). (B) A management services organization that is a party to a transaction identified in subsection (c)(~~11~~10) with a management services organization or a health care entity satisfying subsection (b)(1), (2), or (3).	The reference to subsection (c)(10) and (c)(11) in Section 97435(b)(4)(A) and (B) contain a typo. The proper references should be to subsections (c)(9) and (c)(10), respectively. *See Part IV of CIPPA's Comment Letter.*
Section 97435(b)(5)	***NEW*** (5) If a single transaction or series of transactions requires notice to be filed under this subsection (b) by more than one Submitter, a single notice may be filed by all Submitters involved in the transaction or series of transactions; provided that all individual requirements for each Submitter must be met before the single notice can be deemed complete.	The Proposed Regulations fail to adequately eliminate duplicative reporting, as required by the HCQAA. We propose this new subsection to permit a consolidated filing for transactions in which more than one party is required to file a notice. *See Part III of CIPPA's Comment Letter.*
Section 97435(c)(10)	(10) The transaction involves a management services organization and ~~does one of the following:~~ ~~(A) Results in a management services organization providing management and administrative support services for a health care entity satisfying subsection (b)(1);~~ ~~(B) Results in a management services organization providing management and administrative~~	Paragraphs (A) and (B) of section 97435(c)(10) should be removed because they would significantly expand the scope of transactions and agreements required to file notice with OHCA as compared to the statutorily prescribed universe of transactions that trigger a filing. *See Part II.A. of CIPPA's Comment Letter.*

Attachment A-3

	~~support services for two or more providers;~~ ~~(C)~~ ~~I~~involves a transfer of control, responsibility, or governance, in whole or in part, of the management services organization, as defined in subsection (e), or a change in 25% or more of the management services organization's ownership.	
Section 97438(b)	(b) Form and Contents of Public Notice. A submitter shall indicate which threshold(s) and circumstance(s) are met, pursuant to section 97435(b) and (c), respectively, and ~~either note where in another entity's submission for the same transaction the following information is found or~~ provide the following information to the Office for public posting on the Office's website.	Consistent with CIPPA's proposed amendment to section 97435(b)(5) above, the Proposed Regulations amending section 97438(b) to permit cross-references to another entity's submission are no longer needed. *See Part III of CIPPA's Comment Letter.*
Section 97441(c)	***NEW*** (c) Notwithstanding subsection (a), the Office shall not conduct a CMIR of transactions in which a health care entity is not the subject of the transaction.	To avoid ambiguity regarding OHCA's authority to conduct a CMIR for transactions in which a Health Care Entity is not the subject of the transaction, CIPPA proposes this clarifying language to reflect the statutory limitations of OHCA's authority to conduct CMIRs. *See Part II.C. of CIPPA's Comment Letter.*

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June 11, 2026

CA California Office of Health Care Affordability (OHCA)
Department of Health Care Access and Information
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Informal public comment on proposed emergency regulations at 22 CCR §§ 97431 et seq. implementing AB 1415

The Private Equity Stakeholder Project (PESP) appreciates the opportunity to comment on the Office of Health Care Affordability's proposed emergency regulations at 22 CCR §§ 97431 et seq. implementing AB 1415.

We support the overall direction of the proposed text. The draft gives OHCA better tools to identify healthcare transactions involving private equity, hedge funds, management services organizations (MSOs), and other entities that might otherwise avoid meaningful notice and scrutiny. It is especially effective in addressing governance through contract, MSO-based control arrangements, and sale-leaseback or other real estate structures that can affect affordability, quality, labor conditions, and access to care.

Improved visibility into PE and MSO control

The new private equity and hedge fund trigger in 22 CCR § 97435(c)(9) is one of the strongest parts of the proposal. In healthcare, private equity control can appear through debt or liability positions, governance rights, management agreements, fee arrangements, authority over indebtedness, and control over budgets, distributions, and the use of income. The draft regulatory update improves the ability to capture those pathways.

The new MSO definition and transaction trigger are also important for improving OHCA's ability to reach structures that shift operational and financial control away from licensed providers and into affiliated entities.

The real estate provisions are another important improvement. Proposed 22 CCR § 97435(c)(11) makes certain real estate transactions independently reportable when the real estate where healthcare services are provided is sold or transferred and the surviving entity must lease or pay rent for that property. Proposed 22 CCR § 97438(b)(10)(D) also requires disclosure of post-transaction changes to real estate where healthcare services are provided, including sales,

transfers to affiliates, encumbrances, and updates to landlord-tenant agreements. Proposed 22 CCR § 97438(c)(3) then requires submission of lease-back agreements. Taken together, those provisions do more to surface sale-leasebacks and other real estate arrangements that can change the economics of care delivery while leaving the operating entity in place.

The filing requirements in 22 CCR § 97438 are another strong part of the proposal. The expanded disclosures concerning post-transaction ownership, voting rights, decision-making authority, management and compliance structures, staffing and labor conditions, real estate changes, valuation materials, organizational charts, portfolio information, and leverage documentation are the kinds of disclosures needed to understand how a transaction is actually structured. The new leverage disclosure requirement in 22 CCR § 97438(c)(11) is particularly important because it reveals how the deal is financed and what debt burden may be placed on the provider or MSO after closing.

Clarifying roll-up aggregation and transparency waivers

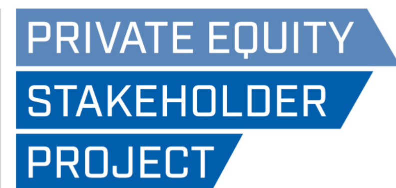
The proposed regulations already include serial-transaction and aggregation provisions in 22 CCR § 97435(c)(7) and (8), but do not clearly state how those provisions apply to repeated acquisitions of sub-25-physician groups. This is relevant because physician organizations with fewer than 25 physicians are excluded from the definition of "health care entity" unless they are high-cost outliers. OHCA should clarify that the aggregation provisions reach a series of sub-25-physician acquisitions when those acquisitions form part of a broader roll-up or platform-building strategy.

The proposed text also retains a waiver pathway in 22 CCR § 97441(b) after a determination to conduct a CMIR, with the Director's decision final, but it does not require public notice of waiver decisions. OHCA should add a requirement that waiver decisions be publicly posted, together with identification of the transaction and the basis for the waiver.

Clarifying non-confidential disclosures

Proposed 22 CCR § 97438(c)(11) requires leverage-related disclosures, including debt ratios, debt source, and post-recapitalization leverage. Proposed 22 CCR § 97438(d)(2), meanwhile, deems certain categories of information confidential, but it does not list the leverage information required by § 97438(c)(11). AB 1415 broadened the transactions and entities subject to OHCA's notice-and-disclosure regime, while the underlying CMIR confidentiality framework remains governed by Health and Safety Code § 127507.2.

OHCA should therefore make clear that leverage information required by 22 CCR § 97438(c)(11) is not presumptively confidential and may be withheld only upon a specific and justified showing under the applicable standards. More broadly, OHCA should preserve the public-record default and confine deemed-confidential treatment to the categories the statute and regulations actually contemplate.



Clarifying required disclosures

One targeted improvement would be to align the real-estate document request with the broader real-estate disclosure requirement. 22 CCR § 97438(b)(10)(D) reaches sales, transfers to affiliates, encumbrances, and updates to landlord-tenant agreements affecting sites where health care services are provided, but 22 CCR § 97438(c)(3) currently requires only copies of lease-back agreements. OHCA should require submission of the agreements effecting the broader set of real estate changes described in the notice requirement, not only conventional lease-backs.

OHCA should also clarify the intended scope of the portfolio disclosure requirement so that it captures the relevant health care and MSO footprint of participating asset managers and funds, rather than only the immediate acquisition vehicle. That information is necessary to assess whether a transaction is part of a broader acquisition strategy or consolidation pattern.

The final rule should also implement a statutory directive the current draft does not yet fully address. Health and Safety Code § 127501.5 directs OHCA to establish requirements for management services organizations to submit data and other information as necessary to carry out the Office's functions. That ongoing MSO reporting authority is one of the most important features of AB 1415 and should not be left unimplemented.

The proposed regulations give OHCA better tools to identify transactions shaped by private equity, hedge funds, MSOs, and real-estate dynamics. We support those improvements and urge OHCA to preserve them while making the clarifications described above.

Thank you for the opportunity to comment.

Sincerely,

Michael Fenne
Senior Policy Coordinator
Private Equity Stakeholder Project

June 11, 2026

Office of Health Care Affordability
Department of Health Care Access and Information
Via Email: CMIR@hcai.ca.gov

Re: Comments on Proposed Emergency Regulations Implementing AB 1415, Title 22 CCR §§ 97431 et seq.

Dear Office of Health Care Affordability:

American Investment Council ("AIC" or "we") submits these comments in response to the Office of Health Care Affordability's ("OHCA") proposed emergency regulations implementing AB 1415, dated May 15, 2026, and published for informal comment on May 22, 2026 (the "Proposed Regulations"). We appreciate OHCA's efforts to implement the updated material change transaction notification framework and welcome the opportunity to provide feedback at this stage.

AIC's members are the world's leading private equity and private credit firms, united by their commitment to growing and strengthening the businesses in which they invest, including investments in the health care sector. Our members are committed to regulatory compliance and to the broader goals of health care affordability and access. We offer these comments in that constructive spirit, with the goal of ensuring that the Proposed Regulations faithfully implement the statute, neither exceeding its bounds nor imposing compliance costs that are disproportionate to the regulatory objectives AB 1415 was designed to advance.

Our comments focus on two categories of concern: (1) provisions that appear to go beyond what AB 1415 authorizes; and (2) provisions that impose significant and disproportionate burdens on submitters without commensurate regulatory benefit.

* * *

I. Sections 97438(b)(1)(D)(iv) and (c)(8): Portfolio-Wide Disclosures.

Section 97438(b)(1)(D)(iv) of the Proposed Regulations requires private equity groups and hedge funds to include in their notice filings the "names of health care entities or management services organizations owned or financed by the participating asset managers and funds they manage." Section 97438(c)(8) requires submission of "documentation showing the names of all health care entities or management services organizations in the portfolios of participating asset managers." Together, these provisions impose a portfolio-wide reporting regime that is not tailored to the transaction under review and exceeds the level of disclosure required by statute.

AB 1415 authorizes OHCA to review specific proposed material change transactions for their competitive, cost, and market effects. The statute does not authorize OHCA to require disclosure of investment holdings that are entirely unrelated to the proposed transaction at issue. Information about portfolio companies that are not parties to, or subjects of, the proposed transaction is not reasonably necessary to evaluate the transaction's effect on health care costs, competition, or access in California.

The burden this requirement imposes is significant. Private equity firms and hedge funds may manage dozens or hundreds of independent funds, each with their own portfolio companies. Many of these portfolio companies will have no geographic overlap with the proposed California transaction, and a significant number will not conduct any operations in California at all. Requiring sponsors to identify, compile, and disclose all such holdings at the time of each notice filing, including for entities in unrelated industries and markets, imposes substantial costs without improving OHCA's ability to evaluate the proposed transaction. Portfolio composition is also among the most commercially sensitive information a fund manager holds, and public disclosure of this information does not result in any public benefit.

We recommend that OHCA strike Section 97438(c)(8) entirely and narrow Section 97438(b)(1)(D)(iv) to only require disclosure of health care entities or management services organizations ("MSOs") that are owned or financed by the specific fund or funds that are a party to the transaction under review and that have California health care operations or California-derived health care revenue. We further recommend that OHCA adopt a definition of "participating asset manager" limited to asset managers that are direct parties to the proposed transaction, or that exercise control over the specific fund or vehicle through which the transaction is being consummated.

II. Sections 97438(c)(10): Financial Statement Disclosures.

Section 97438(c)(10) states that a notice must include "certified financial statements for the prior three years . . . of all entities that are parties to the transaction, including the entities described in subsection (b)(10)(A)(i) and (ii) of this section." This underlined language would require submission of financial statements for all entities and persons with 5% or more ownership of the transacting entity, as well as subsidiaries of the transacting entity, regardless of whether the subsidiary's or owner's operations relate to the provision of health care services. There is no reasonable basis for OHCA to require the submission of financial statements for such unrelated parties. The underlined language is also confusing, as such entities are not considered "parties to the transaction," and it is overbroad and overly burdensome for the reasons described above in Section I. We recommend that OHCA strike the underlined language.

III. Section 97435(c)(9): 5% Ownership Threshold.

Section 97435(c)(9)(A) describes that a transaction resulting in a private equity group or hedge fund holding 5% or more of the assets, equity, debt, or liabilities of a qualifying

health care entity or MSO is a type of “material change transaction.” The threshold set forth in the regulations is too low and will capture transactions involving only modest investment positions that do not result in a material change in ownership, operations, or governance of a health care entity or MSO. A 5% position often represents a small minority stake with no board representation, no governance rights, and no meaningful ability to influence the operations or strategic direction of the health care entity or MSO. Requiring full notice filings, with all accompanying documentation, for such modest positions imposes compliance costs that are disproportionate to any regulatory benefit.

We recommend that OHCA raise the threshold in Section 97435(c)(9)(A) to at least 25%, consistent with its previous thresholds for determining “control” of a health care entity, and establish a safe harbor for changes in minority positions that do not confer governance rights such as board representation, veto rights, or approval authority over material operational or financial decisions of a health care entity or MSO.

We further recommend that OHCA raise the 5% threshold in other areas of the Proposed Regulations for the same reasons as set forth above, including Section 97438(b)(10)(A), Section 97438(b)(11), and Section 97438(c)(7)(B).

IV. Section 97435(c)(11): Real Estate Transactions.

Section 97435(c)(11) makes independently reportable any transaction in which a health care entity sells or transfers real estate where it provides health care services, if the health care entity will be required to lease or pay rent for the property moving forward. This provision effectively makes sale-leaseback transactions independently subject to OHCA’s notice and potential review process.

AB 1415 does not address real estate financing transactions, and sale-leasebacks in the health care context are typically straightforward capital-raising mechanisms that do not alter clinical operations, change the ownership or control of the health care entity, or affect market concentration. A health care provider that sells its facility to a real estate investor and leases it back continues to operate identically before and after the transaction: the same services are provided, by the same clinical staff, to the same patient population, in the same geographic market. The ownership of the underlying real estate has changed, but nothing about the health care entity’s market position, competitive behavior, or provision of patient care has changed.

Making these transactions independently reportable will generate a meaningful volume of notice filings for transactions that are unlikely to warrant OHCA’s attention, consuming OHCA’s resources and imposing compliance costs on health care entities and their financing partners without materially advancing OHCA’s goal of promoting health care affordability. We recommend that OHCA either remove Section 97435(c)(11) entirely or significantly narrow it, such as by limiting its application to sale-leaseback transactions in which the purchaser-lessor obtains governance or operational rights over the health care

entity, or in which the lease terms are structured in a way that would significantly impair the financial stability of the health care entity.

V. Sections 97438(b)(1)(H) and (I): Disclosure of Affiliates and Governing Body Members.

Section 97438(b)(1)(H) requires submitters to provide "names of all affiliates, parents, and subsidiaries," and Section 97438(b)(1)(I) requires "names of all members of the submitter's governing body." For large, complex institutional investors such as private equity firms or hedge fund managers, these requirements could (1) capture hundreds or thousands of affiliated entities and investment vehicles that have no connection to the proposed California health care transaction, and (2) lead to public disclosure of extremely sensitive information that does not have any meaningful connection to OHCA's concerns about health care costs and competition.

The term "affiliates" as used in the Proposed Regulations encompasses all entities that control, are controlled by, or are under common control with a submitter. For a large asset manager with a common controlling principal, this could include dozens of investment funds, general partners, and portfolio companies entirely unrelated to health care in California.

We recommend that OHCA clarify that Section 97438(b)(1)(H) requires disclosure only of affiliates, parents, and subsidiaries that are directly involved in, or materially relevant to, the transaction being noticed, rather than an exhaustive list of the submitter's entire corporate family. We further recommend that OHCA strike Section 97438(b)(1)(I), regarding the obligation to disclose members of the submitter's governing body.

VI. Section 97438(c)(7): Organizational Charts.

Section 97438(c)(7)(A) requires submitters to provide a "current organizational chart for any party to, or subject of, the transaction up through the ultimate parent entity and including any subsidiary organizations." As applied to private equity groups and hedge funds, this requirement raises two significant concerns.

First, private equity funds do not have a single, clearly identifiable "ultimate parent entity." A typical private equity fund structure involves a general partner, which manages the fund and makes investment decisions, and a collection of limited partners, which are passive capital contributors. If "ultimate parent entity" is interpreted to require tracing ownership up through the limited partner base, the organizational chart obligation would be effectively unlimited in scope. A single fund may have dozens or hundreds of limited partners, each of which may itself be an entity with its own ownership chain. Nothing in AB 1415 contemplates or authorizes this degree of disclosure, and there is no plausible regulatory justification for it. Limited partners in a private equity fund have no role in directing a proposed health care transaction and thus have no meaningful connection to the competitive or market concerns OHCA is charged with evaluating.

We recommend that OHCA clarify that, for private equity groups and hedge funds, the organizational chart obligation under § 97438(c)(7)(A) runs only to the general partner of the relevant fund, since it is the general partner that exercises investment and governance authority over the fund and its portfolio companies. This interpretation would be consistent with the statutory definitions of "private equity group" and "hedge fund," which focus on management and control of assets rather than passive capital contribution, and would give OHCA the ownership and control information that is actually relevant for its review.

Second, the requirement to include "subsidiary organizations" in the organizational chart is overbroad, as many of those subsidiary organizations may not operate in the health care industry, may not operate in California, and ultimately may not have any bearing on the competitive, cost, or market effects of the transaction OHCA is reviewing. We recommend that OHCA narrow § 97438(c)(7)(A)'s organizational chart requirement to only include subsidiaries of the transacting entity that have California health care operations or that are otherwise directly involved in the transaction.

VII. Section 97440(b)(1): Third-Party Information Requests.

Section 97440(b)(1) permits OHCA to toll the 45-day and 60-day review periods whenever OHCA has requested and is awaiting information from a third party necessary to complete its review. Transactions are typically structured around the statutory review periods, and parties arrange their financing, regulatory approvals, and business planning around those timelines. Open-ended tolling triggered by requests to third parties over whom the transacting parties have no control creates substantial and potentially indefinite uncertainty.

As drafted, the Proposed Regulations have no limit on the number of tolling periods, no requirement that third-party requests be narrowly tailored or necessary to the review, and no mechanism for parties to challenge an extended or recurring tolling period. This framework effectively gives OHCA the ability to extend the review period indefinitely through successive third-party requests, without any procedural protection for the transacting parties.

We recommend that OHCA amend Section 97440(b)(1) to cap tolling for third-party information requests at no more than 10 additional days per tolling event, set a limit on the total number of such tolling periods, require that third-party requests be reasonably necessary to complete the review of the specific transaction at issue, and require that parties receive prompt written notice of any tolling event with a stated anticipated duration.

VIII. Section 97431(g)(4): Expansion of "Health Care Entity" Definition.

Section 97431(g)(4) of the Proposed Regulations defines "health care entity" to include "an entity that owns, operates, or controls a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended

license." Entities that own, operate, or control a provider are already included in the definition of "noticing entity" in Health and Safety Code Section 127507(h)(4). This demonstrates that the California legislature has already contemplated how to treat these upstream entities, and chose to capture these entities as noticing entities, rather than as health care entities. OHCA's insertion of upstream entities into the "health care entity" definition of the Proposed Regulations effectively overrides that legislative choice and would expand the universe of reportable transactions materially beyond what the statute contemplates. Thus, we recommend that OHCA remove Section 97431(g)(4) from the definition of "health care entity" in the Proposed Regulations.

IX. Private Equity Exit Transactions.

The Proposed Regulations do not address private equity exit transactions, whereby a private equity sponsor reduces or fully relinquishes its ownership or control interest in a health care entity or MSO ("Exit Transactions"). As currently drafted, the Proposed Regulations would subject each party to an Exit Transaction to the same notice requirements and documentation obligations as private equity acquisitions. Requiring the full notice and review process from the private equity sponsors participating in an Exit Transaction, including the extensive documentation requirements that specifically apply to private equity groups and hedge funds, would place a material burden on the exiting private equity sponsor that does not achieve any of OHCA's statutory purposes.

We recommend that OHCA consider whether Exit Transactions warrant distinct treatment, such as an exemption from the private equity specific information and documentation requirements in Sections 97438(b) and 97438(c), a streamlined review process with significantly abbreviated timelines, and/or a rebuttable presumption against CMIR review in cases where the transaction results in an overall reduction of private equity or hedge fund ownership or control of a health care entity or MSO.

X. Publicly Traded Companies.

OHCA should consider whether publicly traded companies warrant distinct treatment with respect to the new ownership and organizational disclosure requirements in Sections 97438(b) and 97438(c). Publicly traded companies are subject to extensive disclosure obligations under federal securities laws, including continuous reporting requirements by the SEC that make ownership structures, parent entities, governing body members, and other organizational information readily available to the public. Requiring these entities to compile and resubmit information that is already publicly available in SEC filings provides limited regulatory benefit while imposing meaningful compliance burdens.

We recommend that OHCA adopt either (1) an exception to such disclosures by publicly traded companies, or (2) a streamlined disclosure pathway for publicly traded noticing entities under which such entities may satisfy certain ownership and organizational disclosure requirements set forth in Sections 97438(b) and 97438(c) by reference to their

most recent publicly filed SEC disclosures rather than through duplicative submission requirements.

XI. Duplicative Reporting.

Health and Safety Code Section 127507(c)(2)(C) directs OHCA to adopt regulations that "eliminate duplicative reporting if a noticing entity or health care entity is required to submit notice to the office under more than one provision in subdivision (c)." The Proposed Regulations do not include any provision implementing this requirement, and we urge OHCA to do so before the regulations are finalized.

A single transaction will frequently trigger reporting obligations under more than one provision of the regulations, and the Proposed Regulations provide no mechanism for consolidating these into a single filing or for specifying how overlapping obligations interact. In the absence of a duplicative-reporting rule, submitters face uncertainty about whether separate, full filings are required under each triggered provision, which could multiply compliance costs for a single transaction without advancing any corresponding regulatory interest.

* * *

AIC appreciates the important work OHCA is undertaking to implement AB 1415 and to promote health care affordability and market transparency in California. We respectfully submit that the issues identified above warrant revision to the Proposed Regulations.

We welcome the opportunity to discuss any of these points further with OHCA staff and are available at OHCA's convenience.

Respectfully submitted,

/s/ Shelby Telle

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June 11, 2026

Sent via Email to CMIR@hcai.ca.gov

Elizabeth Landsberg
Director
Department of Health Care Access and Information
2020 W. El Camino Ave, Suite 800
Sacramento, CA 95833

Dear Director Landsberg:

On behalf of the California Association of Health Facilities (CAHF), thank you for the opportunity to provide comments on proposed revisions to the Cost and Market Impact Review (CMIR) regulations (Material Change Transactions and Pre-Transaction Review, Article 1 of Chapter 11.5 of Division 7 of Title 22, California Code of Regulations) (Proposed Regulations). CAHF represents 870 skilled nursing facilities (SNFs) and 380 intermediate care facilities for the developmentally disabled (ICF/DDs). Although we appreciate the Office of Health Care Affordability's (OHCA) efforts to implement AB 1415, CAHF has concerns with the Proposed Regulations as currently drafted.

Executive Summary

CAHF requests the following changes to the Proposed Regulations to better align them with statutory authority and avoid unnecessary, negative impacts on California's health care providers and patients' access to care:

1. To focus on the corporate practice of medicine (CPOM) issues that led legislators to address MSOs in AB 1415, OHCA should either delete Section 97431(k)(3) or revise it to focus on physician organizations;

2. To align with the existing established criteria for health care entity transactions in Section 97435(e) and the legislative intent to exclude investors that are not private equity groups or hedge funds, OHCA should (1) raise the ownership threshold in Section 97435(c)(9)(A) to 25%; and (2) either delete the last sentence of Section 97435(c)(9)(A) or revise that sentence to remove the reference to "investors".

3. To not unnecessarily restrict common real estate arrangements between affiliated companies sharing common beneficial ownership, OHCA should delete Section 97435(c)(11) in its entirety or revise Section 97435(c)(11)(A) to exclude transactions where the real estate is acquired by an affiliated entity under common beneficial ownership with the health care entity.

4. OHCA should expand the "usual and regular course of business" and "common control" exceptions described in the proposed Section 97431(l) to also apply to noticing entities.

5. As required by AB 1415, OHCA should expressly eliminate duplicative reporting obligations in the Proposed Regulations.

CAHF also requests further information and clarification regarding why a REIT's involvement in a transaction should create an independent basis for OHCA to conduct a CMIR.

MSO Definition

CAHF believes that the legislative intent of AB 1415 with regard to requiring MSOs to file a notice of material transactions was to apply the requirement to business organizations that are not health care entities but that nevertheless "exert significant administrative control over health care delivery and prices"[1] and that are frequently used by private equity groups "to indirectly invest in physician organizations by purchasing providers' nonclinical assets."[2] Legislators noted that "MSOs have been increasingly used by for-profit entities, including private equity firms, to become involved in health care practices without violating states' rules regarding the "corporate practice of medicine."[3]

SNFs are commonly supported by administrative service companies that are different from MSOs with regard to structure, ownership and provided services. The administrative service companies provide administrative services to SNF under administrative services agreements. Although there are some management companies that manage SNF operations in addition to providing the types of administrative services provided by administrative service companies, those types of management companies are in the minority. Administrative service companies often share common beneficial ownership with SNFs and do not typically have private equity or hedge fund ownership. The administrative service companies do not separately own SNFs. These administrative service companies do not exist to navigate California's corporate practice of medicine doctrine. Unlike with physician organizations, a private equity firm can directly invest in a SNF (and such investment would very likely be subject to the material change transaction notice requirements). SNF administrative service companies are therefore not usually involved in SNF mergers, acquisitions, and similar change of control transactions, and a blunt application of the material change transaction notice requirements to SNF administrative service companies could unnecessarily burden them and their affiliated SNFs. In addition, requiring separate notice requirements for administrative service companies that provide administrative services to SNFs under administrative services agreements would not provide OHCA with new information beyond information collected through the existing notice of material change transaction reporting requirements.

Application of the AB 1415 notice requirements for MSOs to entities that provide management and administrative support to health facilities under common beneficial ownership, or that do not support physician organization and professional corporations, is not appropriate and does not align with legislative intent. Broad application of the notice requirements for all MSOs would impose a significant administrative burden on SNFs, and would not yield additional information that supports OHCA's goals for timely evaluation of these transactions to identify market competition issues. A broad MSO definition would risk significant delays in completing transactions without any additional benefit for the state or consumers.

We appreciate OHCA's efforts to narrow the types of entities that may qualify as an MSO under the Proposed Regulations. We oppose, however, the current language of proposed Section 97431(k)(3) which defines any entity described in Health and Safety Code Section 127500.2(o) that shares "directors, officers, investors, or other natural persons with the ability to exercise control with respect to a health care entity" as an MSO. Inclusion of (3) as a standalone criteria establishes an overly broad definition for MSOs and encompasses entities that may provide administrative support services to SNFs but that do not raise the CPOM concerns that animated AB 1415 with respect to MSOs.

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[1] *Sen. Com. on Health*, Analysis of AB 1415 (2025–2026 Reg. Sess.) p. 4.

[2] *Id*. at p. 8.

[3] *Assembly Floor Analysis*, Analysis of AB 1415 (2025 – 2026 Reg. Sess.) p. 3.

Proposal: We request that OHCA either: (1) delete Section 97431(k)(3) or (2) revise Section 97431(k)(3) to focus on physician organizations, as follows: "*Share directors, officers, investors, or other natural persons with the ability to exercise control with respect to a **physician organization**.*"

Section 97435(c)(9)(A): Raising Ownership Threshold and Excluding Investors that Are Not Private Equity or Hedge Funds

Proposed Section 97435(c)(9)(A) requires noticing of transactions involving a private equity group or hedge fund when the transaction results in a private equity group or hedge fund holding 5% or more of the assets, equity, debt, or liabilities of a health care entity satisfying subsection (b)(1),(2) or (3) or a management services organization. This 5% threshold is well below the transfer of control, responsibility, or governance threshold applicable to health care entities under Section 97435(c)(4) (*i.e.*, 25% or more of voting power) and other customary change-of-control triggers, and could reach even passive minority investments.

Proposed Section 97435(c)(9)(A) also goes beyond its statutory authority by stating that the 5% ownership threshold "includes groups of investors….investing collectively to hold 5% of the assets or equity of the health care entity." This inclusion of "investors" exceeds statutory authority and contradicts:

- Health and Safety Code Section 127500.2(l)'s "hedge fund" definition, which specifically excludes "*Natural persons or other entities that contribute, or promise to contribute, funds to the hedge fund, but otherwise do not participate in the management of the hedge fund or the fund's assets, or in any change in control of the hedge fund or the fund's assets;* and
- Health and Safety Code Section 127500.2(s)'s "private equity group" definition, which specifically excludes "*natural persons or other entities that contribute or promise to contribute funds to the private equity group, but otherwise do not participate in the management of the private equity group or the group's assets, or in any change in control of the private equity group or the group's assets*".

Proposal: We request that OHCA: (1) raise the ownership threshold to 25% to align with Section 97435(e)'s control, responsibility, or governance threshold; and (2) either delete the last sentence of Section 97435(c)(9)(A) or revise the sentence as follows to remove the reference to investors: "*This includes groups of private equity firms or hedge funds investing collectively…*".

Section 97435(c)(9)(B): Revise to Remove Over-Breadth and Avoid Making Section 97435(c)(9)(A) Superfluous

Proposed Section 97435(c)(9)(B) requires noticing of transactions involving a private equity group or hedge fund when the transaction "*results in the acquisition of assets, equity, debts, or liabilities of a health care entity satisfying subsection (b)(1), (2), or (3) or a management services organization**, including, but not limited to, by an agreement** where the private equity group or hedge fund has authority*" to engage in eight enumerated activities indicative of control (emphasis added).

As currently drafted, Section 97435(c)(9)(B)'s base trigger ("*results in the acquisition of assets, equity, debts, or liabilities*") contains no minimum threshold. And because the eight control indicia are introduced by the clause "*including, but not limited to*", the current language appears to make those control indicia merely illustrative rather than limiting. This renders Section 97435(c)(9)(A)'s 5% ownership threshold superfluous because **any** acquisition of assets or equity would satisfy (c)(9)(B).

Proposal: We request that OHCA revise Section 97435(c)(9)(B) as follows: "*results in the acquisition of assets, equity, debts, or liabilities of a health care entity satisfying subsection (b)(1), (2), or (3) or a management services organization where the private equity group or hedge fund has authority to do any of the following:*".

Section 97435(c)(11): Real Estate Sale-Leasebacks

Proposed Section 97435(c)(11) adds a new filing circumstance for real estate transactions where: (A) the real estate where a health care entity provides services is sold or transferred to an entity other than the entity acquiring the health care entity or its "direct parent", and (B) the surviving health care entity will be required to lease or pay rent for the property. Although OHCA rightfully excludes transactions where a health care entity's parent acquires the real estate, it is also common for health care entities to structure real estate acquisitions where the operating company (OpCo) health care entity places the real estate assets in a property company (PropCo) entity that is affiliated with the OpCo, but is not the OpCo's "direct parent". These common OpCo/PropCo structures should not be subject to Section 97435(c)(11).

Proposal: We request that OHCA either (1) delete Section 97435(c)(11) in its entirety or (2) revise Section 97435(c)(11)(A) as follows: "*To an entity other than the entity acquiring the health care entity, its direct parent, or any affiliated entity under common beneficial ownership with the health care entity.*"

Expand the "Usual and Regular Course of Business" and "Common Control" Exceptions to Apply to Noticing Entities

The Proposed Regulations do not amend the existing "usual and regular course of business" and "common control" material change transaction exceptions under the proposed renumbered Section 97431(l). These exceptions appropriately excludes from the "material change transaction" definition (1) all "*transactions in the usual and regular course of business of the health care entity, meaning those that are typical in the day-to-day operations of the health care entity*" and (2) "*situations in which the health care entity directly, or indirectly through one or more intermediaries, already controls, is controlled by, or is under common control with, all parties to the transaction, such as a corporate restructuring*." However, the Proposed Regulations do not update these exceptions to include the new "noticing entities" that are now subject to OHCA's material change transaction notice requirements. The reasoning underlying these two exceptions applies equally to noticing entities.

Proposal: We request that OHCA: (1) revise Section 97431(l)(1) as follows: "*Transactions in the usual and regular course of business of the health care entity **or noticing entity**, meaning those that are typical in the day-to-day operations of the health care entity **or noticing entity***"; and (2) revise Section 97431(l)(2) as follows: "*situations in which the health care entity **or noticing entity** directly, or indirectly through one or more intermediaries, already controls, is controlled by, or is under common control with, all parties to the transaction, such as a corporate restructuring*".

Eliminate Duplicative Reporting Obligations

Health & Safety Code § 127507(c)(2)(C) requires OHCA to "*adopt regulations to eliminate duplicative reporting if a noticing entity or health care entity is required to submit notice to [OHCA] under more than one provision*" of the material change transaction notice requirements. The Proposed Regulations do not include any such regulation and, as currently drafted, an entity that is both a noticing entity and a health care entity would need to file two separate notices regarding their involvement in the same transaction.

Proposal: We request that OHCA include a provision in the Proposed Regulations that eliminates duplicative reporting obligations in cases where a noticing entity or health care entity is required to submit notice to OHCA for the same transaction.

Involvement of a Real Estate Investment Trust (REIT) and CMIR

Section 97441 (a)(1)(G) authorizes the OHCA decision to conduct a CMIR based on a real estate investment trust (REIT) is involved in the transaction. In contrast to the other subsections in (a)(1), which are based on OHCA demonstrating potential reduction in access to care or potential weakened financial status, (G) suggests that the involvement of a REIT, and associated transaction terms could be a sufficient basis to trigger a CMIR. While a transaction's likelihood of impacting a health entity's financial stability or access to care may be of concern to OHCA, those transactions would already be captured in transactions captured by (a)(1)(A):

(1) The Office shall base its decision whether to conduct a CMIR on any of the following factors:

(A) The transaction may result in a negative impact on the availability or accessibility of health care services, including a health care entity's ability to offer culturally competent care.

CAHF requests that OHCA provide further information and clarification that demonstrates why a REIT's involvement in a transaction should create an independent basis for OHCA to conduct a CMIR.

CAHF welcomes further discussion on these matters with the Department as the amended regulations are developed. For additional questions, please contact Yvonne Choong at ychoong@cahf.org.

Sincerely,

Yvonne Choong
Vice President, Policy
California Association of Health Facilities

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June 11, 2026

Sent via email:
CMIR@HCAI.CA.GOV

Megan Brubaker
Department of Health Care Access and Information
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833

Re: Proposed Revisions to Cost and Market Impact Review (CMIR) Regulations (Material Change Transactions and Pre-Transaction Review, Article 1 of Chapter 11.5 of Division 7 of Title 22, California Code of Regulations)

Dear Ms. Brubaker:

The California Association of Health Plans ("CAHP") represents 42 public and private health care service plans ("plans") that collectively provide coverage to over 28 million Californians.

Thank you for the opportunity to provide comments on the Office of Health Care Affordability's ("OHCA") proposed revisions to the Cost and Market Impact Review (CMIR) regulations to implement AB 1415. CAHP and its member plans appreciate OHCA's continued engagement with stakeholders as it refines the CMIR framework.

While we recognize the Legislature's intent to increase oversight of transactions involving private equity and other investment entities, we are concerned that several aspects of the proposed regulations exceed the scope of the statute, create ambiguity regarding filing obligations, and impose significant and potentially duplicative administrative burdens without clear connection to OHCA's statutory review factors. We offer the following comments for OHCA's consideration. Further, we encourage OHCA to revise the proposal and provide an additional opportunity for stakeholder input prior to finalizing the regulations, particularly given the scope and complexity of the proposed changes.

1. Definitions and Scope: Overly Broad MSO Definition

CAHP is concerned that the proposed definition of "Management services organization" ("MSO") extends beyond the scope contemplated by AB 1415. As drafted, the definition captures a broad range of entities and relationships that are not clearly tied to the legislation's focus on private equity and hedge fund involvement.

In addition, the proposed MSO definition may inadvertently capture entities based on affiliations that are not directly relevant to the purposes of AB 1415 or to the provision of health care services in California, and the definition is not clearly tied to the statute's focus on private equity-backed transactions.

These concerns are not intended to suggest that MSO transactions should be excluded from review, but rather that the definition should be appropriately tailored to capture arrangements that involve meaningful control or influence over California health care delivery and are consistent with the statute's focus.

We recommend OHCA narrow the MSO definition as follows to align with the statutory focus on private equity and hedge fund involvement, and ensure that entities captured by the definition are directly connected to California health care operations:

> (k) "Management services organization" shall mean entities, as described in section 127500.2(o) of the Code that are additionally at least one of the following:
>
> (1) Owned by a hospital and have two or more physician organizations as clients or affiliates;
>
> (2) Employ the physician-owner of, or otherwise have an agreement with the physician-owner that defines the services to be provided and compensation for such services with, one or more ~~physician~~ Physician organizations; or
>
> (3) Share directors, officers, investors, or other natural persons with the ability to exercise control with respect to a ~~health care entity~~Physician organization.~~; or~~
>
> ~~(4) Affiliated with at least two of the following:~~
>
> ~~(A) A health plan;~~
>
> ~~(B) Two or more physician organizations; or~~
>
> ~~(C) A hospital.~~

2. Lack of a Clear and Consistent California Nexus

The proposed regulations do not consistently incorporate a meaningful California nexus across definitions and filing triggers. For example, certain definitions (e.g., physician organizations) and triggering circumstances do not clearly require that an entity operate in California and that a transaction have a direct and material impact on California markets.

Absent such limitations, the regulations risk capturing extraterritorial activity unrelated to California health care delivery. OHCA should revise the regulations to ensure that reporting obligations are limited to entities that do business in California, and transactions that have a direct and material impact on cost, quality, or access to care in California.

3. Expansion of CMIR Beyond Market Impact Review into Oversight of Capital Structures

CAHP is concerned that the proposed regulations move beyond evaluating impacts on cost, quality, and access, and instead extend into oversight of upstream ownership, financing arrangements, and corporate structures.

The breadth of required disclosures—particularly those related to investor ownership and affiliated governance structures—may capture entities already subject to comprehensive oversight by other regulators, including DMHC, CDI, and the Attorney General.

We recommend OHCA more clearly align required disclosures with the statutory CMIR factors and avoid duplicative oversight of corporate structure and financing arrangements that are not directly tied to the transaction's impact on California health care markets.

4. Ambiguity Regarding "Noticing Entities" and Filing Obligations
The proposed rules would benefit from greater clarity regarding which entities are required to file and under what circumstances. As drafted, the interaction between definitions and filing triggers creates ambiguity that may lead to over-filing and inconsistent interpretation.

OHCA should clarify that "Noticing entities" are subject only to the criteria explicitly set forth in statute, and that MSO filing obligations are limited to the specific circumstances enumerated in the regulations, unless independently triggered by a qualifying transaction.

5. Filing Thresholds for Private Equity and Hedge Fund Transactions
CAHP is concerned that the proposed 5 percent threshold for private equity and hedge fund involvement is too low and may capture transactions that do not reflect meaningful ownership or control.

Additionally, the inclusion of language aggregating collective investments could further expand the scope of reporting in ways that are not aligned with actual control or influence. OHCA should consider increasing the ownership or control threshold (e.g., to 40 percent) and remove or revise the collective investment provisions to ensure the trigger reflects meaningful influence or control.

6. Scope of Disclosure Requirements and Administrative Burden
The proposed regulations significantly expand required disclosures regarding organizational structure, governance, and financial arrangements. These requirements are likely to impose substantial administrative burden, particularly on integrated delivery systems and other entities already subject to extensive regulatory reporting.

To streamline the process and reduce administrative burden, we recommend OHCA narrow the disclosure requirements to those necessary to evaluate CMIR statutory factors, avoid duplicative reporting requirements across state agencies, and tailor requirements to entities of concern (e.g., private equity–backed transactions).

7. Practical Impacts on Operations and Cost of Care
As currently drafted, the proposed regulations may disrupt routine operations and increase compliance complexity, even for transactions occurring in the ordinary course of business. These increased administrative costs are likely to ultimately be borne by consumers without a corresponding benefit to cost containment, quality, or access.

Conclusion
CAHP supports OHCA's efforts to implement AB 1415 and enhance oversight of transactions that meaningfully impact California's health care market. However, as currently drafted, the proposed regulations extend beyond statutory intent, introduce ambiguity, and impose significant administrative burden.

We respectfully urge OHCA to refine the proposal to better align with legislative intent, ensure a clear California nexus, and focus on transactions that demonstrably impact cost, quality, and access to care in California.

Thank you for your consideration. We welcome continued dialogue with OHCA as these regulations are further developed.

Sincerely,

Anete Millers
Vice President of Legal and Regulatory Affairs
California Association of Health Plans

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INSTITUTES
Global Health Institute

June 11, 2026

Elizabeth Landsberg
Director, Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 1016
Sacramento, CA 95833

Submitted via email to CMIR@hcai.ca.gov

Re: Comments on Proposed Revisions to Cost and Impact Review (CMIR) Regulations to Implement AB 1415

Dear Director Landsberg:

University of California Health (UC Health) appreciates the opportunity to provide comments on the Office of Health Care Affordability's (OHCA) proposed revisions to the Health Care Market Oversight regulations implementing Assembly Bill 1415 (Chapter 641, Statutes of 2025).

UC Health supports OHCA's efforts to implement AB 1415 in a manner that promotes transparency while preserving efficient review of health care transactions and minimizing unnecessary burdens on health care entities. UC Health respectfully requests clarification and revision of several provisions in the proposed regulations to ensure that the regulations remain consistent with statutory authority, protect confidential and privileged information, avoid unnecessary delays in transaction review, and ensure entities are not subject to duplicative reporting requirements.

I. Clarify the Scope of the Management Services Organization Definition

While UC Health appreciates OHCA's efforts to provide greater clarity regarding entities that may be subject to reporting requirements, we are concerned that the proposed definition may unintentionally encompass integrated health system structures, including internal shared services organizations and affiliated entities that support care delivery within a health system. These entities are fundamentally distinct from third-party MSOs that the Legislature sought to address, as they do not introduce the same risks related to external investment or control over clinical operations. Without clearer limitations, the proposed definition risks subjecting routine internal operations (e.g., system-wide revenue cycle management, payor contracting support, and administrative consolidation) to regulatory requirements intended for fundamentally different business models.

To address these concerns, UC Health recommends that OHCA:

- Clarify that an entity must provide **both** management and administrative services to qualify as an MSO, and that entities providing administrative or ministerial functions, such as revenue cycle software, back-office support, or similar operational services, are not MSOs solely by virtue of providing those services.

- In addition, consistent with the thresholds for health care entities in section 97435(b)(1)-(3) (Who must file), revise 97435(b)(4)(A) and (B) so that the filing requirement only applies to a management services organization with annual revenue of at least $25 million or that owns or controls California assets of at least $25 million, with annual revenue defined as revenue derived from the provision of management and administrative support services.
  - Or in the alternative, clarify proposed section 97431(k) to state that an "management services organization" is an entity that is primarily engaged in the business of providing management and administrative support services.
- The following entities should not be considered MSOs:
  - a clinically integrated network (CIN) supporting contracting, revenue cycle management, or care coordination among participant groups; and
  - a medical foundation offering supporting contracting, revenue cycle management, or other administrative services to its contracting physician groups.
- Clarify that entities providing services exclusively to organizations that control, are controlled by, or are under common control with the service provider are not considered MSOs for purposes of the regulations.
- Delete reference to "affiliates" in proposed section 97431(k)(1) and delete section 97431(k)(4). Corporate structure and affiliations (i.e., which entity an MSO is affiliated with) should not be dispositive of whether an entity is an MSO for purposes of the regulations, as such corporate relationship or affiliation alone does not impact the provision of management services that meaningfully impact clinical operations.
- Clarify that the threshold for "shar[ing] directors, officers, investors, or other natural persons with the ability to exercise control with respect to a health care entity" under proposed section 97431(k)(3) means a majority or more. If there is just one individual director that overlaps between a health care entity and an MSO, that alone should not raise "control" issues that the office is concerned with.

These clarifications would better align the regulations with the Legislature's intent and provide regulated entities with greater certainty regarding reporting obligations.

II. Protect Attorney-Client Privileged and Attorney Work Product Materials

The proposed amendments to section 97438 significantly expand the categories of documents that must be submitted with a notice of material change transaction. Certain categories of requested documents may include attorney-client privileged communications, attorney work product, or other legally protected materials.

For example, valuation analyses, appraisals, transaction assessments, legal memoranda, and materials prepared for governing bodies frequently contain privileged legal advice or attorney work product. Requiring submission of such materials could create uncertainty regarding privilege protections and may discourage candid legal review during transaction planning.

UC Health respectfully requests that OHCA expressly state that:

- Submitters are not required to provide attorney-client privileged communications or attorney work product;
- Submitters may provide redacted versions of responsive documents when necessary to protect privileged information; and
- Submission of nonprivileged portions of responsive documents will satisfy the requirements of the regulations.

Such clarification would protect established legal privileges while ensuring that OHCA receives the substantive information necessary to conduct its review.

III. Eliminate Tolling Based on Requests to Third Parties

UC Health is concerned by proposed revisions to section 97440 that would permit OHCA to toll statutory review timelines while awaiting information from third parties that are not participants in, or are subject to, the transaction. Unlike parties to a transaction, third parties are outside the control of submitters. As a result, third party delays in responding to OHCA requests could significantly extend review periods and create uncertainty regarding transaction timing, financing, regulatory approvals, and operational planning.

UC Health respectfully requests that OHCA eliminate tolling based on requests directed to third parties. These modifications would better align the regulations with the statutory review framework and ensure that transaction participants are not adversely affected by circumstances beyond their control.

IV. Strengthen Confidentiality Protections

UC Health appreciates OHCA's efforts to protect confidential business information submitted during the review process. However, several aspects of proposed section 97437 warrant further clarification.

First, section 97437 permits disclosure of confidential materials to the Attorney General. If OHCA retains this provision, UC Health recommends adding corresponding language requiring the Attorney General to maintain the confidentiality of such materials to the same extent as OHCA.

Second, the categories of documents deemed confidential should be expanded to include transaction documents comparable to those already identified in the regulations. For example, confidentiality protections should extend to definitive agreements, letters of intent, term sheets, leaseback agreements, and other transaction documents submitted pursuant to section 97438(c).

These changes would better protect sensitive commercial information while preserving OHCA's ability to conduct meaningful oversight.

V. Avoid Duplicative Reporting Requirements

Towards the end of the legislative process, AB 1415 was amended to require OHCA to adopt regulations to eliminate duplicative reporting if a noticing entity or health care entity is required to submit notice to the office under more than one paragraph of Health and Safety Code Section 127507(c). While UC Health appreciates proposed sections 97438(b) (allowing a submitter to cross reference information provided by another entity) and 97438(c) (allowing a submitter to cross reference documents submitted by it or another entity), , the possibility of an entity having to file both as a health care entity and a noticing entity (or as two types of noticing entities) remains.

Accordingly, UC Health respectfully requests that OHCA add a provision that expressly states that if an entity is both a health care entity and a noticing entity for a transaction (or qualifies as two different types of noticing entities), the entity will be required to file only one notice.

VI. Conclusion

UC Health appreciates OHCA's willingness to engage stakeholders during implementation of AB 1415. The recommendations outlined above would improve clarity, reduce uncertainty, protect privileged and confidential information, and ensure efficient administration of the CMIR program.

Thank you for your consideration of these comments. We would welcome the opportunity to discuss these issues further with OHCA staff.

Sincerely,

Tam Ma
Associate Vice President
Health Policy and Regulatory Affairs

cc: Members of the Health Care Affordability Board:
Kim Johnson
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, PhD
Dr. Richard Pan

June 11, 2026

Megan Brubaker
Department of Health Care Access and Information
Office of Health Care Affordability
2020 W. El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments on Proposed Revisions to Material Change Transactions and Pre-Transaction Review Regulations to Implement Assembly Bill 1415**

Dear Ms. Brubaker:

The California Hospital Association (CHA), on behalf of nearly 400 hospital and health system members, thanks the Office of Health Care Affordability (OHCA) for the opportunity to comment on proposed changes to the Cost and Market Impact Review (CMIR) regulations, intended to implement Assembly Bill (AB) 1415 (Statutes of 2025). Hospitals appreciate OHCA's commitment to a public process by providing advance notice and consideration of stakeholder feedback. **However, hospitals have significant substantive concerns about the regulations and request various changes to align the proposed rules with the letter and intent of AB 1415, prevent standard and beneficial business practices from being upended, and protect access to care in an increasingly unstable environment.**

The proposed expansion of OHCA's market oversight authority comes as patient care in California is under threat. The One Big Beautiful Bill Act (OBBBA) enacted the deepest Medi-Cal coverage and payment cuts in the program's history. Even before these cuts are felt, nearly half of hospitals are operating at a loss — and the 40 hospitals with the worst financial performance had average operating margins of **negative 39%** in 2024. In "The Big Ugly Threat to Safety Net Hospitals," Public Citizen found that 83 California hospitals are at heightened risk of closing, cutting services, or laying off staff.

Collaboration — whether through wholesale purchases and affiliations, timely investments, or obtaining outside help with daily operations — is a critical lifeline for hospitals in financial distress. Unfortunately, the proposed regulations would substantially narrow these pathways to financial recovery and undermine access to care in communities throughout California.

To ensure the proposed regulations not only align with statutory authority, but also prevent avoidable and widespread negative impacts on California's health care providers and their patients, hospitals ask that OHCA revise its regulations to:

- Not include entities that "own, operate or control a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license" in the definition of **"health care entities"** because there is no statutory authority in AB 1415 or elsewhere to define these entities as such. Rather, the Legislature has clearly deemed such entities to be **"noticing entities"** that are subject to the noticing entity requirements.
- Categorically exclude from the definition of a "management services organization" (MSO) all entities that own, control, are controlled by, or are under common control with one or more hospitals, to align with statutory authority.
- Revise Section 97435(c)(10) to align with the existing established criteria for health care entity transactions that involve a transfer of control, responsibility, or governance of a health care entity in Section 97435(e). Section 97435(c)(10), which defines certain MSO transactions as material change transactions, is too broad and will substantially delay or stymie even ordinary course MSO arrangements that do not have any material impact on the control, operations, or governance of MSOs or health care entities.
- Revise Section 97435(c)(9) to only capture transactions involving hedge funds and private equity that could actually result in a change of control, responsibility, or governance of a health care entity or MSO by making use of the established criteria for health care entity transactions that involve a transfer of control, responsibility, or governance of a health care entity in Section 97435(e). Section 97435(c)(9), which defines certain private equity group or hedge fund transactions as material change transactions, is too broad and will likely chill or delay the ability of distressed hospitals and other health care entities to find necessary capital, regardless of whether or not the private equity group or hedge fund retains any actual authority or control over the operations or assets of the health care entity or MSO.
- Expand the "usual course" and "common control" exceptions to also apply to noticing entity transactions. OHCA has previously stated that these types of transactions are not material in nature.
- Delete Section 97435(c)(11) covering real estate leasebacks in its entirety. This provision is too broad and captures common and de minimis arrangements. The other circumstances listed in Section 97435(c) that require filing would cover any arrangements that rise to material level of concern.
- Expand confidentiality protections to: (1) include additional transaction documents containing sensitive information, (2) deem sensitive information otherwise provided to OHCA as confidential, and (3) extend non-disclosure requirements to confidential information shared with the Attorney General.
- Expressly eliminate duplicative reporting obligations in the proposed regulations as required by AB 1415.

More details about each recommendation are provided below. CHA would also welcome the opportunity to discuss these matters further with OHCA.

An Entity That Owns, Operates, or Controls a Provider May Not Be Defined as a "Health Care Entity"

AB 1415 introduced (1) a separate "noticing entity" category, as defined in Health & Safety Code § 127507(h), that includes "an entity that owns, operates, or controls a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license" and (2) separately defines the types of material transactions for which a "noticing entity" must provide notice. Importantly, AB 1415 did not revise or otherwise alter the existing statutory definition of "health care entity" found at Health & Safety Code § 127500.2(k) — which does not include an "entity that owns, operates, or controls a provider."

By contrast, the proposed regulations treat entities that own, operate, or control a provider as both a "noticing entity" and a "health care entity" pursuant to the revised definition of "health care entity" found at Section 97431(g) of the proposed regulations. This would subject such entities to health care entity filing requirements. Including such entities within the definition of "health care entity" clearly exceeds statutory authority, eliminates the clear statutory distinction between health care entities and noticing entities, and improperly imposes all the thresholds and filing duties of a "health care entity" on entities that own, operate, or control a provider. Accordingly, in this regard, the proposed regulations frustrate clear statutory intent to separately address the notice obligations of such entities through the "noticing entity" requirements, rather than through the "health care entity" notice obligations.

Proposed Resolution

OHCA should align the proposed regulations with AB 1415 by deleting Section 97431(g)(4) so that "an entity that owns, operates, or controls a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license" is not considered a "health care entity."

Categorically Exclude from the MSO Definition All Entities That Own One or More Hospitals

The proposed regulations define an MSO in Section 97431(k) to refer to "entities, as described in [Health & Safety Code § 127500.2(o)] that are additionally at least one of the following:

(1) Owned by a **hospital** (emphasis added) and have two or more physician organizations as clients or affiliates;
(2) Employ the physician-owner of, or otherwise have an agreement with the physician-owner that defines the services to be provided and compensation for such services with, one or more physician organizations;
(3) Share directors, officers, investors, or other natural persons with the ability to exercise control with respect to a health care entity; or
(4) Affiliated with at least two of the following:
    (A) A health plan;
    (B) Two or more physician organizations; or
    (C) A **hospital**." (emphasis added)

By contrast, Health & Safety Code § 127500.2(o) clearly states that an MSO "does not include entities that own one or more health facilities, as defined in subdivision (a) or (b) of Section 1250" (referring to entities that own one or more general acute care hospitals or psychiatric hospitals).

CHA appreciates OHCA's efforts to narrow the types of entities that may qualify as an MSO under the proposed regulations by limiting MSOs to only those entities that meet certain additional criteria. However, the proposed regulations' MSO definition exceeds statutory authority by including MSOs that are owned by a hospital, something clearly excluded under Health & Safety Code § 127500.2(o).

Additionally, in nearly all cases, an entity that owns a hospital will also share directors, officers, investors, or other natural persons that have the ability to exercise control with respect to a health care entity, since a general acute care or psychiatric hospital is itself a type of health care entity. This means that **any** entity that both (1) owns a general acute care or psychiatric hospital, and (2) provides certain management and administrative support services to the hospital or other providers — an almost universal occurrence — will be swept up in the proposed regulations' definition of an MSO. This is exactly why the Legislature revised prior drafts of AB 1415 that referenced "health systems" to remove all such references, and instead elected to expressly state in the final AB 1415 language that MSOs do not include entities that own one or more general acute care hospitals or psychiatric hospitals.

Proposed Resolution

The definition of MSO found in Section 97431(k) of the proposed regulations should be revised to clearly exclude any entity that owns, controls, is controlled by, or is under common control with one or more health facilities, as defined in subdivision (a) or (b) of Health & Safety Code § 1250, regardless of whether it meets one or more of the criteria set forth in Section 97431(k)(1) through (4).

Criteria for Transactions Involving MSOs Have No Materiality Thresholds and Will Adversely Impact the Ability of MSOs and Health Care Entities to Enter into Ordinary Arrangements

Section 97435(c)(10) in the proposed regulations defines a "material change transaction" subject to notice to include transactions involving an MSO that does one of the following:

(A) Results in an MSO providing management and administrative support services for a health care entity satisfying Section 97435(b)(1);

(B) Result in an MSO providing management and administrative support services for two or more providers that collectively generate $10 million annually from California patients; or

(C) Involves a transfer of control, responsibility or governance, in whole or in part, of the MSO, as defined in Section 97435(e), or a change in 25% or more of the MSO's ownership.

This material change circumstance is too broad and, as drafted, would subject ordinary course management and administrative support transactions to the notice obligations, regardless of whether the transactions involve any transfer of the assets or operations of a health care entity or MSO. Notably, Section 97435(c)(10)(A) and (B) do not include any limiting threshold. That is, **any** transaction involving **any** MSO that results in the MSO providing management and administrative support services to a qualifying health care entity, or two or more qualifying health care providers, would be subject to OHCA's notice obligations, regardless of whether the transaction gives the MSO any control over the health care entity's or providers' assets, operations, or governance. As written, the proposed regulations would increase costs and substantially

delay the ability of MSOs and qualifying health care entities to enter into the most ordinary course management and administrative support service arrangements, including for minor transactions and the provision of limited administrative support activities that have no material market impacts. Providers not seeking a change in ownership but who need help with administrative and management functions would effectively lose their ability to expeditiously and reliably contract for these services, making them more likely to close outright while nullifying opportunities to improve administrative efficiencies. For these reasons, significant changes are needed.

Proposed Resolution

Section 97435(c)(10) should be revised to capture only those transactions that could actually result in a change of control, responsibility, or governance of a health care entity or MSO. Specifically, OHCA should delete Sections 97435(c)(10)(A) and (B) in their entirety, and Section 97435(c)(10)(C) should be revised to apply to transfers of control, responsibility, or governance of an MSO or health care entity, making use of OHCA's existing materiality standard.

Provisions Delineating "Material" Transactions Involving a Private Equity Group or Hedge Fund Would Chill Distressed Health Care Entities' Ability to Raise Capital

AB 1415 requires that a noticing entity notify OHCA of certain transactions that do either of the following: (1) sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a **material amount** of the health care entity's or MSO's assets to one or more entities; or (2) transfer control, responsibility, or governance of a **material amount** of the assets or operations of the health care entity or MSO to one or more entities [Health & Safety Code § 127507(c)(2)]. This noticing obligation is nearly identical to the existing noticing obligations of health care entities. Yet, the proposed regulations define a "material change transaction" so broadly as to sweep up ordinary course and passive investment transactions that do not involve a material amount of the assets or operations of the health care entity or MSO.

First, Section 97435(c)(9)(A) defines a "material change transaction" to include a transaction involving a private equity group or hedge fund that "results in the private equity group or hedge fund holding 5% or more of the assets, equity, debt, or liabilities of a health care entity satisfying [Section 97435(b)(1), (2), or (3)] or a management services organization[,]" including "groups of investors, private equity firms, or hedge funds investing collectively hold 5% of the assets or equity of the health care entity[.]" The 5% threshold is substantially lower than the standard applicable to health care entities in the existing regulations, where a change of control, responsibility, or governance of a health care entity is defined in reference to a transfer of 25% or more of the voting power of the members of the governing body of a health care entity. This means that under the proposed regulations, a noticed transaction would include passive investment transactions that do not impact or alter the control of a health care entity or MSO.

Second, Section 97435(c)(9)(B) is ostensibly an even broader circumstance than the 5% threshold in Section 97435(c)(9)(A), which renders Section 97435(c)(9)(A) superfluous. Notably, Section 97435(c)(9)(B) pertains to transactions involving a private equity group or hedge fund that "results in the acquisition of assets, equity, debts, or liabilities of a health care entity satisfying [Section 97435(b)(1), (2), or (3)] or a management services organization," but without any minimum materiality threshold. Section 97435(c)(9)(B) also includes a list of

eight control indicia, but notably, these indicia are introduced by the clause “including, but not limited to” suggesting the listed indicia are merely illustrative, rather than limited. A literal interpretation means that **any** transaction wherein a private equity group or hedge fund acquires **any** assets, equity, debts or liabilities of a qualifying health care entity or MSO could constitute a material change transaction.

Even if Section 97435(c)(9)(B) were limited to those transactions that meet one or more of the listed eight control indicia, certain of the listed control indicia still cast too wide of a net and would sweep in common and ordinary course arrangements that have no impact on the ownership or control of a health care entity or MSO. For example, the control indicia would capture even routine transactions resulting in the charging of a nominal fee to the health care entity or MSO, regardless of whether the private equity group or hedge fund retains any actual authority or control over the operations or assets of the health care entity or MSO.

Amid unprecedented funding cuts at the federal and state level, health care entities need flexibility to move quickly and secure financing in order to keep their doors open and ensure patients in their community continue to have access to quality care. The proposed regulations would make it much more difficult and costly for distressed hospitals and other health care entities to raise much-needed capital, and could further turn investors away from the California health care market altogether. OHCA must balance its interest in reviewing an expanded set of transactions with the imperative to sustain access, for which investment is critically needed. To do this, it must focus only on those transactions that actually change the control of health care entities or MSOs.

Proposed Resolution

Section 97435(c)(9) should be revised to capture only those transactions that could actually result in a change of control, responsibility, or governance of a health care entity or MSO. OHCA has already established criteria for health care entity transactions that involve a transfer of control, responsibility, or governance of a health care entity in Section 97435(e).

As OHCA previously noted in its Findings of Emergency and Notice of Proposed Emergency Regulations, dated November 2023 (the “**Emergency Findings**”), it previously drafted Section 97435(e) to establish the “tipping point” for materiality as to when a transfer of control could affect affordability, access, and equity. Notably, OHCA comments in the Emergency Findings that it originally contemplated establishing a 10% threshold for transfer of voting power that constitutes a material transfer of control pursuant to Section 97435(e)(1), but decided on the existing 25% threshold as the appropriate tipping point for materiality. OHCA noted that it further adopted Section 97435(e)(2), categorizing transfers of supermajority rights, veto rights, and similar provisions based on the Attorney General regulations found in 11 Cal. Code Regs. § 999.5. Accordingly, OHCA has already determined that Section 97435(e) appropriately identifies the threshold in which a transaction becomes sufficiently material to constitute a transfer of control that could affect affordability, access, and equity and which warrants further scrutiny. OHCA should, therefore, revise Section 97435(c)(9) to align with the same criteria set forth in Section 97435(e).

Extend to Noticing Entities the Exception for Transactions in the Usual and Regular Course of Business and Common Control

In OHCA's Emergency Findings for its initial regulations, it stated that exceptions are "necessary to define those transactions that require the filing of a notice," in reference to the statutory requirement for OHCA to focus on only those transactions that involve a **material amount** of the assets or operations of a health care entity. OHCA stated:

*"The Office also enumerates transactions that are **not material**, such as those in the day-to-day, usual and regular course of business, and situations that amount to internal adjustments or restructurings . . . [t]his is necessary to minimize the Office's burden from receiving notices of transactions that would not typically trigger health care consolidation concerns."* (emphasis added)

However, OHCA did not revise the "ordinary course" and "common control" exceptions to the definition of a material change transaction found in its existing regulations to also apply to noticing entities. Specifically, Section 97431(l) of the proposed regulations state that a "material change transaction" does not include: "(1) transactions in the usual and regular course of business of the **health care entity**, meaning those that are typical in the day-to-day operations of the health care entity; and (2) situations in which the **health care entity** directly, or indirectly through one or more intermediaries, already controls, is controlled by, or is under common control with, all parties to the transaction, such as a corporate restructuring" (emphasis added).

Although AB 1415 includes the same operative language — for OHCA to receive notice of noticing entity transactions that involve a **material amount** of the assets or operations of a health care entity or MSO — the proposed regulations fail to extend these same exceptions to MSO transactions that are either in the usual and regular course of business or that pertain only to internal adjustments or restructurings. The same logic enumerated in OHCA's prior Emergency Findings should be applied to ordinary course transactions and internal restructurings of MSOs.

Moreover, as noted previously, given the broad MSO definition and the extent to which Section 97435(c)(10) would seemingly capture any management and administrative support arrangement between the MSO and a qualifying health care entity, extending these exceptions to MSO transactions is necessary to focus resources and attention on transactions that are most likely to have a material impact, and to reduce the burden on health care entities and MSOs to notify OHCA of transactions that are not material.

Proposed Resolution

OHCA should revise Section 97431(l) of the proposed regulations to exempt from the notice obligations transactions that are in the MSO's usual and regular course of business, as well as transactions where the MSO directly or indirectly through one or more intermediaries, already controls, is controlled by, or is under common control with, all parties to the transaction.

Provisions Covering Real Estate Sale-Leaseback Arrangements Are Too Broad

The proposed regulations include a "material change transaction" circumstance targeted at real estate transactions for the first time. Section 97435(c)(11) proposes to define a "material change transaction" to

include transactions that result in the sale or transfer of real estate where a health care entity provides health care services: (A) to an entity other than the entity acquiring the health care entity or its direct parent; and (B) the surviving health care entity will be required to lease or pay rent for the real estate.

While hospitals appreciate that OHCA acknowledges that transactions where the health care entity or its direct parent acquires the real estate do not warrant scrutiny, Section 97435(c)(11) as proposed by OHCA still captures usual, customary, inappreciable transactions that should not raise concerns. This shortcoming stems from the lack of a materiality threshold for transactions that include leasebacks. As a consequence, under the proposed regulations, notice would have to be provided and OHCA would have to review all such transactions that have a qualified submitter, no matter how small the agreement is or whether it would impact the market. For example, health care entities routinely sign professional services agreements with small physician groups — often with only a couple of physicians — and offer to take over the group's lease. Often, this occurs as the physicians near retirement, and allows the health care entity to maintain services at the same location when otherwise the office would close. Going forward, such agreements, which protect access to care, would cease to exist if subject to CMIR requirements.

Proposed Resolution

Delete Section 97435(c)(11) in its entirety. The other circumstances requiring filing specified in Section 97435(c) would adequately cover leaseback arrangements that would have an appreciable impact on the health care market.

Certain Confidentiality Provisions Reflect an Improvement, but Changes to Protect Sensitive Information Are Needed

Confidentiality protections are essential to protect competitively sensitive information from being released into the public domain, which could not only sink a proposed transaction, but also increase health care costs to the extent third parties find that they are being paid comparatively less. The proposed regulations make various changes to the rules and process governing the confidentiality of information provided to OHCA. For example, the updated rules deem certain documents confidential, including stock purchase agreements, compensation documents, contract rates, transaction valuation documentation, and unredacted résumés. This change is appropriate given the competitively sensitive nature of the information contained in these documents, but does not extend to all the documents containing sensitive information required to be submitted under Section 97438(c).

While the documents listed above would be deemed confidential, the related information otherwise provided to OHCA would have to be determined confidential on a case-by-case basis — adding unnecessary uncertainty and workload to the review process.

Finally, the regulations permit disclosure of confidential information to the Attorney General. However, there are no protections ensuring that the Attorney General keep this same information confidential.

Proposed Resolution

To comprehensively protect documents that by nature contain confidential information, OHCA should deem confidential all the documents submitted pursuant to Section 97438(c). OHCA should further specify that competitively sensitive information otherwise submitted, including but not limited to the price of the transaction, stock valuations, compensation amounts, contracted rates, and detailed resume information, shall be deemed confidential. OHCA should also add a provision to limit disclosure by the Attorney General of any confidential information shared, whether through an interagency agreement or other means.

Tolling Based on Third-Party Information Requests Would Create Unwarranted Uncertainty and Delays

OHCA proposes changes to Section 97440 to allow OHCA's review timelines to be tolled while awaiting information from third parties that are not participants in the transaction under review. Third parties are entirely outside the control of the submitter. Submitters cannot compel a third party to respond to OHCA's requests, cannot accelerate the pace of a third party's production of information, and cannot anticipate how long a third-party review may take. Allowing open-ended tolling based on third-party information requests would expose compliant submitters to indefinite extensions of the review period through no fault of their own, creating profound uncertainty regarding transaction timing, operational planning, financing, and regulatory approvals from other agencies.

For hospitals and health systems already operating in financial distress — the very entities most likely to be engaged in time-sensitive transactions necessary to preserve access to care — this uncertainty is not merely an inconvenience. An indeterminate review timeline would cause financing to fall through, require renegotiation of transaction terms, or cause a potential partner to walk away entirely. The practical effect could be to make beneficial transactions impossible to complete, threatening patient access to care in vulnerable communities.

Proposed Resolution

OHCA should revise Section 97440 to eliminate tolling of the 45-day and 60-day review periods based on information requests directed to third parties. Tolling should be limited to periods during which OHCA is awaiting information or documents from the submitter itself, or during periods of parallel review by another state or federal agency whose findings may directly affect OHCA's determination.

Proposed Regulations Fail to Eliminate Duplicative Reporting Obligations, as Required by AB 1415

AB 1415 requires OHCA to adopt regulations to eliminate duplicative reporting if a noticing entity or health care entity is required to submit notice under more than one subdivision [*see* Health & Safety Code § 127507(c)(2)(C)]. However, the proposed regulations fail to include any such regulation and, as currently drafted, an entity that is both a noticing entity and a health care entity would need to file two separate notices pertaining to their involvement in the same transaction.

The information and documentation required to be included as part of the notices to OHCA are extensive, particularly under the proposed regulations. There is no question that the process of an entity completing the analysis as to whether it needs to file a notice or submission, and then compiling all required information and documentation for such notice, is time-consuming, costly, and burdensome.

Proposed Resolution

OHCA should expressly include a provision in the proposed regulations that eliminates duplicative reporting obligations in cases where a noticing entity or health care entity is required to submit notice to OHCA under more than one subdivision, as required by AB 1415.

Conclusion

CHA has significant concerns with the proposed regulations as currently drafted, and urges OHCA to incorporate these requested revisions in final regulations. Hospitals appreciate the opportunity to comment on these important regulations and would welcome further discussion.

Sincerely,

Lois J Richardson

Lois Richardson
Vice President, Legal Counsel

cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

June 11, 2026

Megan Brubaker
Department of Health Care Access and Information
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833

CMIR@HCAI.CA.GOV

Subject: **Comments on Proposed Revisions to Cost and Market Impact Review (CMIR) Regulations Implementing AB 1415**

Dear Ms. Brubaker,

Kaiser Permanente (KP) appreciates the opportunity to comment on the Office of Health Care Affordability's (OHCA) proposed revisions to the Cost and Market Impact Review (CMIR) regulations implementing AB 1415. We support OHCA's goal of promoting health care affordability, transparency, and accountability in California's health care market.

We support the industry comments submitted to OHCA by the California Association of Health Plans (CAHP). Given the complexity and broad scope of these proposed revisions, KP strongly urges OHCA to further revise the proposed regulations based on CAHP's industry comments and recirculate a new draft for additional stakeholder review. Kaiser Permanente would welcome the opportunity to meet with OHCA to discuss these comments and provide additional context on the practical implications of the proposed regulations.

We would also like to address OHCA's use of the emergency rulemaking process to adopt the proposed CMIR regulations. Emergency rulemaking is intended for situations requiring immediate action to avoid serious harm to the public peace, health, safety, or general welfare, or where the Legislature has expressly deemed the situation an emergency. The proposed CMIR regulations raise complex questions that warrant the full public notice-and-comment process, not an expedited emergency process. We are concerned about the unintended impact of requiring immediate action on such important regulations without adequate stakeholder input.

Sincerely,

Deborah Espinal

Deborah Espinal
Vice President, Enterprise Regulatory Services
Policy and Regulatory Affairs

cc: Members of the Health Care Affordability Board:
- Dr. Sandra Hernández
- Dr. Richard Kronick
- Ian Lewis
- Elizabeth Mitchell
- Donald B. Moulds, PhD
- Dr. Richard Pan

Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

June 11, 2026

Megan Brubaker
Office of Health Care Affordability
Department of Health Care Access and Information
2020 West El Camino, Suite 1200
Sacramento, CA 95833

Sent via email to CMIR@HCAI.CA.GOV

RE: Proposed Emergency Text: Promotion of Competitive Health Care Markets; CMIR Regulations – Draft Revisions 5/15/2026

Dear Ms. Brubaker:

On behalf of the California Medical Association (CMA) and our more than 50,000 physician and medical student members, CMA appreciates the opportunity to comment on the pre-notice draft revisions to the Office of Health Care Affordability's (OHCA) Cost and Market Impact Review (CMIR) regulations implementing AB 1415 (Bonta, 2025). CMA values the Office's continued efforts to refine these regulations. We offer the following comments and recommendations to further revise these regulations before formally noticing the proposed amendments through the emergency rulemaking process.

§97431(g)(4) – Definition of Health Care Entity

The draft revisions, in proposed section 97431(g)(4), seek to expand the definition of health care entity" to include "an entity that owns, operates, or controls a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license." CMA is concerned that this change broadens the definition of "health care entity," and the corresponding scope of the CMIR regulations, in a matter that is inconsistent with the underlying statute and exceeds the Office's statutory authority.

AB 1415 did not expand or otherwise change the statutory definition of "health care entity" or any of its components (payer, provider, or fully integrated delivery system). Instead, the Legislature established a new, separate category of "noticing entities," in Health and Safety Code section (HSC) 127507(h), that are subject to the transaction notice requirements specified in paragraph (c)(2) of that section. These "noticing entities" are a separate statutory concept from "health care entities." Accordingly, the inclusion, in subsection 97431(g)(4), of entities who own, operate, or control a provider is inconsistent with the plain language of the underlying statutes, and improperly conflates these distinct categories. This conflation has the potential to create duplicate reporting requirements for entities, once as a "health care entity," and once as a "noticing entity," contrary to HSC 127507(c)(2)(C), which directs the Office to "adopt regulations to eliminate duplicative reporting if a noticing entity or health care entity is required to submit notice to the office under more than one provision in subdivision (c)."

Additionally, the term "health care entity" is used in contexts other than the CMIR framework, so expanding that definition has consequences that extend beyond transaction notices. These include health care spending targets, Total Health Care Expenditure data submission, and other legal requirements that the Legislature did not impose

on "noticing entities." Redefining entities that own, operate, or control a provider as "health care entities" may, at worst, improperly subject those entities to these other requirements in contravention of the underlying statutes, and at best creates regulatory confusion and inconsistency.

Accordingly, CMA strongly recommends deleting subsection 97431(g)(4) from the definition of "health care entity."

§97431(k) – Definition of Management Services Organization

The draft definition of management services organization (MSO) in subsection 97431(k) includes criteria describing various contractual or organizational relationships with certain health care entities. CMA appreciates the Office's efforts to target MSOs that may be in a position to control or influence the provision and cost of health care services. We are concerned, however, that the definition of MSOs is still overly broad, and would capture a wider range of businesses that provide administrative or consulting services that support a medical practice.

As an example, one of the criteria in paragraph (k)(1) is that the MSO have two or more physician organizations "as clients or affiliates." Any business that meets the statutory definition of MSO in HSC 127500.2(o) ("an entity that provides management and administrative support services for a provider in support of the delivery of health care services, excluding the direct provision of health services") and that is a going concern would have health care entities—most often physician practices—as clients. As such, this criterion does not provide any meaningful limitation.

Similarly, the second criterion in paragraph (k)(2) ("otherwise have an agreement with the physician owner that defines the services to be provided and compensation for such services with, one or more physician organizations") would capture any business entity that provides management and administrative support services to physician groups. These relationships are generally always contractual, and involve an agreement for the MSO to provide specified services in exchange for specified compensation. So this criterion is also not limiting, and would apply to any entity that provides such support services.

During the legislative process, OHCA indicated it did not intend to capture these other consulting or administrative support services, but instead was primarily interested in the businesses that are commonly thought of as MSOs in healthcare. The draft revisions, however, would impose pre-transaction notice filings on businesses and individuals that are not considered to be MSOs, and would capture any organization that is contracted with a physician organization to provide support services, even if they have no control over the practice.

Subjecting sole proprietors or small businesses to the CMIR notice requirements would create a barrier to entry for smaller entities to compete to provide such services to practices, and leave only the larger, well-resourced entities who can absorb the regulatory compliance costs to offer administrative and support services, as well as related consulting services. Implementing a broad definition that would require material change notice filings for a large universe of transactions involving the provision of management and administrative support services will impede access to these services, which could lead to further market consolidation, driving physicians to join larger groups or health systems with the resources to employ in-house staff to cover most of these functions that would be economically unfeasible for smaller practices.

Accordingly, at a minimum, CMA believes paragraphs (k)(1) and (2) should be revised to delete the broad criteria discussed above. Furthermore, paragraph (k)(4) appears to conflict with the second sentence in HSC 127500.2(o),

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which excludes from the definition of MSO any entity that owns one or more health facilities. “Affiliated with” is a broad concept, and could be construed to include an ownership relationship as well as more tenuous contractual relationships.

CMA acknowledges the complexity and challenges of crafting an appropriately targeted definition for implementation, but we believe additional deliberation is needed to implement this definition in the regulations to avoid the unintended consequences of broadening the CMIR rules to entities that are not MSOs by any conventional understanding. We would welcome further collaboration with the Office to assist in those efforts, in order to minimize notices of extraneous transactions to the Office.

§97431(l) – Expansion of Usual and Regular Course of Business Exclusion to MSOs

CMA requests that the existing exclusion for transactions occurring in the usual and regular course of business and transactions, in subsection 97431(l), be revised to include MSOs. These exclusions appropriately recognize that routine business activities generally do not result in changes to the ownership, control, or competitive dynamics of a health care entity that would warrant CMIR review. Applying different standards to routine transactions based solely on whether they involve a health care entity or an MSO would create unnecessary reporting obligations. Extending these existing exclusions to MSO transactions will promote consistency within the regulations and allow OHCA to focus its resources on transactions that present a meaningful potential impact on California's health care market.

§97435(b) – Absence of Entity Thresholds for MSOs

The existing regulations provide two sets of materiality thresholds that must be met for a material change notice to be required for a transaction. Subsection 97435(b) of the existing regulations provide thresholds that must be met by the health care entity that is a party to or a subject of the transaction; subsection (c) of that rule provides thresholds that the transaction must meet. Unless both thresholds are met—at the entity level and at the transaction level—pre-transaction notice is not required. The entity thresholds are designed to avoid imposing notice requirements on entities that are too small to warrant that level of regulatory review.

The draft revisions do not implement any parallel entity thresholds for MSOs, meaning even a very small business or sole proprietor who might fall within the broad definition of MSO, and is involved in a transaction that otherwise meets the transaction thresholds in subsection 97435(c), would be swept into the CMIR notice process, while a health care entity in the same transaction but who falls below the entity asset/revenue thresholds in 97435(b) would not.

CMA recommends establishing appropriate entity-level materiality thresholds for MSOs to ensure very small entities are not subjected to notice requirements.

§97435(c)(9) – Circumstances Requiring Filing for Private Equity and Hedge Funds

CMA requests that subsection 97435(c)(9) be revised to apply only to transactions involving a private equity group or hedge fund that could result in an actual transfer of control, responsibility, or governance of a health care entity or MSO, as defined in 97435(e)—using the CMIR regulations’ existing criteria or transfers of control, responsibility, or governance. As drafted, subsection 97435(c)(9) could require notice for financing or investment transactions in which a private equity group or hedge fund acquires a passive interest that does not impact the control or provide any meaningful authority over the operations, governance, or assets of a health care entity or MSO.

Aligning subsection 97435(c)(9) with the control standards in subsection 97435(e) would provide a consistent framework for determining when a transaction is sufficiently material to warrant review, and would capture only those transactions that involve an actual change of control, responsibility, or governance of a health care entity or MSO.

§97435(c)(10) – Circumstances Requiring Filing for MSOs

Similarly, subsection 97435(c)(10) establishes MSO transaction thresholds that are significantly lower than those adopted for health care entity transactions.

Subsection (c)(10)(A) would make any arrangement between an MSO, as broadly defined, and a large health care entity (those meeting the entity thresholds in 97435(b)(1)), for management and administrative support services a "material change transaction." This could involve an contract between a large health care entity and a medical billing company or a payroll/HR services company. Subsection (c)(10)(B) is similarly broad in application, requiring notice whenever the transaction results in an MSO providing support services for "two or more providers that collectively generate $10 million annually from California patients," regardless of the size of the MSO's role or impact in the providers' operations.

Requiring a material change notice for such transactions would exceed the authority granted by HSC 127507(c)(2)(A), because they do not involve a transfer "of a material amount of the assets," or a "[t]ransfer [of] control, responsibility, or governance of a material amount of the assets or operations," of a health care entity or MSO. Accordingly, CMA recommends deleting subsections 97435(c)(10)(A) and (B).

Subsection 97435(c)(10)(C) provides a separate transfer of control standard for MSOs. As with 97435(c)(9), CMA believes OHCA should use the existing transfer of control standards set forth in 97435(e). Thus, we recommend similarly revising 97435(c)(10)(C) to apply to transfers of control, responsibility, or governance of an MSO or health care entity, as defined in 97435(e).

CMA appreciates OHCA's efforts revising these regulations and the opportunity to provide feedback. We respectfully request that revisions be made before these regulations are submitted to OAL. I can be reached by phone at (916) 551-2548 or by email at sghoddoucy@cmadocs.org should you require additional information regarding our comments.

Sincerely,

Sheirin Ghoddoucy
Sr. Legal Counsel, Director of Legal Advocacy
California Medical Association

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board

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